Metropolitan Health Service

Annual Report 2002/2003

Statement of Compliance

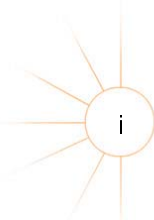
To the Hon Jim McGinty MLA
MINISTER FOR HEALTH

In accordance with Section 62 of the *Financial Administration and Audit Act 1985*, I hereby submit for your information and presentation to Parliament, the Report of the Department of Health, Metropolitan Health Service for the year ended 30 June 2003.

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

Michael Daube
Director General of Health
Accountable Authority for The Minister For Health in his Capacity as the Deemed Board of Metropolitan Public Hospitals

August 2003



The 2002/2003 financial year was both eventful and challenging. What began as a busy year, with the Department in the midst of a major restructure of its operations, quickly became frenetic when several unforeseen events were thrust upon us, including the SARS epidemic and the aftermath of the Bali bombing incident.

It was testimony to the high quality of our staff, systems and infrastructure that the State's health service rose to meet these and many other challenges, and performed so well in the process.

During the year, a major restructure of the entire health system has been successfully completed, which brought together all parts of a previously fragmented system in terms of organisational reporting arrangements. This has resulted in a single health system with a State Health Management Team providing a solid basis for system-wide coordination, reporting and accountability. This has clearly been a time-consuming process, the outcome which ensures that our system is much better placed to address all the challenges that inevitably face health systems.

An important and successful development was the establishment of the WA Country Health Service, which has brought together the regional health services into one unified country system with six new administrative regions. This has led to greater coordination for country services, with the Executive Director also holding a place on the State Health Management Team.

District Health Advisory Councils have been established. Drawn from the community, consumers, agency providers and health services, their members will play a very important role in influencing health policies and developments. These councils will take us into a new era in community participation and ensure that country people are in a better position to influence policy and health developments.

The State's first Clinical Senate was established, with representation from a broad range of health sector professionals – including doctors, nurses and allied health professionals from the public and private sectors, and from metropolitan and rural areas. The Senate will provide advice to the Director General of Health and the State Health Management Team on the coordination and development of clinical planning, clinical and resource decision-making and other relevant clinical issues for health service delivery in Western Australia.

The new Health Reform Committee, which was established in March 2003, has provided the system with a tight focus on improving clinical services and ensuring expenditure growth remains sustainable. The committee has an ongoing role, with its final report due in March 2004.

In acknowledgment of the steady ageing of the Australian population a statewide consultation process was undertaken, drawing on the expertise of key health and aged care stakeholders and the wider community. This culminated in the release of the State Aged Care Plan in March 2003, which provides clear objectives for future services that will be diverse while at the same time sensitive to individual client preferences.

In August 2002 existing arrangements to improve quality care processes and patient outcomes in the WA health system were strengthened by the establishment of the WA Council for Safety and Quality in Health Care. This Council has a leadership and strategic management role in Safety and Quality and focuses on developing strategies and programs to support consumer focussed health care, clinical practice improvement, risk management and system improvement and accountability.

In May 2003 the Council, in conjunction with the Department's Office of Safety and Quality in Health Care finalised the 2003-2008 Strategic Safety and Quality Plan for Western Australia which provides a unified platform for an improved system approach to better meet the care needs of consumers and patients using WA health services.

A capital works program totalling almost $100 million was undertaken, including the provision of new facilities and major equipment upgrades and purchases. These ranged from state-of-the-art CT scanning facilities and a MRI scanner, to a $10.3 million expansion at Osborne Park Hospital.

Several milestones were reached: Royal Perth Hospital's Cardiac Transplant Unit undertook its 50th heart transplant operation and Osborne Park Hospital, which celebrated 40 years of operation, saw the delivery of its 50,000th baby. All health campuses that sought re-accreditation by the Australian Council on Healthcare Standards were successful, with many receiving bonus commendations.

The Centre for Nursing Research – a collaborative project between Sir Charles Gairdner Hospital and Edith Cowan University – was launched and will focus on acute care nursing, aged care nursing, and cancer care nursing.

The Department made a major effort to reduce the reliance on agency nursing staff. A high profile media campaign for attracting former nurses back to the profession was very successful. At Fremantle Hospital, for example, agency staff numbers were able to be reduced from 70 per day to an average of 15, resulting in both significant savings as well as improved productivity.

Throughout the year, the calibre of Department of Health services was acknowledged with awards and public accolades. For example:

- Fremantle Hospital and Health Service won the National Industry Award for Excellence in Training in Community Services and Health;
- The Department's State Forensic Mental Health Service Community Program and the Oral Health Centre (University of WA-Health Department joint project) were both finalists in the 2002 Premier's Award for Excellence in Public Sector Management category;
- Royal Perth Hospital's Shenton Park Campus received a Road Safety Council award for commitment to patients; and
- The Health Promotion Directorate's "Go for 2&5" nutrition education campaign won the Campaign Effectiveness Award at the major advertising and media industry awards event for WA. Quit WA won the award for Best Print Campaign.

Acknowledgments of excellence were also received by individual staff members. For example, the Indigenous Nurse of the Year award went to Ms Teresa Peucker,

a community nurse with the East Metropolitan Population Health Unit; while in January 2003 Professor Assen Jablensky accepted an invitation to join the Prime Minister's Science, Engineering and Innovation Council as a member of its Neuroscience Working Group.

The Department is also proud to be associated with colleagues in the system who have achieved wide National recognition; Professor Fiona Stanley – Australian of the Year, and Professor Linda Kristjanson, named Telstra's 2002 Business Woman of the Year (community and government category).

I want to pay a special tribute to the efforts of the army of volunteers and service sponsors. Their selfless contributions are greatly appreciated by patients, families and staff alike.

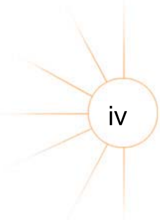
The significant progress that was made in service provision and administrative improvements during the year was punctuated by several unusual events that tested the system's resilience and capacity.

A unique infectious disease threat emerged in the form of the SARS epidemic (Severe Acute Respiratory Syndrome), which arose in East Asia. The Department's Communicable Disease Control Directorate worked closely with other Departmental staff and the Commonwealth in developing and implementing a National response, the result of which is that we are now in a high state of readiness should SARS cases emerge in Western Australia.

The Bali bombing incident in October 2002 was another test of the State's emergency preparedness. From the outset, there was excellent coordination and cooperation across the entire health system, within both Government and non-government agencies. Fremantle Hospital Disaster Response Team staff were on the tarmac to meet all aircraft carrying casualties. They set up an airport triage and stabilised all incoming casualties before sending them to various hospitals. The Royal Perth Hospital Burns Unit, assisted by the Princess Margaret Hospital Burns Team and staff from the entire system, received and treated over 34 badly injured victims, including some Balinese patients. A Bali Mental Health Disaster Management Strategy Group was formed and provided counselling for in-patients and their relatives. The experience was the impetus for establishment of a State Mental Health Disaster Response Plan.

The coordinated effort and rapid action taken in WA to address the SARS epidemic and the Bali bombing incident is a testimony to the professionalism and dedication of all of the staff involved.

The public health risks associated with international terrorism were acknowledged in a review of the State health system's chemical, biological and radiological response capabilities. In collaboration with other State and Commonwealth agencies the Department participated in Exercise New Horizon and Exercise Raw Horizon, which included a testing of Fremantle Hospital's decontamination procedures. In April 2003 the Emergency Management Service coordinated medical supplies from Perth to the Middle East, as part of Operation Baghdad Assist.



A fire at the Brookdale Liquid Waste Treatment Facility saw the Department take a lead role, alongside the Department of the Environment, in identifying toxic emissions and assessing health complaints.

In 2002/2003, a comprehensive process was in place to ensure implementation of the recommendations of the Douglas Inquiry. A review of Western Australia's obstetric services was completed (Cohen Report). The report's recommendations are currently undergoing a period of public consultation. Meanwhile, major changes were made to the operation of the State's key maternity institution, King Edward Memorial Hospital and a new Medical Director for Obstetrics and Gynaecology was appointed to KEMH in March 2003. At year's end 233 of the 237 recommendations of the Douglas Inquiry had been implemented.

There has been a strong focus on emergency department issues, including a more than $20 million capital works program to improve emergency Departments at Sir Charles Gairdner Hospital, Rockingham/Kwinana District Hospital, Princess Margaret and Swan District Hospital, and a range of further initiatives. In recognition of the importance of addressing these issues on a coordinated, system-wide basis John Burns was appointed State Health Emergency Department Director, supported by the establishment of an Acute Demand Management Unit.

During the year the Department of Health also faced the enormous challenge of medical indemnity insurance. Despite the complexity of this issue, it was well handled with good cooperation from medical organisations and has led to some good and sustainable resolutions.

The health system is one of the State's largest organisations, providing a range of complex services across a vast area. Inevitably, there will be problems and some mistakes, but we should be proud of the calibre of the system and the high level of services the Western Australian public receive.

This was a momentous year but one which I have no doubt left the Department of Health stronger and more focussed than ever on its primary role of delivering to Western Australians health services of a quality equal to any in the world.

Michael Daube
Director General of Health

August 2003

Contents

Statement of Compliance i

Director General's Overview ii

About Us
Address and Location 5
Mission Statement 7
Broad Objectives 7
Services Provided and Core Activities 7

Compliance Reports
Enabling Legislation 10
Ministerial Directives 10
Statement of Compliance with Public Sector Standards 11

Management Structure
Accountable Authority 13
Pecuniary Interests 13
Senior Officers 14
Department of Health Structure 15
East Metropolitan Health Service Structure 16
North Metropolitan Health Service Structure 17
South Metropolitan Health Service Structure 18
Women's and Children's Health Service Structure 19
Dental Health Service Structure 20

Achievements and Highlights
East Metropolitan Health Service 21
North Metropolitan Health Service 26
South Metropolitan Health Service 30
Women's and Children's Health Service 34
Dental Health Service 36

Major Capital Works 37

Customers
Demography 39
Disability Services 40
Equity and Diversity 41
Cultural Diversity and Language Services 42
Youth Services 44

Contents

Human Resources
Employee Profile ... 47
Recruitment ... 48
Staff Development ... 49
Workers' Compensation and Rehabilitation ... 51
Industrial Relations ... 52

Reports on other Accountable Issues
Freedom of Information ... 54
Advertising and Sponsorship ... 56
Public Relations and Marketing ... 57
Publications ... 60
Research and Development ... 60
Evaluations ... 71
Internal Audit Controls ... 72
Pricing Policy ... 73
Risk Management ... 73
Energy Smart Government Program ... 75
Waste Paper Recycling ... 76

Key Performance Indicators
Certification Statement ... 77
Performance Indicators Audit Opinion ... 78
Performance Indicators ... 79

Financial Statements
Certification Statement ... 130
Financial Statements Audit Opinion ... 131
Financial Statements ... 133

Tables

Table 1: Statement of Compliance with Public Sector Standards 11
Table 2: Senior Officers 14
Table 3: Major Capital Works – Projects in Progress 37
Table 4: Major Capital Works – Projects Completed during the year 38
Table 5: Postcodes in the Metropolitan area 39
Table 6: Employee Profile 47
Table 7: Workers' Compensation and Rehabilitation 51
Table 8: Freedom of Information (FOI) Contact Officers for Metropolitan Health Service 55
Table 9: Advertising and Sponsorship 56
Table 10: Teaching and Research – Major clinical education programs provided in 2002/2003 61
Table 11: Summary of evaluations 2002/2003 reviews 72
Table 12: Energy Smart Government Program 75
Table 13: Respective indicators by health sector 81
Table 14: Rate of screening per 1,000 population in children 82
Table 15: Rate of referral per 1,000 population of children as a result of childhood screening schedule 83
Table 16: Rate per 1,000 of population for childhood immunisation 84
Table 17: Rate of hospitalisation per 1,000 of population for children with infectious diseases 85
Table 18: Rate of hospitalisation per 1,000 of population for tonsillectomies (0 - 12 years) 86
Table 19: Rate of hospitalisation per 1,000 of population for gastroenteritis in children (0 - 4 years) 87
Table 20: Rate of hospitalisation per 1,000 of population for acute asthma 88
Table 21: Rate of hospitalisation for acute bronchitis per 1,000 of population 89
Table 22: Rate of hospitalisation for bronchiolitis per 1,000 of population 89
Table 23: Rate of hospitalisation for croup per 1,000 of population 89
Table 24: Rate of screening of pre-primary school children 90
Table 25: Rate of screening of primary school children 90
Table 26: Rate of screening of secondary school children 91
Table 27: Rate of children free of dental caries when recalled 91
Table 28: Average number of decayed, missing or filled teeth for school children 92
Table 29: Average number of decayed, missing or filled teeth for adults 92
Table 30: Cost of service for community health services 94
Table 31: Average cost of service for school dental service 95
Table 32: Respective indicators by health sector 96
Table 33: Number of people on waiting list at 30 June 97
Table 34: Number of people admitted from the waiting list 98
Table 35: Number of people admitted from the waiting list during 2002/2003 with mean and median waiting times (in weeks) 98

Table 36: Average length of stay for people remaining on the waiting list at the end of the financial year with mean and median waiting times (in weeks) by indicator procedure ... 99
Table 37: Proportion of Emergency Department patients seen within recommended times ... 100
Table 38: Rate of unplanned hospital re-admissions within 28 days, ... 101
Table 39: Rate of post operative pulmonary embolism ... 103
Table 40: Rate of discharge directly home from birth hospital for babies with an APGAR score of 4 or less five minutes after delivery ... 105
Table 41: Rate of acute myocardial infarction (AMI) heart attack survival ... 107
Table 42: Rate of fractured neck of femur survival ... 108
Table 43: Rate of stroke survival ... 108
Table 44: Survival rate of patients following coronary artery bypass grafts ... 109
Table 45: Survival rates across 3 years for patients undergoing coronary angioplasty ... 110
Table 46: Access to dental treatment services for eligible people ... 111
Table 47: Rate of completed dental care ... 111
Table 48: Average cost per casemix adjusted separation for teaching hospitals ... 113
Table 49: Average cost per casemix adjusted separation for non-teaching hospitals ... 114
Table 50: Average cost per Emergency Department presentation for Metropolitan Health Services hospitals ... 115
Table 51: Average cost per doctor attended outpatient episode for Metropolitan Health Services hospitals ... 116
Table 52: Average cost per non-admitted occasion of service for Metropolitan Health Services hospitals (excludes emergency occasions and doctor attended outpatient occasions) ... 117
Table 53: Average cost of completed courses of adult dental care ... 118
Table 54: Respective indicators by health sector ... 119
Table 55: Mean and median waiting time to first outpatient appointment for chronic illness ... 120
Table 56: Median waiting time for community and allied health services (hospitals & community based) ... 123
Table 57: Median bed-days for persons under mental health community management who were admitted to hospital ... 124
Table 58: Rate of ACAT assessments within targeted age groups per 1,000 population ... 125
Table 59: Rate of first assessments by Aged Care Assessment Teams ... per 1,000 of population ... 126
Table 60: Median waiting time (days) for ACAT assessment for a first referral ... 127
Table 61: Recommended care outcomes for aged care assessments ... 127
Table 62: Average cost per person with mental health illness under community management ... 128
Table 63: Average cost per Care Awaiting Placement (CAP) day ... 129

ADDRESS AND LOCATION

Department of Health (Metropolitan Health Service)
189 Royal St
EAST PERTH WA 6004

PO Box 8172
Perth Business Centre
PERTH WA 6849

☎ (08) 9222 4222
(08) 9222 4046
prcontact@health.wa.gov.au
www.health.wa.gov.au

The Metropolitan Health Service is one part of Western Australia's State Government health system, which is managed by the Director General of Health. Apart from the Metropolitan Health Service, there are four other services that report to the Director General. These services (which produce their own Annual Reports) are – WA Country Health Service, South West Area Health Service, Peel Health Services and the Royal Street Divisions (comprising Corporate and Finance, Health Care and Population Health).

The five Health Services that form the Metropolitan Health Service, and reported in this annual report, are:

- East Metropolitan Health Service;
- North Metropolitan Health Service;
- South Metropolitan Health Service;
- Women's and Children's Health Service; and
- Dental Health Service.

Contact Details for the five Health Services are provided below.

East Metropolitan Health Service	
Royal Perth Hospital Wellington Street Perth Western Australia 6000 ☎ (08) 9224 2244 (08) 9224 3511	Includes: • Royal Perth Hospital - Wellington Street and Shenton Park Campuses; • Bentley Health Service; • Swan Kalamunda Health Service; and • East Metropolitan Population Health Unit.

North Metropolitan Health Service

Sir Charles Gairdner Hospital
Hospital Avenue
Nedlands
Western Australia 6009
☎ (08) 9346 3333
🖷 (08) 9346 2534

Includes:
- Sir Charles Gairdner Hospital;
- Area Mental Health Service - Graylands Selby-Lemnos & Special Care Services;
- Population Health Program; and
- Osborne Park Hospital - includes area rehabilitation & aged care services.

South Metropolitan Health Service

Fremantle Hospital
Alma Street
Fremantle
Western Australia 6160
☎ (08) 9431 3333
🖷 (08) 9431 2921

Includes:
- Fremantle Hospital & Health Service - Fremantle Hospital, Woodside Maternity Hospital and Rottnest Island Nursing Post;
- Rockingham/Kwinana Health Service;
- Armadale Health Service;
- South Metropolitan Mental Health Service; and
- South Metropolitan Population Health
  - Public Health Unit
  - Community Health Service.

Women's and Children's Health Service

King Edward Memorial Hospital
374 Bagot Road
Subiaco
Western Australia 6008
☎ (08) 9340 2222
🖷 (08) 9388 1780

Includes:
- Princess Margaret Hospital for Children;
- King Edward Memorial Hospital for Women;
- State Child Development Centre;
- Stubbs Terrace Paediatric Mental Health Service; and
- Sexual Assault Resource Centre.

Dental Health Service

43 Mt Henry Road
Como
Western Australia 6152
☎ (08) 9313 0555
🖷 (08) 9313 1302

Includes:
- School Dental Service;
- Special Services (for housebound and disabled);
- Oral Health Promotion; and
- Satellite metropolitan and country clinics.

MISSION STATEMENT

Our Mission
To improve and coordinate the delivery of public health services and access to public hospitals in the metropolitan area.

BROAD OBJECTIVES

The vision of the Metropolitan Health Service is to be recognised as a provider of high quality, accessible and integrated publicly funded health services in the metropolitan area.

In particular, the broad objectives of the Metropolitan Health Service are to:

- Establish an integrated Health Service for the metropolitan area based on equity of access and resource allocation;
- Provide high quality, patient focused health services;
- Promote health delivery based on the best available scientific evidence and judgement; and
- Operate according to the principles and practices of good corporate governance.

SERVICES PROVIDED AND CORE ACTIVITIES

The Metropolitan Health Service provides an extensive range of health services across the entire spectrum of health. Services include provision of care to people in their homes, community centres, schools, emergency departments, outpatient clinics, satellite clinics, hospital wards and special care units. Additionally modern technology such as telemedicine is utilised to provide specialist services to remote clinicians and patients.

The restoration of the health of people with acute illness consumes most of the Metropolitan Health Service's resources. Most of the tertiary hospitals, and some of the secondary hospitals, provide 24 hour emergency services. Special Care Units in each of the Health Services provide care to seriously ill patients, with Intensive Care, Coronary Care and Neonatal Units providing 24 hour care to extremely ill patients, many of whom require life-support.

In addition to meeting the health needs of the metropolitan population, the health service plays a key role in providing specialist and tertiary services on a statewide basis. Many medical specialists routinely travel to remote areas of the State to provide regular specialist health services to the rural populations. Where country patients are in need of tertiary hospital services, they travel to the metropolitan area to receive their complex care.

The range of services provided by the Metropolitan Health Service include:

Direct Patient Services
Acute Surgical
Adult Mental Health
Ambulatory Care
Amputee Service
Anaesthesia
Antenatal Clinic
Bone Marrow Transplants
Burns
Cardiology
Cardiothoracic Surgery
Cardiovascular Medicine
Chest Clinic
Child and Adolescent Mental Health
Clinical Haematology
Clinical Immunology
Coronary Care
Dental Care Emergency and General
Dermatology
Ear, Nose and Throat
EEG/ECG
Elderly Mental Health
Emergency Medicine
Endocrinology
Epilepsy Service
Gastroenterology
General Medicine
General Surgery
Geriatric Medicine and Extended Care
Gynaecology
Haemophilia
Hand Surgery
Hepatology
HIV/AIDS
Hospital Allied Health and Nursing
Discharge Service
Hyperbaric Medicine
Infection Control
Infectious Diseases
Intensive Care
Intra-Ocular Surgery
Maternal Foetal medicine
Maxillo-Facial Surgery
Neonatal Intensive Care
Neonatology
Neurology
Neurosurgery
Nuclear Medicine
Obstetrics and Midwifery
Oncology
Ophthalmology
Orthopaedics
Paediatrics
Palliative Care
Plastic Surgery
Radiation Oncology
Radiology
Refractory Epilepsy Service
Renal Services and Dialysis
Respiratory Medicine
Rheumatology
Same Day Surgery
Sexual Health Service
Stomal Therapy
Stroke Unit
Tropical Medicine
Ultrasound
Urogynaecology
Urology
Vascular Surgery
Visiting Midwifery Service

Medical Support Services
Aged Care Assessment
Antenatal clinic
Audiology
Bio-Engineering
Breast Feeding Service
Clinical / Psychology
Continence Services
Dental Prosthetics
Dietetics
Infertility Treatment
Medical Illustration
Occupational Therapy
Orthotics and Prosthetics
Parent Education
Pathology/ PathCentre Service
Perinatal Loss Service
Pharmacy
Physiotherapy
Podiatry
Psychiatry
Radiology (PRC)
Rehabilitation
Respite Care
Social Work
Speech Pathology

Community and Support Services
Chaplaincy
Child Health and Development
Diabetes Education
Domiciliary Dental Services for Housebound
Persons
Family and Child Health Services
Health Promotion
Home Care
Physiotherapy
Primary Health Care
Respite Care
School Health

Teaching and Research

In addition to those clinical services listed above, the Metropolitan Health Service undertakes teaching and research activities. It plays a key role in the provision of an on-going supply of health professionals with the skills and knowledge to meet current and future health service needs. Each Health Service provides programs, in liaison with the universities, for undergraduates studying medicine, nursing or allied health courses. Additionally, postgraduate courses within the Teaching Hospitals are conducted in partnership with relevant Colleges, ensure that a significant number of doctors can specialise in a wide range of medical specialties. Nurses and allied health professionals are also provided with support for postgraduate courses to enable them to achieve qualifications in specialised fields.

Publication of clinical and health service research, to contribute to world-wide knowledge, is of key importance to the Metropolitan Health Service. Most of the research activity is conducted within the Teaching Hospitals, with a large proportion done in partnership with universities and other research institutions. Details about teaching and research activities are provided later in the report.

ENABLING LEGISLATION

The Metropolitan 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 Minister for Health is incorporated as the board of the hospitals formerly comprised in the Metropolitan Health Service Board under Section 7 of the *Hospitals and Health Services Act 1927,* and has delegated all the powers and duties as such to the Director General, in his capacity as Commissioner of Health.

MINISTERIAL DIRECTIVES

The Minister for Health did not issue any directives on Metropolitan Health Service operations during 2002/2003.

STATEMENT OF COMPLIANCE WITH PUBLIC SECTOR STANDARDS

In the administration of the Metropolitan Health Service, I have complied with the *Public Sector Standards in Human Resources 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:

- Conducting regular reviews of human resource policies to ensure consistency with public sector standard requirements.
- Providing a comprehensive induction and orientation program that raises staff awareness of relevant human resource policies and practices.
- Providing appropriate training to human resource staff enabling them to provide accurate advice and support to managers and employees in all areas of human resource management.
- Providing relevant staff development programs to managers and employees to ensure they acquire a knowledge and understanding of human resource processes and compliance requirements.
- Facilitating access to policies, procedures and guidelines by publishing information on intranet sites and in manuals and making available information in pre-prepared Recruitment and Selection kits.
- Reviewing and auditing relevant paperwork and processes to ensure continued compliance.
- Analysis and follow-up of all grievances lodged and development and implementation of remedial actions where appropriate.

Summarised below are the ‘Breach of Standards’ claims made in 2002/2003 (there were no outstanding claims from previous years).

Table 1: Statement of Compliance with Public Sector Standards

HR Practice	Number of Applications Lodged	Number Resolved	Number Under Review	Breach of Standard Identified
Recruitment & Selection	22	22	0	Nil
Performance Management	7	7	0	Nil
Termination	3	3	0	Nil
Grievance Resolution	15	12	3	Nil
Total	**47**	**44**	**3**	**Nil**

There were also four complaints received relating to the Code of Ethics and/or the Code of Conduct. All were resolved within the Health Service concerned.

The Metropolitan Health Service has not been investigated or audited by the Office of Public Sector Standards Commissioner for the period to 30 June 2003.

Michael Daube
Director General of Health
Accountable Authority for The Minister for Health in his capacity as the Deemed Board of Metropolitan Public Hospitals

August 2003

ACCOUNTABLE AUTHORITY

The Director General of Health Mike Daube, in his capacity as Commissioner of Health, is the Accountable Authority for the Metropolitan Health Service.

PECUNIARY INTERESTS

Senior officers of the Department of Health have declared the following pecuniary interests:

- From 1 July 2002 until 31 August 2002 South Metropolitan Health Service Chief Executive John Burns was a board member of the Health Services Credit Union. The Credit Union operated a branch two days a week from the premises of Fremantle Hospital and Health Service.

SENIOR OFFICERS

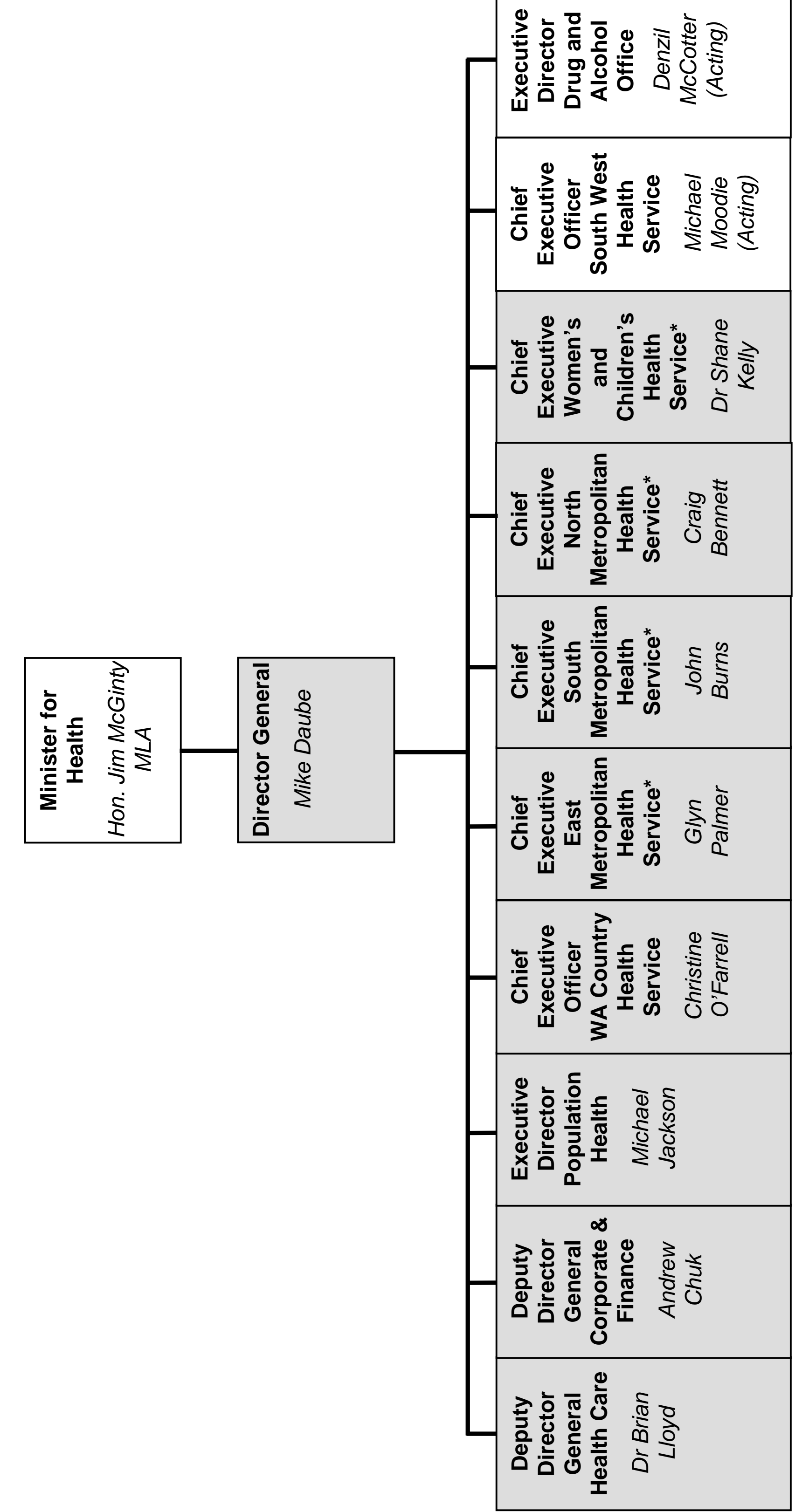
The senior officers of the Department of Health and their areas of responsibility are listed below:

Table 2: Senior Officers

Area of Responsibility	Title	Name	Basis of Appointment
Health Care	Deputy Director General, Health Care	Dr Brian Lloyd	Contract Term 5 Years
Corporate and Finance	Deputy Director General, Corporate and Finance	Andrew Chuk	Contract Term 5 Years
Population Health	Executive Director, Population Health	Michael Jackson	Contract Term 5 Years
WA Country Health Service	Chief Executive Officer, WA Country Health Service	Christine O'Farrell	Tenured
East Metropolitan Health Service	Chief Executive, East Metropolitan Health Service	Glyn Palmer	Contract Term 5 Years
North Metropolitan Health Service	Chief Executive, North Metropolitan Health Service	Craig Bennett	Contract Term 5 Years
South Metropolitan Health Service	Chief Executive, South Metropolitan Health Service	John Burns	Contract Term 5 Years
Women's and Children's Health Service	Chief Executive, Women's and Children's Health Service	Dr Shane Kelly	Contract Term 5 Years
South West Health Service	Chief Executive Officer, South West Health Service	Michael Moodie	Seconded
Drug and Alcohol Office	Executive Director, Drug and Alcohol Office	Denzil McCotter	Acting

Senior officers of the Department of Health, as shown above, form the members of the State Health Management Team (SHMT), excluding the Chief Executive Officer, South West Health Service and the Executive Director, Drug and Alcohol Office. The SHMT members manage and provide leadership to the Western Australian public health system. The Director General of Health, Mike Daube, is also a SHMT member.

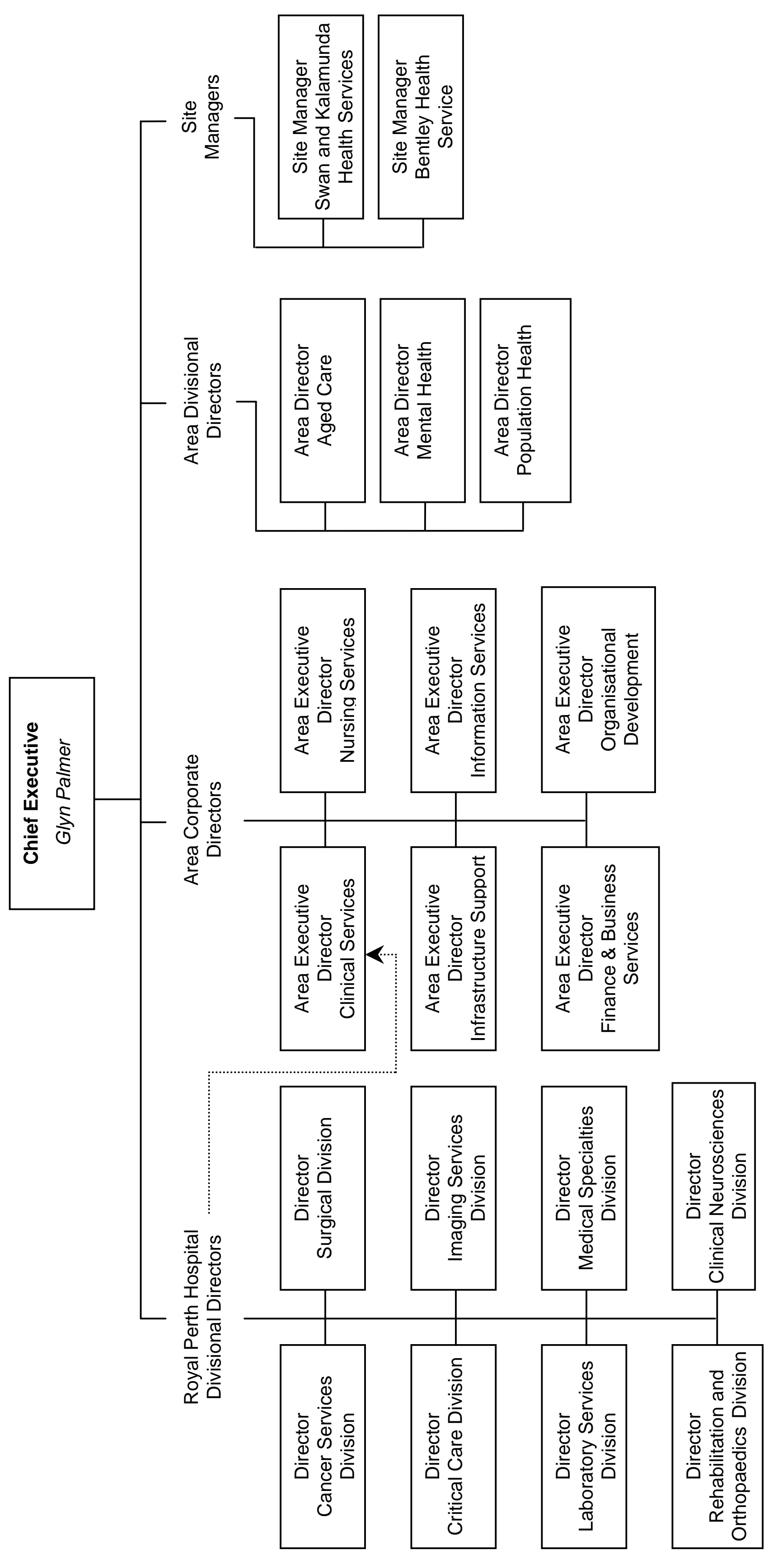
Department of Health Structure at 30 June 2003



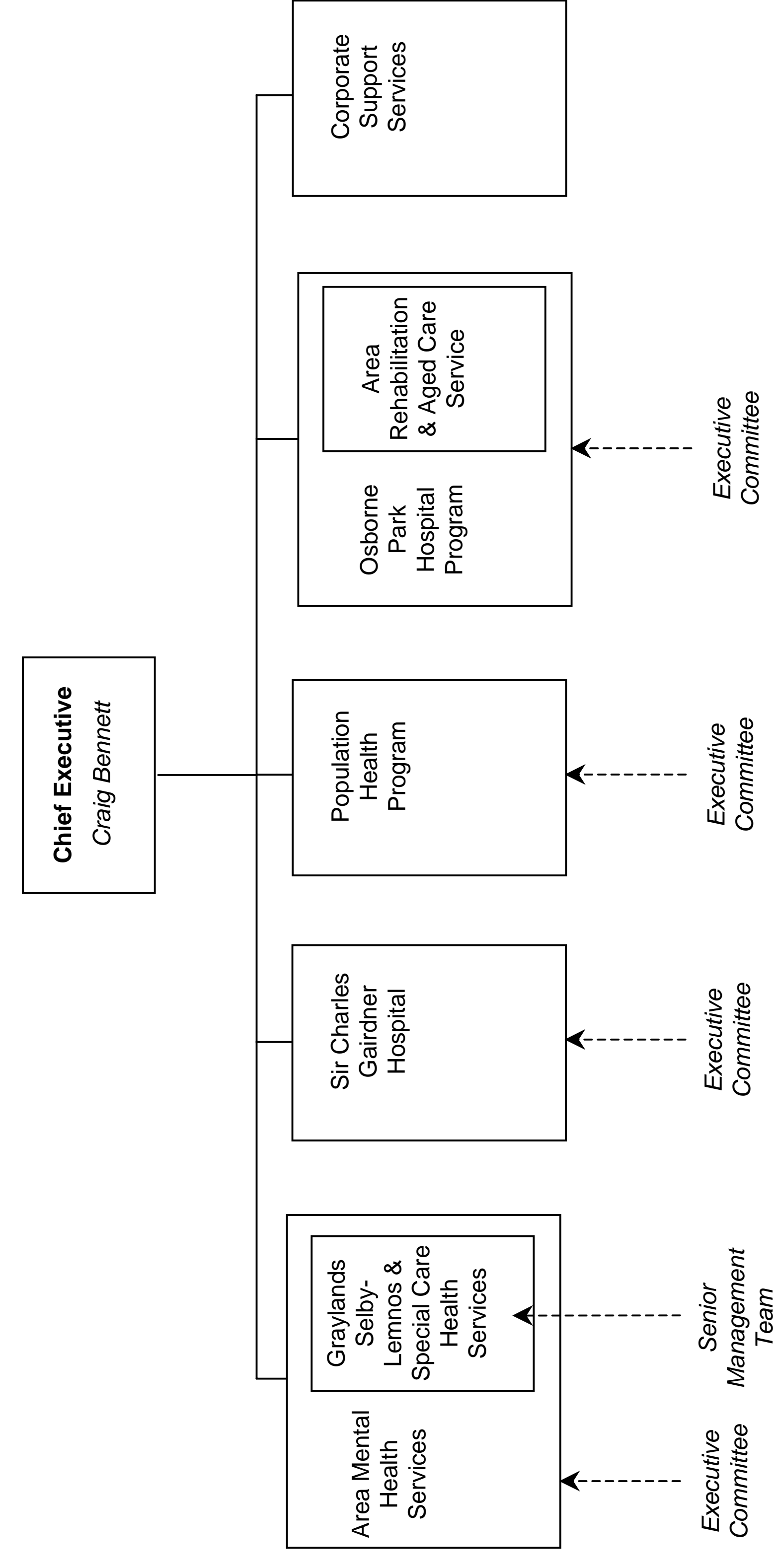
Form the State Health Management Team, responsible for the overall management of the health system.

* These four Health Services, plus the Dental Health Service (which reports through the Deputy Director General Health Care) are reported within the Department of Health Metropolitan Health Service Annual Report.

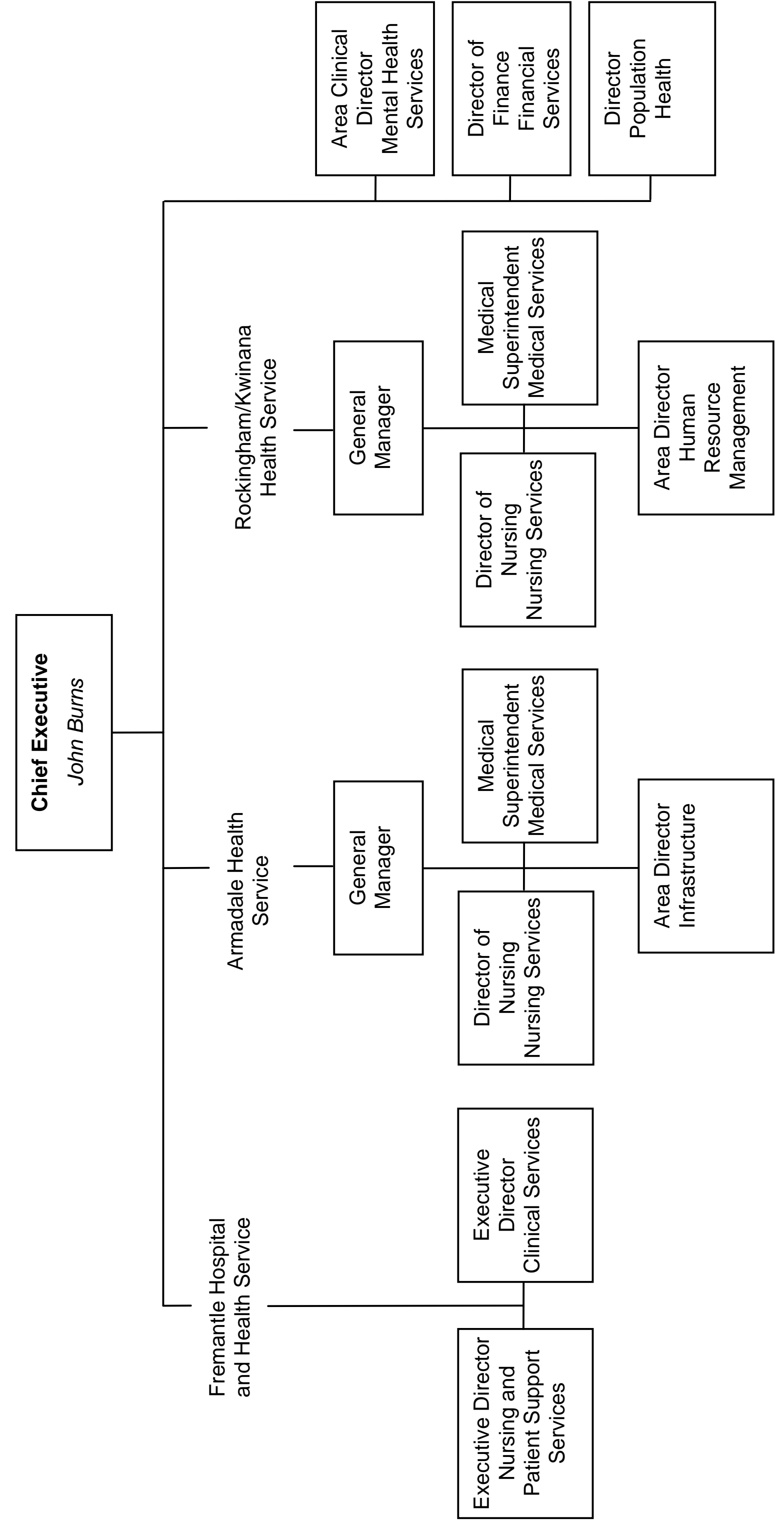
East Metropolitan Health Service Structure at 30 June 2003



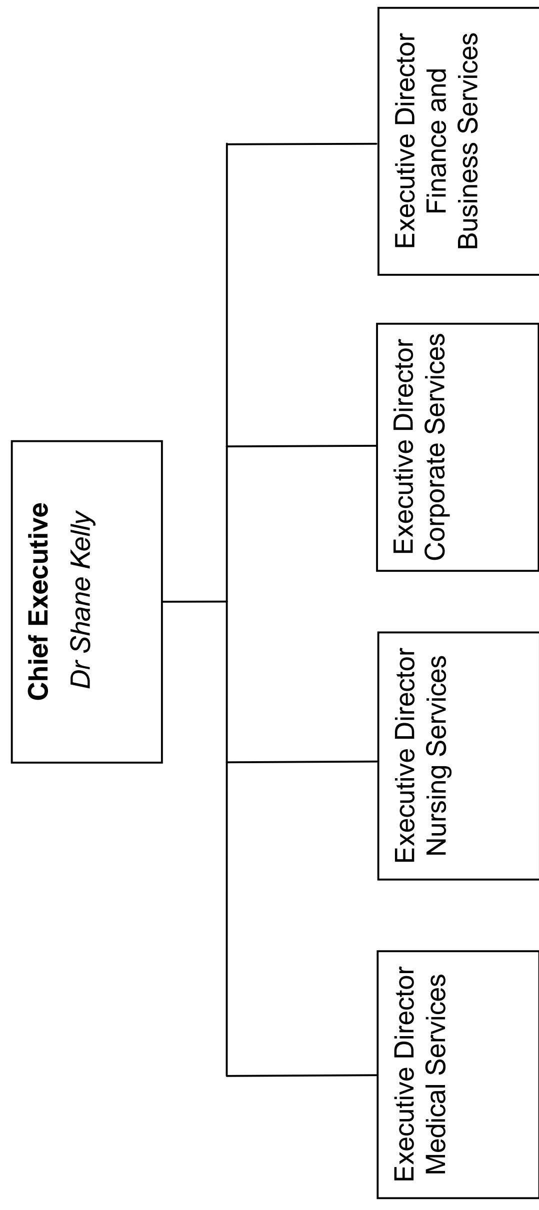
North Metropolitan Health Service Structure at 30 June 2003



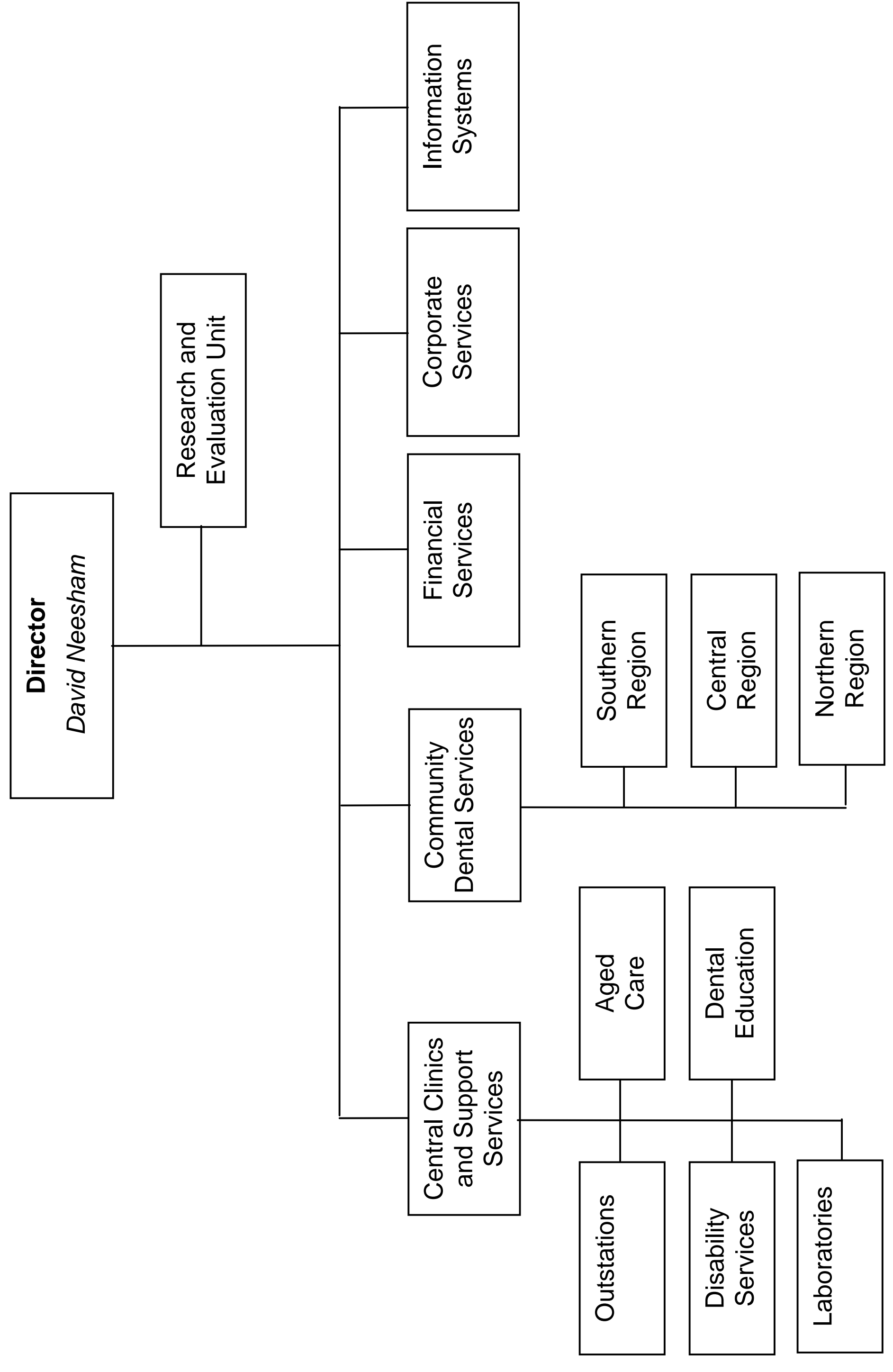
South Metropolitan Health Service Structure at 30 June 2003



Women's and Children's Health Service Structure at 30 June 2003



Dental Health Service Structure at 30 June 2003



EAST METROPOLITAN HEALTH SERVICE

The East Metropolitan Health Service (EMHS) includes the Wellington Street and Shenton Park campuses of Royal Perth Hospital, the East Metropolitan Population Health Unit, Bentley Health Service (BHS), and Swan Kalamunda Health Service (SKHS).

The implementation of area-based corporate services for finance, human resources, information technology and facilities management provided opportunities to both rationalise resources and expand service provision and support across the EMHS.

This administrative restructure, which commenced in early 2002, included the appointment of a chief executive for the EMHS, Mr Glyn Palmer. It continued with the appointment of area directors for Mental Health, Aged Care and Population Health, and area executive directors for Nursing Services, Finance and Business Services, Organisational Development, Infrastructure Support and Information Services.

Key Achievements

- Development of new facilities and installation of new equipment including a $1.5 million renal dialysis facility and a $1 million state-of-the-art CT scanner at RPH
- Commencement of a new coagulation service at RPH
- Construction of a $1.3 million CT scanner suite at SHS (Swan Health Service)
- Construction of a 6 bed observation ward adjacent to the emergency department at SHS
- Central role in providing victim care and support following Bali bombing incident
- Implementation of a policy of 'zero tolerance' to patient or visitor-initiated aggression in RPH's Emergency Department
- RPH's Cardiac Transplant Unit undertook its 50th heart transplant operation
- Awards received by staff throughout the year including a Road Safety Council award at RPH Shenton Park Campus, and Indigenous Nurse of the Year award to a Population Health Unit staff member
- Introduction of computerised systems for notifying General Practitioners of the admission and discharge of their patients
- Completion of a review of general psychiatric hospital services and formation of the Psychiatric Emergency Department Liaison Team at RPH

New facilities, services and initiatives

- A new $1.5 million renal dialysis facility was installed at Royal Perth Hospital (RPH) in March 2003, providing emergency and acute care for unstable end-stage renal patients.

- The first orb scanner in the WA public health system was donated to RPH's Department of Ophthalmology in March 2003 by the Rotary Club of Armadale.
- A review of neurosurgical services confirmed RPH as the main statewide treatment centre for neurovascular disease. A new Interventional Unit has ensured best practice treatment for patients with sub-arachnoid haemorrhage.
- A program of progressive ward renovations at both Wellington Street and Shenton Park Campuses of RPH was commenced, including construction of four negative-pressure rooms in the intensive care facilities.
- A new acute coagulation service was commenced at RPH, providing specialist support for patients on anti-coagulation for deep venous thrombosis (DVT) and other conditions.
- RPH Cardiology Department commenced using drug-eluding stents for treating acute coronary heart disease. The stents, so far used with more than 500 patients, reduce the incidence of recurring heart attacks by as much as 30 percent.
- A new surgical division was formed at RPH in December 2002.
- A $1 million state-of-the-art CT scanner was installed at RPH (Shenton Park) in November 2002 – the first of its kind in the WA public health system.
- A 17 in-patient Geriatric Evaluation and Management (GEM) unit was opened at RPH in July 2002, providing early and intensive rehabilitation for acute care patients.
- Computerised additions were made to RPH's patient administration system, which has been expanded to provide improved management of patient admissions for all public emergency service hospitals.
- The information systems and technology functions of all EMHS hospitals were integrated into a single service arrangement.
- SHS implemented a new model of obstetric care with the introduction of salaried specialist obstetricians available 24-hours 7-days-a-week, with on-call support from paediatricians and anaesthetists. The service ensures local deliveries for babies from 35 weeks gestation.
- A $1.3 million CT Scanner suite was constructed at SHS, enabling increased accuracy and more timely diagnosis for emergency department presentations and a reduced requirement for off-site patient transfers.
- A six-bed $600,000 observation ward was constructed adjacent to the emergency department at SHS.
- Physiotherapy services at Kalamunda District Hospital (KDH) was in-sourced and integrated with SHS to create a Swan and Kalamunda Physiotherapy Department.
- A $270,000 remedial works program was completed at KDH in January 2003, including upgrades to fire safety features, air conditioning, ceilings and car parks.
- BHS commenced programs for gestational diabetes (includes risk reduction strategies, screening and post-delivery follow-ups); and smoking intervention aimed at women who smoke (Tobacco Brief Intervention Pilot Project).

- BHS implemented a Family and Domestic Violence Policy, involving extensive education of staff in early detection and strategies for curbing violence.
- A grant of $1.5 million dollars was secured for upgrading air conditioning in 'A' Block at BHS.

Bali

- RPH was instrumental in both the planning of and participating in the State's response to the Bali bombings incident of October 2002, receiving over 34 badly burned and injured victims.
- With assistance from the Princess Margaret Hospital Burns Team the RPH Burns Unit treated patients, including Balinese victims, with primary radical burns debridement.
- The additional workload created by the Bali incident will continue for at least two years in the form of ongoing intensive physiotherapy, burns dressings and cosmetic surgery for victims.
- The Inner City Mental Health Service played a critical role in mediating and treating the psychological distress of patients, their families and RPH staff. Funding of $100,000 was provided to employ a 0.5 FTE (full-time equivalent) clinical psychologist to work in RPH's trauma/burns area.

Community and outside linkages

- The EMHS signed a memorandum of understanding with the Canning and the Perth and Hills Divisions of General Practice in May 2003, to ensure better cohesion in the planning and delivery of health services.
- A policy of 'zero tolerance' to patient or visitor-initiated aggression was implemented for RPH's Emergency Department in March 2003.
- With funding from AusAid, the RPH Burns Team visited Nepal to assist with an upgrade of Nepalese services. A reciprocal training visit is anticipated in late 2003.
- A position for a practitioner scholar in emergency nursing was established in April, as a joint appointment between RPH and Edith Cowan University.
- RPH was re-accredited by the Australian Council on Healthcare Standards (full four-year accreditation). This year the Inner City Mental Health Service also underwent accreditation, receiving a number of commendations in the process.
- RPH's Cardiac Transplant Unit undertook its 50th heart transplant operation.
- The Clinical Safety and Quality Committee was created at RPH to ensure patients receive the best possible care by identifying ways of improving care.
- Awards received during the year included a Road Safety Council award for commitment to patients, received by staff from Ward 11 at the RPH Shenton Park Campus; and Indigenous Nurse of the Year award to EMHS Population Health Unit community nurse, Teresa Peucker.
- All Years 7 to12 students in public schools within the EMHS area were offered immunisation against hepatitis B and meningococcal disease (group C), with uptake extremely high.

- Initiatives undertaken by the EMHS Population Health Unit included participation in: the Midvale 'Wrap Around School' project (inter-agency initiative for supporting indigenous families); and 'Family Strengths' (partnership arrangement with the Department of Community Development and the City of Swan for providing co-located maternal and child health services for families in Midland).
- Computerised systems for promptly notifying general practitioners of the admission and discharge of their patients were introduced.
- Strategies for management of aggression toward staff by patients at BHS were implemented, including training for all mental health staff, building modifications, and the introduction of security personnel.
- An agreement was reached to hand over responsibility for the management of the Wooroloo Health Facility to the Ministry of Justice, effective 1 July 2003.
- In collaboration with the Canning Division of General Practitioners, BHS joined the 'Health Partners' program, which targets clients with chronic illness. Along with RPH, BHS participated in a project linking indigenous clients to general practitioners.

Mental health

- RPH Professor of Psychiatry Assen Jablensky developed a clinical program that targets patients experiencing psychotic illnesses.
- The Inner City Mental Health Service (ICMHS) received a grant of $330,000 from the Office of Mental Health Service to establish the new Psychiatric Outpatient Clinic at 74 Murray Street.
- Two RPH programs – 'Challenging Habitual Attitudes by Nurturing Growth, Education and Self-responsibility' (CHANGES) and 'Enabling Health Approaches to Nurture, Coping and Esteem' (ENHANCE) – were amalgamated as the Centre for Psychotherapy.
- A review was commenced of all ICMHS clinical streams to ensure compliance with requirements of the Chief Psychiatrist and National Mental Health Standards.
- In conjunction with Derbarl Yerrigan, ICMHS commenced development of a business plan for providing mental health services for indigenous people.
- The 12-bed Ursula Frayne Unit at the Mercy Hospital was opened. This is part of the Mental Health Services for Older Adults program.
- Completion of a review of general psychiatric hospital services resulted in the formation the Psychiatric Emergency Department Liaison Team at RPH. The presence of psychiatric liaison nurses in the emergency department, 7 days a week, has reduced average waiting times from approximately 4 hours to 37 minutes.
- BHS built closer ties with mental health and the general practice community through a Shared Care Protocol, memorandum of understanding and establishment of a General Practice Reference Group.

- BHS's 'The Families at Work' mental health program (formerly the Child Residential Unit) secured funding from the Department of Education for a dedicated teacher (most children admitted to the unit are educationally at risk).
- The BHS Mental Health Program developed strong community linkages, including memoranda of understanding with both the Ministry of Housing and Sevenoakes College, and had regular liaison with the WA Police Service, local governments and Supported Accommodation Assistance Program agencies.
- A review of community, day hospital and in-patient services was undertaken by the BHS Elderly Mental Health Program, to ensure compliance with the National Standards of Mental Health Services. Issues identified, including acuity and security, are now being addressed.
- The involvement of consumers and carers in the planning, implementation and evaluation of the BHS Mental Health was increased by their inclusion on operational teams, and establishment of a local area implementation group and the Adolescent Unit Management Team.

NORTH METROPOLITAN HEALTH SERVICE

The North Metropolitan Health Service (NMHS) officially came into being on 1 July 2002. It services the area extending from Mosman Park in the south to Two Rocks in the north, providing tertiary and secondary hospital services, population and community health services and mental health services to about 500,000 people.

The NMHS incorporates Osborne Park Hospital, Graylands Selby-Lemnos and Special Care Health Services, Sir Charles Gairdner Hospital (SCGH), and an extensive network of community health and community mental health facilities.

In January 2003 a comprehensive and up-to-date audit of the region's population, epidemiological data, key clinical data and facilities was completed, providing an important basis for planning future NHMS operations.

The Department's implementation of area-based corporate services for finance, human resources, information technology and facilities management (July 2002) provided opportunities to both rationalise resources and expand service provision and support across the NMHS.

Key Achievements

- Stage one of the redevelopment of the SCGH main entrance and emergency department was completed
- Contract let for a $3 million MRI scanner to be installed in the SCGH Radiology Department
- Launch of the Centre for Nursing Research in October 2002
- Commencement of operation of the State-Commonwealth funded Positron Emission Tomography (PET)/cyclotron service
- Professor Linda Kristjanson was named Telstra's 2002 Business Woman of the Year (community and government category)
- WA's only high-dose-rate Brachytherapy Unit was commissioned at SCGH's Radiation Oncology Department in August 2002
- Australia's first and only State tissue bank, the WA Research Tissue Network, was opened at SCGH
- 50,000th baby born at OPH since its opening in 1962 and celebration of OPH's 40th anniversary
- Establishment of key clinics, such as a Falls Clinic, Parkinson's Clinic and Memory Clinic, through the Department of Rehabilitation and Aged Care.
- Successful pilot of a Canadian-designed Early Development Index in Joondalup Education District
- State Forensic Mental Health Service Community Program was a finalist for the 2002 Premier's Award
- Breakthrough in schizophrenia research by the Centre for Clinical Research in Neuropsychiatry

New facilities, services and initiatives

- Stage one of the redevelopment of the SCGH main entrance and emergency department was completed in June 2003, coinciding with commencement of Stage two of the three-phased works program. The full project is due for completion in mid-2004 and is expected to overcome operational inefficiencies, eliminate excessive overcrowding and improve patient comfort, and reduce occupational health and safety problems. It will cater for up to 45,000 patients per year (20,000 - 22,000 admissions), an 18% increase on current levels.
- Due to significant structural problems the former nurses quarters, known as Anstey House (S Block), on the QEII Medical Centre site was demolished.
- The existing maximum accreditation status of SCGH was confirmed by the Australian Council on Healthcare Standards following a Periodic Review in February 2003. The surveyors' report commented specifically on the hospital's clear commitment to quality at all levels.
- Contract let for a $3 million MRI scanner, funded in equal parts by the hospital and the State Government, to be installed in the Radiology Department during 2003.
- The Centre for Nursing Research – a new approach to collaborative research between SCGH and Edith Cowan University – was launched in October 2002. The centre replaces previous arrangements under the SCGH Nursing Research Unit and focuses on three formalised programs of research: acute care nursing, aged care nursing, and cancer care nursing.
- The State-Commonwealth funded Positron Emission Tomography (PET)/cyclotron service began operating at SCGH in December 2002 with the commissioning of the service's scanning camera. PET is cutting edge body imaging technology for revealing chemical activity inside human tissue. The cyclotron component of the service was installed in April 2003 and is scheduled to be operational by August 2003.
- The inaugural Director of the Centre for Nursing Research at SCGH, Professor Linda Kristjanson, was named Telstra's 2002 Business Woman of the Year (community and government category).
- Western Australia's only high-dose-rate Brachytherapy Unit was commissioned at SCGH's Radiation Oncology Department in August 2002. The $500,000 unit treats patients suffering from prostate, lung, oesophageal, bile duct, rectal and breast cancers. The unit was part-funded with a $250,000 donation from The Gala Charity Ball Committee, Department of Health ($100,000) and revenue from treatment of private patients who received prostate seed implant brachytherapy.
- SCGH was one of five Australian hospitals chosen for a collaborative project under Phase 4 of the National Demonstration Hospitals Program (NDHP4). The hospital was previously involved in phases one, two and three. Phase 4 – 'Care of the Frail Aged' –identified and promoted innovative hospital-based programs for improving services to older Australians.

- Australia's first and only State tissue bank, the WA Research Tissue Network, was opened at SCGH in April 2003. The bank operates by elective surgery patients consenting to donate tissue (in excess of their diagnostic needs) for medical research. All WA hospitals have access to the facility.
- Six patients injured in the Bali bombings were treated at SCGH.
- An additional 90 FTE nursing positions were allocated to SCGH as a result of the nursing workload decision. A subsequent recruitment and retention program by the hospital has resulted in the filling of many of these positions, with a positive impact on nursing practice.
- Work began in May 2003 on a $10.3 million expansion of Osborne Park Hospital (OPH), including three new theatres, day procedure unit, endoscopy suite, central sterile supply department and management office accommodation. The new facilities should enable OPH to undertake more complex elective surgery.
- A feasibility study for a 50-bed adult in-patient mental health unit on the OPH campus commenced, including preparation of a full site structure plan.
- OPH’s Day Procedure Unit led the State in the Department’s 2002 Patient Satisfaction Survey, achieving an overall satisfaction level of 88%. A new purpose-built unit is scheduled for completion in late 2004.
- September 2002 saw the delivery of the 50,000th baby born at OPH since its opening in 1962. OPH’s 40th anniversary was celebrated with an open day in October 2002.
- A Falls Clinic within the Department of Rehabilitation and Aged Care (DRAC) started in January 2003. It aims to recognise at-risk patients and develop strategies for overcoming these risks.
- A Parkinson's Clinic (run by DRAC) was established and a consultant physician appointed in January 2003. The clinic treats an average of 50 patients per month.
- A Memory Clinic was established by DRAC and now treats approximately 50 patients on-site and at outpatient clinics.
- The existing maximum accreditation status of OPH was confirmed by the Australian Council on Healthcare Standards following a Periodic Review in November 2002. OPH is the longest continuously accredited secondary hospital in metropolitan Perth (14 years).

Population Health Program

- The Population Health Program (PHP), in conjunction with the Joondalup Education District, successfully ‘Australianised’ and piloted the Canadian-designed Early Development Index (EDI) in August 2002. The EDI – a population health measure and community mobilisation tool – will be implemented across the NMHS and other areas of the State as a component of the Communities for Early Life strategy.
- The PHP, in conjunction with the Telethon Institute for Child Health, obtained $400,000 from Healthway and the WA Lotteries Commission to conduct a three-year evaluation trial of the Preconception Intervention Program.

Mental health and special care services

- A parliamentary review of the future of the Selby Child and Adolescent Service was completed in May 2002, resulting in a decision to split the service into a Selby service and a new Mirrabooka service, with a new facility to be built at Selby and additional recurrent funding for Mirrabooka.
- Graylands Selby-Lemnos and Special Care Health Service was awarded the maximum four-year accreditation status by the Australian Council on Healthcare Standards in September 2002. Graylands Selby-Lemnos also participated in an in-depth mental health review, confirming its commitment to the National Standards for Mental Health.
- In January 2003, the service’s Professor Assen Jablensky was invited to join the Prime Minister's Science, Engineering and Innovation Council. He sits as one of 10 members of the Neuroscience Working Group.
- The State Forensic Mental Health Service Community Program was a finalist in the 2002 Premier’s Award for Excellence in Public Sector Management (Social and Community Development category).
- The Area Mental Health Service received specific research funding for advanced post-natal depression (April 2003).
- A breakthrough in schizophrenia research was achieved by the Centre for Clinical Research in Neuropsychiatry (CCRN) at Graylands Hospital, with the discovery that a region on chromosome 6 is linked to a sub-type of schizophrenia. Details are to be published in the Journal of Molecular Psychiatry.

SOUTH METROPOLITAN HEALTH SERVICE

The South Metropolitan Health Service (SMHS) oversees the operation of Fremantle Hospital and Health Service (FHHS), Armadale Health Service (AHS), Rockingham/Kwinana Health Services (RKHS), South Metropolitan Mental Health Service and Population Health.

The Department's implementation of area-based corporate services for finance, human resources, information technology and facilities management provided opportunities to both rationalise resources and expand service provision and support across the SMHS.

The 2002-2003 year was notable for record hospital demand, area-wide management changes, consolidation of the operations of SMHS and the introduction of several new services. SMHS Chief Executive John Burns was appointed State Health Emergency Director, a role that was to the fore in the State's response to the Bali bombings.

Key Achievements

- Establishment of a new Public Health Unit for the SMHS
- FHHS won the 2002 National Industry Award for Excellence in Training in Community Services and Health, and the City of Fremantle's Family-Friendly Award
- New service developments such as:
  - an operating theatre complex at FHHS
  - 'wet-lab' at FHHS Ophthalmology Department
  - Hand Therapy Clinic
  - Changes in processes to improve service and decrease waiting times
- Redevelopment of the Rockingham Health Service's emergency department, including a new restorative unit, was commenced
- Rottnest Island's Telehealth facilities were upgraded with the installation of new ISDN telecommunication facilities
- Mental health milestones achieved such as refurbishment of the Alma Street Centre's aged psychiatry in-patient area and relocation of Child and Adolescent Mental Health Services from Kelmscott to Armadale/Kelmscott Memorial Hospital
- Support for the treatment of Bali victims provided through the conversion of Fremantle Hospital's Children's Ward to a 'Bali ward' and the utilisation of the Diving and Hyperbaric Medicine Unit to treat septic wounds caused by embedded metals

New facilities, services and initiatives

- A new Public Health Unit was established in Pakenham Street, Fremantle, to provide population health services to the SMHS target population.
- The FHHS won the 2002 National Industry Award for Excellence in Training in Community Services and Health, as well as a State award for Large Employer of the Year (2002). At a local level, the hospital won the City of Fremantle's Family-Friendly Award.
- Fremantle Hospital, Woodside Maternity Hospital, Rottnest Island Nursing Post and Armadale/Kelmscott Memorial Hospital were all successful in gaining four-year accreditation (the highest possible) from the Australian Council of Healthcare Standards.
- A periodic review at Rockingham/Kwinana District Hospital (RKDH) resulted in the hospital receiving five commendations and a positive review outcome for its Rockingham/Kwinana Mental Health Services, as measured against the National Standards for Mental Health Services.
- There was a major effort by the nursing executive to reduce the reliance on agency nursing staff, while at the same time increasing permanent hospital-based staff.
- Fremantle Hospital nurses 'starred' in State-wide television advertising for attracting staff back to the industry, with significant results. There has been a decrease from about 70 agency staff each day at Fremantle Hospital to an average of 15, which has brought significant financial savings and improved productivity.
- The work of nurses in Fremantle Hospital's unique Diving and Hyperbaric Medicine Unit set new Australian standards. Also, special praise was given to nurses working with elderly patients in the hospital's Supervised Care Unit.
- New services were added to the SMHS portfolio, including:
  - A $2.6m operating theatre complex at Fremantle Hospital;
  - Medical Sciences Centre at University of Western Australia Department based at Fremantle Hospital;
  - New 'wet-lab' in Fremantle Hospital's Ophthalmology Department;
  - Hand Therapy Clinic (Fremantle Hospital);
  - Molecular diagnostics facility in Pathology Services;
  - $800,000 refurbishment for Ward F6 at Fremantle Hospital;
  - Introduction of a 'transit lounge' at Fremantle Hospital to free up beds and enable people to move more smoothly through the Trauma and Emergency Centre;
  - Commencement of 'Get to Know a Local GP' program at Rockingham/Kwinana District Hospital (joint project with the Division of General Practice); and
  - Appointment of an Aged Care Coordinator at Rockingham/Kwinana District Hospital.
- A vancomycin-resistant enterococci (VRE) cluster at Fremantle Hospital was overcome, thanks to diligent work by a range of staff, led by the infection control coordinators.

- The FHHS successfully made urgent contingency plans for sudden acute respiratory syndrome (SARS) and for incidents of terrorism that might involve chemical, biological or radiological agents.
- Redevelopment of the Rockingham Health Service's emergency department, including a new restorative unit, was commenced.
- A computerised tomography scanner was commissioned at Rockingham Health Service.
- Rottnest Island's Telehealth facilities were upgraded with the installation of new ISDN telecommunication facilities. A new aerial on Wadjemup Hill (installed by the Department of Health) improved radio communication to Fremantle Hospital's Trauma and Emergency Centre and to areas around the island.
- Accommodation for visiting staff was upgraded with the acquisition and renovation of the former nursing post by volunteers from the Rottnest Island Authority, Winnit Club and Fremantle Hospital.
- A multi-disciplinary Medical Admissions and Planning Unit was established at Armadale/Kelmscott Memorial Hospital to streamline planning of patient care.
- An orthopaedic joint-replacement surgical program was also implemented.

Mental health

- South Metropolitan Mental Health Services (SMMHS) developed and implemented new frameworks for clinical governance, which enable participation by all stakeholders in planning and improving service quality.
- Other important milestones in mental health were:
  - Refurbishment of the Alma Street Centre's aged psychiatry in-patient area;
  - Relocation of Child and Adolescent Mental Health Services from Kelmscott to Armadale/Kelmscott Memorial Hospital; and
  - New offices for Community Health, Child and Adolescent and Adult Mental Health Services, and Rockingham/Kwinana Mental Health Services, costing $780,000.

Bali

- SMHS staff responded in a very professional manner to the Bali incident. Fremantle Hospital Disaster Response Team staff were on the tarmac to meet all aircraft carrying casualties, set up an airport triage and stabilised all incoming casualties.
- Fremantle Hospital's Children's Ward was converted to a 'Bali ward' and the Diving and Hyperbaric Medicine Unit treated septic wounds caused by embedded metals. Social work, nursing and medical staff received high praise for their efforts from political leaders. Nurses, doctors, executives and others made regular contributions to a fund for clothing, feeding and educating Bali children badly affected by the bombings.

Volunteers/community

- Volunteers continued to make a very significant contribution to SMHS services:
  - Ladies' auxiliaries at Fremantle Hospital, Rockingham/Kwinana District Hospital and Armadale/Kelmscott Memorial Hospital operated kiosk-style food and drink outlets, donating the proceeds to their respective hospitals;
  - Community Advisory Council representatives met regularly to investigate issues and suggest improvements;
  - Volunteer drivers ferried patients to and from hospitals; and
  - At Fremantle Hospital the 'Nara' companions and volunteers from Red Cross and the Heart Patients Support Group attended to in-patient needs; Radio Lollipop entertained child patients; Fremantle Football Club sponsored an annual Children's Ward bravery award; and HomesWest provided housing for mental health patients.

WOMEN'S AND CHILDREN'S HEALTH SERVICE

The Women's and Children's Health Service (WCHS) comprises King Edward Memorial Hospital for Women (KEMH), Princess Margaret Hospital for Children (PMH), the State Child Development Centre, Stubbs Terrace Paediatric Mental Health Services and the Sexual Assault Resource Centre.

The WCHS vision – that all women and children in the State will have access to the highest quality health services – is pursued through a wide range of specialist services and maintenance of strong links with academic institutions, aimed at ensuring clinical research continues to play a key role in service delivery.

A priority for WCHS during 2002/2003 was the ongoing implementation of the 237 recommendations handed down by the Douglas Inquiry Report into King Edward Memorial Hospital.

Key Achievements

- Implementation of 233 out of 237 Douglas Inquiry recommendations
- Increase in numbers of senior medical staff at KEMH
- Appointment of a new Medical Director for Obstetrics and Gynaecology
- Completion of a statewide review of obstetric services and development of report (Cohen Report) – currently undergoing public consultation
- Major upgrades of facilities commenced: PMH – re-development of Ward 9A; and KEMH – emergency centre, delivery suite (birthing rooms), neonatal nursery, admissions, main entry and West Wing clinic
- A magnetic resonance imaging (MRI) scanner was purchased for PMH
- Extra resources allocated for the Child Protection Unit and at the Sexual Assault Resource Centre, in line Gordon Inquiry recommendations
- Community-based facilities were introduced at Lady Lawley Cottage
- A new management and committee structure for WCHS was implemented

New facilities, services and initiatives

- There were continuing high levels of patient contact for the full range of tertiary sub-specialities at PMH and KEMH and through direct services provided in rural areas (37,150 in-patient admissions, 51,950 presentations at emergency departments, and 91,500 outpatient attendances).
- Two hundred and thirty three of the 237 Douglas Inquiry recommendations were implemented, in line with the deadline of 30 June 2003. The remaining four recommendations require legislative action, to be coordinated by the Department of Health. Forty-three recommendations are the subject of ongoing audit.
- Senior medical staff numbers at KEMH were increased (recommended by the Douglas Inquiry) resulting in greater consultant presence in areas such as the Delivery Suite and the Emergency Centre.

- A new Medical Director for Obstetrics and Gynaecology was appointed at KEMH (March 2003).
- A State-wide review of obstetric services was completed and a report published (Cohen Report), which recommended establishment of a State-wide Obstetrics Support Unit. The report is currently undergoing a period of public consultation.
- Major upgrades of facilities were commenced: PMH – re-development of Ward 9A; and KEMH – emergency centre, delivery suite (birthing rooms), neonatal nursery, admissions, main entry and West Wing clinic.
- A magnetic resonance imaging (MRI) scanner was purchased for PMH, expected to be fully operational in late 2003.
- Extra resources have been allocated for the Child Protection Unit and at the Sexual Assault Resource Centre, in line with recommendations of the Gordon Inquiry.
- Community-based facilities were introduced at Lady Lawley Cottage to accommodate technology-dependent high-needs children, who might otherwise have had to remain as long-term patients at PMH.
- A Review of Research and Education was commenced, expected to lead to more collaborative activities, especially in child health.
- There was a reduction in numbers of patients on elective surgery waiting lists, in both the ‘urgent’ (category 1 – have waited more than 30 days) and ‘routine’ (have waited more than 1000 days). There were less than 10 routine cases at 30 June 2003.
- Evidence-based clinical practice guidelines were made available on both the intranet (for in-house medical staff) and Internet (for practitioners outside WCHS).
- A new management and committee structure for WCHS was implemented, designed to improve safety and service quality.
- An additional 50 nurses and midwives were employed to meet clinical needs and to ensure compliance with industrial awards and Government policy.

DENTAL HEALTH SERVICE

The Dental Health Service maintained its strong commitment to improving the oral health of Western Australians, a goal that was pursued through four key programs: the School Dental Service; Dental Care for the Financially and Geographically Disadvantaged; Special Services; and Oral Health Promotion.

Key Achievements

- Preventative/restorative care provided to about 250,000 school children
- Subsidised general dental care to 80,000 eligible people
- Expansion of dental services with the Morley Dental Clinic, a new clinic at Newman and a new dental therapy clinic for Perth's southern corridor
- Implementation of the Aged Care Program

- Preventative and restorative dental care was provided to approximately 250,000 school children throughout the State, ranging from pre-primary to Year 11. The program also included Year 12 students in remote locations.
- Subsidised general dental care was provided to approximately 80,000 eligible patients through public dental clinics and private practitioners who participated in the Country Patients' Dental Subsidy Scheme (CPDSS) and the Metropolitan Patients' Dental Subsidy Scheme (MPDSS).
- Through the Special Services Program, dental care was provided to housebound patients, special groups and institutionalised patients. An after-hours emergency service was also provided for the general public.
- The Oral Health Promotion Program provided education on relevant dental health issues to support both clinical staff and the wider community, including the targeting of key health provider groups, teachers and community leaders.
- The reach of Dental Health Services was expanded with the provision of several new services and facilities. Foremost were:
  - The Morley Government Dental Clinic to provide additional dental care opportunities in the northern suburbs for pensioners and Healthcare card holders;
  - A new dental clinic at Newman, which has replaced an old facility. The clinic is expected to assist in the recruitment of a dentist to the area; and
  - A new dental therapy centre at the South Coogee Primary School (May 2003), established to cater for the rapid population growth in Perth's southern corridor.
- A new aged care program offers an oral health assessment to approximately 12,000 residents of aged care facilities. The program includes a specific care program and treatment at Government clinics for eligible seniors. About 8,600 eligible people took up the offer throughout the year. An accompanying education program to assist staff and carers in meeting the oral health care needs of aged care facility residents was also widely accessed.

MAJOR CAPITAL WORKS

The projects outlined below are the capital works approved at Health Service level for the Metropolitan Health Service. Projects commenced and completed as part of the system-wide Capital Works Program are included in the Department of Health (Royal Street) Annual Report 2002/2003.

Table 3: Major Capital Works – Projects in Progress

PROJECT DESCRIPTION	Expected Year of Completion	Estimated Cost to Complete $'000	Estimated Total Cost $'000
East Metropolitan Health Service			
WSC ICU Isolation Rooms	2003	1,000	1,000
WSC Refurbishment of A Block Wards	2003	500	900
SPC Refurbishment of Spinal Unit	2003	700	700
BHS Upgrade of A Block air-conditioning,	2004	1,400	1,500
North Metropolitan Health Service			
SCGH ED Redevelopment	2004	5,270	9,270
MRI Suite Level 1 "G" Block – SCGH	2003	600	3,300
Osborne Park Hospital Operating Theatres & Mental Health Unit	2004	12,770	14,000
Selby CAMHS Relocation	2004	750	750
Graylands Frankland Unit –"Beam Set" Perimeter and Courtyard Security	2003	750	750
South Metropolitan Health Service			
FHHS Ward F6 Redevelopment	2003/2004	800	800
FHHS Department of Respiratory Medicine & Associated Relocations	2003/2004	150	200
FHHS Chiller Replacement – B Block	2003/2004	430	430
FHHS Alteration/Additions to Ward W4.3	2003/2004	40	40
FHHS Public/Population Health Facilities	2002/2003	40	160
Rockingham Emergency Department/ Restorative unit redevelopment	2003/2004	9,800	9,800
Rockingham Birthing en-suite upgrade	2003/2004	50	50
Women's and Children's Health Service			
KEMH Major Works	2004	7,100	8,000
PMH Ward 8A/9A	2004	5,040	5,500
PMH ED, CPU, Front Entry	2004	2,420	2,600
PMH Haematology Refurb	2004	340	340
PMH MRI	2003	3,500	3,500
PMH Endo/Dietetics Upgrade	2004	400	400
Dental Health Service			
Newman Dental Clinic	2003	150	500
Perth Dental Hospital Devolution*	2004	980	2,380
Spearwood/Cockburn Dental Clinic	2004	1,480	1,500
Joondalup Dental Clinic	2004	1,330	1,350

Project in Progress cont.

* Perth Dental Hospital Devolution outstanding funding is for the provision of a Maintenance Workshop, which has been deferred pending a review of services.

Table 4: Major Capital Works – Projects Completed during the year

PROJECT TITLE	Final Total Cost $'000
East Metropolitan Health Service	
WSC In-Centre Renal Dialysis Unit, Up-grade	1,500
SPC Ward 9 en-suites and single- room isolation facilities	750
SHS CT Scanning Suite	1,300
SHS Observation Ward	600
KHS Remedial Works Program	270
North Metropolitan Health Service	
South Perth Community Hospital - Gairdner Interim Care Unit	120
WA PET/Cyclotron Service – SCGH	8,590
SCGH Anstey House "S" Block Demolition	1,400
South Metropolitan Health Service	
FHHS Additional Operating Theatre & Support Facilities (reported as "in progress" last year)	1,600
FHHS Discharge / Transit Lounge	100
FHHS Hand Clinic / Dietetics New Accommodation	300
FHHS Alterations and Additions to T Block	1,600
AHS Relocation of Child and Adolescent Mental Health Services	90
Rockingham/Kwinana Goddard Street Project	1,100
Women's and Children's Health Service	
KEMH Diagnostic Imaging Upgrade	300
Dental Health Service	
Morley Dental Clinic	1,400

DEMOGRAPHY

The population of the Metropolitan area increased from 946,737 in 1981 to 1,482,645 in 2002. This represents an average increase of 24,359 persons per year. In 2001 the life expectancy for males and females in the metropolitan area was 80.0 years and 85.6 years respectively. This compares favourably with the 1992 figures of 76.6 years and 83.2 years.

Postcodes in the Metropolitan area

The postcodes covered by the Metropolitan Health Service are outlined below. The majority of people who utilise the services provided by the Metropolitan Health Service reside in these postcode areas. It is important to note however that the Metropolitan Health Service plays a key role in providing specialist and tertiary services on a statewide basis, and to inter-state and international patients.

Table 5: Postcodes in the Metropolitan area

6000	6003	6004	6005	6006	6007
6008	6009	6010	6011	6012	6014
6015	6016	6017	6018	6019	6020
6021	6022	6023	6024	6025	6026
6027	6028	6029	6030	6031	6032
6033	6034	6035	6036	6037	6038
6050	6051	6052	6053	6054	6055
6056	6057	6058	6059	6060	6061
6062	6063	6064	6065	6066	6067
6068	6069	6070	6071	6072	6073
6074	6076	6081	6082	6083	6084
6085	6090	6100	6101	6102	6103
6104	6105	6106	6107	6108	6109
6110	6111	6112	6113	6121	6122
6123	6124	6125	6126	6147	6148
6149	6150	6151	6152	6153	6154
6155	6156	6157	6158	6159	6160
6161	6162	6163	6164	6165	6166
6167	6168	6169	6170	6171	6172
6173	6174	6175	6176	6201	6202
6203	6204	6205	6206	6207	6208
6210	6211	6213	6214	6215	6500
6555	6556	6558			

DISABILITY SERVICES

The *Disabilities Services Act 1993* was introduced by the State Government to ensure that people with disabilities have the same opportunities as other West Australians. As required under that Act, each Health Service has developed and implemented a Disability Services Plan. In the year ending 30 June 2003, the initiatives undertaken by the MHS to achieve the desired outcomes included:

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

- Reference groups provided advice on the accessibility of existing services enabling the identification of problems. Priorities were addressed through the Disability Service planning process.
- Patient transport services were improved to allow better access.
- Access issues were addressed when planning for public events.
- Health Service policies were reviewed and, where necessary, updated to meet disability access standards.

OUTCOME 2
Access to buildings and facilities is improved.

- The Health Services, having identified priorities on their Disability Services Plan, undertook minor works projects to ensure that existing facilities met the needs of their disabled clients, for example, installation of ramps, hand rails, toilet and bathroom upgrades and automatic doors.

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

- Each Health Service identified its own priorities in relation to communicating information to disabled clients, and has made improvements in those areas. For example many sites have made available TTY telephones for the hearing impaired, large print brochures and/or audio cassettes for sight impaired.

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

- Some of the Health Services provided disability awareness training as part of their orientation programs. Others included it in staff education and development programs or delivered individual sessions to key groups.

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

- Community consultation was utilised by most of the Health Services to support decision making.
- Health Services have in place complaints procedures suitable for clients who are unable to make written complaints.
- Health Services have in place grievance mechanisms that allow people with disabilities to participate without impediment.

EQUITY AND DIVERSITY

The Metropolitan Health Service (MHS) is committed to managing its Human Resources in compliance with the 'Whole of Government's Equity and Diversity Plan for the Public Sector Workforce 2001-2005'. The MHS aims to promote equal opportunity for all persons, according to the *Equal Opportunity Act 1984,* and has in place, strategies to achieve the equity and diversity desired outcomes. Activities undertaken in 2002/2003 to support equity and diversity within the MHS workforce include:

OUTCOME 1
The organisation values Equal Employment Opportunity (EEO) and diversity and the work environment is free from racial and sexual harassment.

- Policies and procedures were reviewed and updated to include the recent changes to the *Equal Opportunity Act 1984* in relation to Sexual Orientation and Gender History.
- Business Plans included strategies to achieve Equity and Diversity
- Equity and Diversity Committees met regularly and Grievance and Contact Officers were appointed.
- Grievance resolution procedures were put in place.

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

- Recruitment and Selection training modified to encompass EEO.
- Job descriptions for management and supervisory staff were amended - knowledge of legislative requirements for EEO and diversity is an essential criterion.
- New employees were educated through induction courses and information was made available through intranet sites and health service manuals.
- Where possible, flexible working arrangements were negotiated with staff, for example, women returning from maternity leave and telecommuting.
- Child care and vacation care continued to be available in some Health Services and a new (free) vacation care program was commenced at RPH.

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

- Health Services provided work experience programs to people from minority groups including people from non-English speaking backgrounds, Aboriginal and Torres Strait Islanders and people with disabilities.
- The EMHS established an Aboriginal Employment Reference Group to develop strategies to increase the number of Aboriginal people employed. They plan to be involved in the Indigenous Cadetship Program and Indigenous School-based Traineeships.

CULTURAL DIVERSITY AND LANGUAGE SERVICES

In line with State government policy, The Metropolitan Health Service endeavours to ensure that language is not a barrier to accessing health services for people who require assistance in English. It also recognises that English is a second language to many Indigenous people who may experience cultural barriers and communication difficulties while trying to access the services.

Throughout 2002/2003 the Health Services were at different levels in relation to meeting the communication requirements of people who have special language or cultural needs. A variety of communication support strategies were in place at the individual service providers, with the Teaching Hospitals and, to a lesser extent, the Secondary Hospitals providing a wide range of mechanisms to facilitate access by these special-need clients. Some of the smaller agencies currently have limited ways of providing optimal assistance to meet the need. However, it is envisaged that, with the bedding-down of the MHS area-health organisational structure, there will be more opportunities for the strategies in place in the larger hospital to be migrated out to all smaller service providers in each area.

The Health Services' interpreter services were well utilised during 2002/2003. For example the Women's and Children's Health Service (WCHS) provided 3,920 occasions of interpreter services in 50 languages and RPH provided over 7,500 occasions of service to RPH patients (at the Wellington Street and Shenton Park Campus, Ursula Fraye Unit at Mercy Hospital and home visits). Demand for RPH interpreting services increased by 24% in 2002/2003 and by 64% since 1999/2000.

For the year ending 30 June 2003, the Health Services improved access to health services for people who experienced language or cultural difficulties. This is illustrated by the following:

- Services increasingly followed Language Services Policy guidelines using, professional NAATI accredited interpreters, wherever possible. Bi-lingual staff members were used in limited situations such as an emergency;
- The East, North, South and Women's and Children's Health Services had budgets to support Language Services Policy requirements;
- Health Services participated in a Language Needs Analysis workshop
- An increased number of pamphlets were translated into different languages, however interpreters were used to communicate important information;
- Significantly more MHS staff became aware of cultural and language issues having attended training sessions during the year with all Teaching Hospitals and most Secondary Hospitals offering education programs. As well as the broader issues, sessions included instruction on how to work with interpreters. Staff also received instruction in relation to the appropriate action to be taken when a Western Australian Interpreter Card is presented;
- Written instructions for staff were made more available across sites;
- Some Health Services conducted professional development sessions for interpreters;

Cultural Diversity and Language Services cont.

- Conference/dual handset telephones/TTYs were installed in some public contact areas and interview rooms and wards; and
- All services had procedures in place to record feedback from clients and some services had mechanisms in place to consult with appropriate reference groups for advice on priorities.

2002/2003 Highlights - Cultural Diversity and Language Services

- Royal Perth Hospital (RPH) Language Services extended their hours and are now available on Saturdays and Sundays between 9 am and 5 pm.
- RPH translated the *Patients' Information* booklet into eight languages.
- RPH Language Services Unit, together with the Division of Surgery, developed criteria for booking interpreters for surgical wards and theatres.
- Swan Health Service (SHS) introduced a risk communication risk assessment tool.
- Swan and Kalamunda Health Service's developed a new *Death of a Patient* Policy to incorporate multicultural issues.
- Armadale Health Service (AHS) improved the provision of multicultural information by revising the Multicultural Resource Manual and establishing an Intranet site
- AHS established Multicultural Access portfolio holders who advised on resources available and facilitated interpreter use in all clinical service sites. They formed a Multicultural Access Committee which met monthly with Management & community members.
- WCHS, in consultation with community representatives, created & translated a pamphlet & poster about why male staff may provide care to public patients.
- WCHS created a cultural safe place for Aboriginal women attending KEMH (one already exists at PMH).
- The Dental Health Service (DHS) developed culturally appropriate teaching aids for health workers/teachers to provide oral health instruction in rural and remote Indigenous communities.
- 2002/2003 educational sessions included:
  - "Interpreting for Elderly Patients Suffering from Mental Disorders" at RPH for interpreters;
  - AUSIT session on "Professional Ethics" " at RPH for interpreters;
  - A Multicultural Mental Health Forum for Clinicians conducted at SHS;
  - "Valuing Cultural Diversity" for the Refresher Nurses program and SHS staff;
  - "Cultural Shock" presentation delivered to SCGH Social Work Department;
  - "Aboriginal Awareness" education sessions provided by AMS; and
  - Sessions about Men, Families and Health of Middle-Eastern and East African countries, presented by male interpreters at WCHS.

YOUTH SERVICES

Action: A State Government Plan for Young People, 2000/2003, which focuses on young people aged between 12 and 25 years, is based on four guiding principles:

- Young people should have access to a range of opportunities, services and resources that will assist them in reaching their full potential;
- Young people should be encouraged to participate actively in positive and meaningful ways, especially in relation to decision making on issues that are significant to them;
- Young people are valued and respected as individuals who should be treated fairly and with integrity, and given the opportunity to further develop their potential to contribute to society in a responsible way; and
- Better coordination of services for young people throughout the community must be encouraged.

The Metropolitan Health Service (MHS) played a role in the achievement of the six goals that were articulated in the plan. MHS activities that supported the six goals included the following activities:

1. **Promoting a positive image of young people:**
   - Where appropriate and with permission, drew public attention to young people who had demonstrated outstanding courage in coping with disease or injury.
   - The South Metro Population Health Unit organised the YOH Fest (Youth on Health Drama Festival) which included:
     - The delivery of a drama festival with about 70 schools involved;
     - Provision of the services of a young Aboriginal person (traineeship) to visit Aboriginal schools to encourage participation; and
     - Three traineeships to support the program.

2. **Promoting the broad social health, safety and wellbeing of young people:**
   - The School Dental Service provided preventative and restorative dental care to 250,000 school children (to year 11) throughout the State.
   - The Adolescent Mothers' Support Service provided education aimed at improving parenting skills and neonatal health outcomes to metropolitan women under 18 years having their first baby and planning to give birth at KEMH.
   - The Swan Youth Therapy Service provided mental health services to at risk youth.
   - East Metropolitan Population Health Unit provided a number of youth programs for example:
     - *Let's Talk About Sex* package for Aboriginal young people;
     - Youth Suicide Prevention Network Program - 4-5 forums annually (for health professionals who work with youth); and
     - Healthy Connections – a youth suicide prevention program conducted in several East Perth schools.

Youth Services cont.

- Inner City Mental Health Service provided a number of youth programs. For example:
  - YouthLink - a statewide tertiary mental health service for marginalised youth supported over 150 young people and a range of youth; and
  - Youth Counsellor Program - prevention and early intervention for mental health problems in inner city male youth.
- BHS provided mental health services to youth including:
  - The Way Centre Adolescent Unit;
  - The Way Centre Transition Unit; and
  - Bentley Family Clinic.
- Child and Adolescent Mental Health Services (Selby, Hillarys, Warwick and Clarkson) provided services to the young.
- Services were provided by Peel Youth Counselling program.
- PMH provided across the board services for children and young adolescents. The following are especially geared for adolescents:
  - Eating Disorders Team;
  - Adolescent Diabetic Clinic;
  - Spina Bifida Transition Program; and
  - Adolescent Oncology.

3. Better preparing young people for work and adult life

- All Health Services provided work experience opportunities across a wide range of trades and professions for school children and university students.
- All Health Services collaborated with the universities to provide clinical experience placements for students undertaking clinical under-graduate courses.
- The Hope Garden project – a sensory garden was established at Rockingham Hospital by local high school students. The project was supported by the Health Service and the local shire, enabled students to achieve goals for *The Red Cross Challenge*.
- The South Metro Population Health Unit organised the City of Fremantle *Dreaming Project* whereby*:*
  - Aboriginal young people were involved in a 10 week series of performance and circus skill development; and
  - Contemporary dance performance was developed with assistance from Ningali Lawford.

4. Encouraging employment opportunities for young people

- All Health Services conduct a variety of postgraduate training programs for young health professionals recently graduated from university.
- Dental Health Services, in collaboration with Curtin University, TAFE Colleges and Dental Nursing Australia, provided training opportunities in the areas of dental therapy and dental clinic assisting - targeting school leavers.
- In partnership with Apprenticeships WA, the Swan and Kalamunda Health Services established a Gardens and Grounds Trainee Position.

Youth Services cont.

5. **Promoting the development of personal and leadership skills**
   The South Metro Population Health Unit ran an Adolescent Peer Health Educator Project (PARK) which involved conducting a camp to train Peer Educators. Twenty five youths were trained as peer educators, 25 parents trained in communication skills, drug awareness and parenting skills and two traineeships were provided to support program.

6. **Encouraging young people to take on roles and responsibilities that lead to active adult citizenship**
   All Health Services provided support and encouragement to young employees (both professional and non-professional) to take on roles and responsibilities which would widen their horizons and to help them become well-rounded citizens. Where it was appropriate, Health Services supported staff who volunteered for community projects, eg volunteers for Camp Quality programs and Variety Club charitable events.

EMPLOYEE PROFILE

The Metropolitan Health Service (MHS) is a major employer of public servants, employing more than sixteen thousand full-time equivalent staff in 2002/03. As such, it takes very seriously its responsibilities to utilise its resources efficiently. It also has a commitment to individual staff members ensuring that public sector standards are maintained.

The tables below show the number of full-time equivalent staff employed by the MHS over the last three years.

Table 6: Employee Profile

CATEGORY	2000/2001	2001/2002	2002/2003
EAST METROPOLITAN HEALTH SERVICE			
Nursing Services/Dental Care Assistants	1,985.6	1,888.4	2,177.0
Administration & Clerical*	899.5	964.3	940.5
Medical Support*	930.7	1,000.4	980.1
Hotel Services*	629.1	637.1	735.0
Maintenance	86.0	85.1	93.2
Medical (salaried)	504.1	544.0	555.3
Medical (sessional)	70.3	66.5	74.3
EMHS TOTAL	**5,105.3**	**5,185.8**	**5,555.4**
NORTH METROPOLITAN HEALTH SERVICE			
Nursing Services/Dental Care Assistants	1,709.2	1,753.2	1,790.4
Administration & Clerical*	706.6	720.7	737.6
Medical Support*	584.8	623.1	640.1
Hotel Services*	598.2	628.0	632.6
Maintenance	110.5	106.9	103.0
Medical (salaried)	413.9	428.1	433.4
Medical (sessional)	52.8	52.1	55.9
NMHS TOTAL	**4,176.0**	**4,312.1**	**4,393.0**
SOUTH METROPOLITAN HEALTH SERVICE			
Nursing Services/Dental Care Assistants	1,264.9	1,336.7	1,428.5
Administration & Clerical*	547.3	578.5	621.7
Medical Support*	404.3	427.1	444.5
Hotel Services*	386.3	402.4	445.5
Maintenance	43.5	43.6	44.1
Medical (salaried)	256.4	291.4	318.2
Medical (sessional)	55.8	36.5	37.4
SMHS TOTAL	**2,958.5**	**3,116.2**	**3,339.9**
WOMEN'S AND CHILDREN'S HEALTH SERVICE			
Nursing Services/Dental Care Assistants	932.9	973.6	1,023.2
Administration & Clerical*	405.1	438.0	444.5
Medical Support*	337.9	355.6	371.0
Hotel Services*	275.1	274.7	269.8
Maintenance	54.9	57.1	58.6
Medical (salaried)	221.5	232.5	257.2
Medical (sessional)	47.1	49.8	51.3
WCHS TOTAL	**2,274.5**	**2,381.3**	**2,475.6**

Employee Profile cont.

CATEGORY	2000/2001	2001/2002	2002/2003
DENTAL HEALTH SERVICE			
Nursing Services/Dental Care Assistants	292.2	276.0	241.3
Administration & Clerical*	85.3	79.2	64.3
Medical Support*	179.6	174.4	168.3
Hotel Services*	30.9	23.3	13.4
Maintenance	12.6	10.5	10.4
Medical (salaried)	116.0	110.2	96.7
Medical (sessional)	0.0	0.0	0.0
DHS TOTAL	**716.6**	**673.6**	**594.4** [#]
MHS TOTAL EMPLOYEE	**15,230.9**	**15,669.0**	**16,358.3**[#]

* Note: These categories include the following:

- **Administration and Clerical** – Administrative and executive staff, ward clerks, receptionists and clerical staff
- **Medical Support** – physiotherapists, speech pathologists, medical imaging technologists, pharmacists, occupational therapists, dietitians and social workers
- **Hotel Services** – cleaners, caterers and patient service assistants

[#] Dental Health Service figures do not include the Oral Health Centre for 2002/2003.

RECRUITMENT

Industry-wide problems with the recruitment and retention of medical and nursing staff continued to be of concern to the Metropolitan Health Service and to the Government during 2002/2003.

As well as each Health Service undertaking their own local and overseas recruitment campaigns for nurses, a system-wide campaign coordinated by the Department of Health Royal Street Divisions was implemented. This campaign, which consisted of television, electronic and print advertising featured Fremantle Hospital nurses.

A number of the Health Services made improvements to their web-sites during the year and the East Metropolitan Health Service established a *Jobs in Health @ EMHS* web site which has been fully operational since January 2003. The web-site is being managed by the newly established Recruitment and Selection Unit. Since its inception the web-site has had over 251 positions entered into the system. The Recruitment and Selection Unit has processed 1,136 applications and the web site has had 17,768 visits to 123 advertised vacancies (from January 2003), resulting in an average of 144 visits per position.

Recruitment cont.

To support the nursing recruitment process, the Metropolitan Health Service has extended existing courses and introduced new refresher courses for both registered and enrolled nurses. The Women's and Children's Health Service continued refresher courses for paediatric nurses and midwives and also had a *Renewal of Midwifery* course for midwives.

Staff Development programs across the Health Services continued to make a valuable contribution to the attraction and retention of nursing staff. Recruitment and Selection training courses continued to be offered to all staff across the services, and the *Recruitment and Selection* policy manual was updated.

A campaign to recruit more junior medical staff to the Metropolitan Health Service was also implemented. This included advertising both nationally and internationally and the doctors recruited have made a significant contribution.

There continued to be a shortage of Radiation Therapists and a twelve-month recruitment process was only partially successful - producing four recruits.

There were also significant difficulties in recruiting dentists to rural and remote locations and attracting and retaining experienced dentists for other locations. Initiatives are being investigated to overcome this situation including a review of pay and conditions, a scholarship scheme and an advertising campaign in the United Kingdom. The use of a limited registration scheme for oversees dentists is also being considered.

STAFF DEVELOPMENT

The Metropolitan Health Service recognises the important role of staff development in maintaining high standards in the delivery of clinical and support services and in the management of the organisations. During 2002/2003 each health service met the routine training/education needs of their staff and also targeted key areas where additional needs were identified through training needs analysis exercises. As a result, a large range of training and education courses were made available to staff.

Clinical Teaching is considered to be a core business activity for the Metropolitan Health Service. The Clinical courses offered and the 2002/2003 clinical teaching activity has been reported in a later section of this report (see Teaching and Research).

Staff Development cont.

Staff Development courses offered during the year included the following:

Corporate Induction/Orientation	Human Resource Skills
Code of Ethics and Conduct Equal Employment Opportunity Disability and Diversity Cultural Awareness Use of Interpreter Services Occupational Safety and Health Quality and Improvement Infection Control Emergency Preparedness Intern Orientation	Recruitment and Selection Leadership & Management Skills Performance Management Management Development Team Building Preceptorship Managing Aggression Bullying Awareness
Occupational Safety and Health Manual Handling Safer Patient Handling. Computer Ergonomics Assessment Security Training	Clinical Support Skills Mental Health Control and Restraint Program Enrolled Nurse Medication competency Patient Care Assistant courses
Computer Training Health Systems Office Software Internet and Intranet	Trainee-ships (in partnership with AMA)

Staff Development Highlights

- Introduction of a system to ensure the mandatory back-safe education for patient care assistants and other support staff at RPH.
- The Management Development program has been extended to the whole EMHS area, with three separate programs completed last year.
- Preliminary training of RPH Emergency Department Staff in the use of National Outcomes Casemix Collection in preparation for the implementation of PSOLIS (Mental Health Information System).
- 3 day Mental Health Control and Restraint Program at Swan Health Service
- *'Manutention'* approach to manual handling training presented by NMHS at the 45th Annual Scientific Convention of the Royal Australian College of General Practitioners.
- Implementation of a 'Bullying Awareness' program commenced in NMHS.
- Computer Ergonomics Assessment Training course for managers and supervisors, developed and implemented across NMHS.
- Fremantle Hospital & Health Service won the "Large Employer of the Year" category in the State Training Excellence Awards in August 2002
- Fremantle Hospital & Health Service won an Industry Award for "Excellence in Training in Health and Community Services" at the Australian National Training Authority Awards in Sydney, November 2002.

Staff Development cont.

- Mapping of the Patient Care Assistant Course (Acute Hospital Setting) across to the new Health Training Package. Fremantle Hospital & Health Service delivered three qualifications at Certificate II from Health Service Support and two Statements of Attainment at Certificate III.
- Five Patient Care Assistant courses were completed at Fremantle Hospital & Health Service with 99 participants successfully receiving qualifications, the majority from a non English speaking background, many of whom had been unemployed for a considerable length of time.

WORKERS' COMPENSATION AND REHABILITATION

The Metropolitan Health Service endeavours to provide a safe workplace by having in place active Occupational Safety and Health programs throughout its areas of responsibility. Where injuries do occur, support is offered to injured employees and there is a commitment to supporting their early and safe return to the workplace. This is achieved through an integrated on-site injury management service that combines the early identification of injured employees, processing of workers' compensation claims, and return to work programs. Injury management is complemented by established injury prevention programs.

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

Table 7: Workers' Compensation and Rehabilitation

CATEGORY	2000/2001	2001/2002	2002/2003
Nursing Services/Dental Care Assistants	414	376	361
Administration & Clerical*	72	67	80
Medical Support*	40	35	65
Hotel Services*	121	117	233
Maintenance	27	36	48
Medical (salaried)	12	9	6
Other	10	13	19
TOTAL	**696#**	**653#**	**812**

* Note: These categories include the following:

- **Administration and Clerical** – administration staff and executives, ward clerks, receptionists and clerical staff
- **Medical Support** – physiotherapists, speech pathologists, medical imaging technologists, pharmacists, occupational therapists, dietitians and social workers
- **Hotel Services** – cleaners, caterers and patient service assistants

Note: 2000/2001 and 2001/2002 figures in this table exclude the Graylands Selby-Lemnos and Special Care Health Services, the Swan Health Service, King Edward Memorial Hospital and Princess Margaret Hospital. Figures for 2000/2001 exclude the Rockingham/Kwinana Health Service.

Workers Compensation and Rehabilitation cont.

Occupational Safety and Health (OS&H) - Summary of 2002/2003 Activities

In order to achieve better outcomes, all Health Services within the Metropolitan Health Service implemented improvements to their OH&S programs. The East Metropolitan Health Service implemented a wide range of innovative strategies and the South Metropolitan Health Service reorganized their OH&S program by devolving responsibility to a Unit level. Metropolitan Health Service OH&S activities included:

- Continuation of OH&S Committees to advise Health Service executives;
- On-going risk management assessments at a Unit level;
- Continuation of rehabilitation coordination services and early intervention programs to assist injured staff to return to the workforce;
- Expansion of Manual Handling training;
- Workplace minor works programs to improve safety eg securing obstetric facilities, installation of emergency assist alarms;
- Continuation and expansion of training programs including courses for OH&S representatives and Fire Warden training;
- Revision of policy and procedure manuals, updating evacuation procedures and reporting processes;
- Reviewing and updating Security Officer rosters to improve safety; and
- Improving OH&S databases to allow easier access to information to support the implementation of proactive initiatives.

INDUSTRIAL RELATIONS

The Metropolitan Health Service' *Human Resource Management Committee* and the *Industrial Officers Group* met regularly during 2002/2003 to ensure relevant issues were managed in a consistent manner across the Health Service.

Industrial relation issues arising across the health sites during 2002/2003 included the following:

- All workplace agreements registered on or after 22 March 2001 ceased on 14 March 2003, and employee conditions were replaced by statutory contracts or enterprise agreement coverage;
- Negotiations resulted in a new enterprise agreement for Enrolled Nurses. All other enterprise agreements are due for renewal during the course of 2004;
- The Senior Registered Nurses (SRN) Work Value Review was released on 7 August 2002. The ongoing reclassification of SRNs is to continue for a further 12 months to maintain the integrity of the process. An independent Appeal Panel is due to release its recommendations;

Industrial Relations cont.

- The Hospital Salaried Officers Association raised reclassification issues concerning Clinical Psychologists and Level 1/2 Competencies - awaiting WA Industrial Relations Commission (WAIRC) resolution;
- The Hospital Salaried Officers Association raised the issue of fixed term contracts in the WAIRC. The Commission issued an Order for employees on long term contracts to be appointed into permanent positions;
- Patrol Officers have been consolidated under a single management structure and have been reclassified from Patrol Officers to Security Officers (with different agreement conditions);
- The consolidation of all the metropolitan and rural Plant Operators under the *MHS Engineering & Building Services Award* and *WA Government Health Services Agreement* has been negotiated. The *WA Government Health Services Engineering and Building Services Enterprise Agreement* was registered in February 2003 and it is currently being implemented;
- Graylands Selby-Lemnos employees were transferred from the *Graylands Selby-Lemnos and Special Care Health Services Award 1999* to the *Hospital Salaried Officers Award, 1968* and the *Hospital Salaried Officers Metropolitan Health Service Enterprise Agreement 2001*. This placed staff on the same employment conditions as other administrative staff in public hospitals;
- Fremantle Hospital and Health Service implemented a 12 hour shift roster agreement for Security Officers. This was done to promote safety by having two staff on duty at all times;
- In order to attract and retain nurses by allowing flexibility, Fremantle Hospital implemented a trial of 12 hour shift rosters for staff in ICU; and
- All Industrial Relations functions in the EMHS have been combined into a single service within the EMHS Human Resource Service.

FREEDOM OF INFORMATION

For the year ending 30 June 2003, 3,261 formal applications for access to information in accordance with the *Freedom of Information Act 1992* were received by the Metropolitan Health Service. A further 95, which had been carried over from the previous financial year, were also dealt with. In accordance with section S28 of the Act, full access to the information requested was given to 87% of all applicants and a further 6% of applicants were given partial access. Two percent (2%) of applications were subsequently withdrawn and one percent (1%) of applications were refused.

Formal applications were defined as requests which:

- Were in writing;
- Gave enough information to enable the requested documents to be identified;
- Gave an address in Australia to which notices under the *Freedom of Information Act 1992* could be sent;
- Gave any other information or details required under FOI regulations; and
- Were lodged at an office of the agency, with any application fee required under Freedom of Information (FOI) regulations.

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

Any information could be the subject of a formal application. There was no charge to access personal information, but a fee of $30 was applied to those wishing to access non-personal information. Any application relating to documents the Hospital or Health Service did not hold was transferred to the relevant agency and the applicant was notified.

Applicants who were unhappy with the Hospital or Health Service's decision regarding their FOI request were able to lodge a further application in writing within 30 days.

The types of documents held by the Metropolitan Health Service included:

- Patient medical and dental records;
- Patient information brochures and instruction sheets;
- Policy and Procedure manuals;
- Human Resource records;
- Financial and Accounting records; and
- Administrative records, for example committee meeting minutes and business correspondence.

A number of FOI Officers have appointments across the Metropolitan Health Service, with a role to receive FOI applications and to assist the public with their queries. The contact details for these officers are provided below.

Freedom of Information cont.

Table 8: Freedom of Information (FOI) Contact Officers for Metropolitan Health Service

Organisation	Designated Officer	Contact Details
EMHS, Bentley Health Service	FOI Officer	P O Box 158 Bentley WA 6982
EMHS, Kalamunda Health Service	FOI Officer	PO Box 243 Kalamunda WA 6076
EMHS, Royal Perth Hospital	FOI Officer	GPO Box X2213 Perth WA 6842
EMHS, Swan Districts Hospital	FOI Officer	P O Box 195 Midland WA 6936
NMHS, Graylands Selby-Lemnos & Special Care Health Services	FOI Officer David Broughton	Private Bag 1 Post Office Claremont WA 6910 Phone: (08) 9347 6475 Email: david.broughton@health.wa.gov.au
NMHS, Osborne Park Hospital	Coordinator Patient Information Services Lyn Pilling	Osborne Place Stirling WA 6021 Phone: (08) 9346 8054 Email: lyn.pilling@health.wa.gov.au
NMHS, Sir Charles Gairdner Hospital	FOI Officer Jean Addie	Hospital Avenue Nedlands WA 6009 Phone: (08) 9346 2427 direct, or (08) 9346 3333 pager 4719 Email: jean.addie@health.wa.gov.au
SMHS, Armadale Health Service	Health Information & Clerical Rostering Officer	PO Box 460 Armadale WA 6112 Phone: (08) 9391 2060 Fax: (08) 9391 2129
SMHS, Fremantle Hospital & Health Service	FOI Officer	PO Box 480 Fremantle WA 6959
SMHS, Peel and Rockingham/ Kwinana Health Services	FOI Officer	PO Box 2033 Rockingham WA 6168
Women's and Children's Health Service	FOI Officer Lorraine Sims	GPO Box D184 Perth 6840
Dental Health Service	Coordinator FOI	Locked Bag 15 Bentley Delivery Centre WA 6983

ADVERTISING AND SPONSORSHIP

In accordance with section 175ZE of the *Electoral Act 1907*, the Metropolitan Health Service incurred a total of $1.544 million expenditure in advertising, market research, polling, direct mail and media advertising.

Table 9: Advertising and Sponsorship

Expenditure Category	2001/2002	2002/2003
Advertising Agencies	712,558.04	1,483,510.13
Market Research Organisations	0.00	0.00
Polling Organisations	0.00	0.00
Direct Mail Organisations	295.30	0.00
Media Advertising Organisations	3,575.80	60,882.48
Total	**$716,429.14**	**$1,544,392.61**

Note: The expenditure increase 2002/2003 compared to the previous year is primarily attributed to the advertising of staff vacancies.

Expenditure for 2002/2003 was incurred in the following areas:

Expenditure Category	Total Expenditure	Person, Agency or Organisation
Advertising agencies *	$1,483,510.13	Seabreeze Communications Pty Ltd Bower Bird Information Services Concept Media Marketforce Productions Pelican Graphics Pty Ltd Sensis Media Monitors Pty Ltd Terry Dymock Advertising Austereo Pty Ltd The Media Shop
Market research organisations	Nil	Not Applicable
Polling organisations	Nil	Not Applicable
Direct mail organisations	Nil	Not Applicable

Advertising and Sponsorship cont.

Expenditure Category	Total Expenditure	Person, Agency or Organisation
Mail advertising organisations	$60,882.48	Audiological Society Of Australia Inc Australian Business Pages Directory Bower Bird Information Services Community Newspaper Group GP Network Health Information Management Association of Australia Husen Pty Ltd Markeray Holdings Pty Ltd Pacific Access Pty Ltd Pelican Graphics Pty Ltd Sensis The Fremantle Book The Royal Australasian College Of Physicians Public Sector Development (WA) Jill Ilott Macwrite Publicity Services ANZ Business Card Service The Family Nurturing Centre Inc Rural Press Regional Media (WA) Pty Limited WA Local Business & Community Services The Department of Premier & Cabinet Community Newspaper Group West Australian Newspaper Ltd RCN Publishing The University Of Western Australia Australian Dental Journal Dental Update Journal

* *The majority of expenditure in this category was for advertising of vacant positions.*

PUBLIC RELATIONS AND MARKETING

The Metropolitan Health Service played a key role keeping the public informed on health issues. The Public Relations departments of the Health Services used a variety of strategies to ensure that the public of Western Australia received information on both the health services available and innovations in clinical practice. They also played an important role in the dissemination of disease prevention and health promotion information.

Public Relations and Marketing cont.

Information was disseminated in the following ways:

- Publication of pamphlets and information sheets;
- Newsletters;
- Websites;
- Community forums;
- Displays at fairs and doctors' surgeries; and
- Through the media.

A vivid example of media coverage, which highlighted the services offered by the Metropolitan Health Service and the dedication of its staff, was the massive media coverage that resulted from the aftermath of the Bali bombing of October 2002. This event generated national and international media coverage of RPH's role in treating over thirty victims, more than any other hospital in Australia.

Some examples of media campaigns and publicity generated during 2002/2003 include:

- A SCGH campaign to launch WA's only high dose rate Brachytherapy Unit;
- A NMHS Mental Health Service campaign to announce the expansion of mental health services for Perth children by relocating the Selby Child and Adolescent Mental Health Service;
- A SCGH campaign to promote WA's first DNA bank for Retinitis Pigmentosa sufferers;
- Media coverage of organ donor families across MHS in association with DonateWest, and official presentations of Donor Family Charters at each teaching hospital;
- Aboriginal Women's Day was held by SKHS as part of a cervical cancer and breast cancer awareness-raising program;
- The further development of Web sites by Dental Health Services and WCHS;
- The opening of the upgraded Ultrasound Rooms at KEMH by the Premier;
- Osborne Park Hospital held a ceremony to celebrate its 50,000th baby delivery to coincide with the hospital's 40th anniversary;
- In collaboration with Edith Cowan University, SCGH launched the Centre for Nursing Research;
- Dental Health Services assisted the Health Consumers' Council in the production of a health consumer brochure on oral health issues;
- An Ageing Seminar was conducted at KHS, with more than 100 community members attending;
- A campaign focusing on the new $8 million PET Scanner at SCGH;
- Open days for the maternity wards at KHS and SHS;
- Fremantle Hospital nurses participated in television documentaries and advertisements to show the face of the profession in 2003;
- A campaign highlighting SCGH's Nurse Support Centre, an Australian first. SCGH created Australia's first 24-hour, seven days a week, support centre for nurses in aged-care facilities;

Public Relations and Marketing cont.

- SHS, KHS and WCHS participated in the Nursing Expo;
- Weekly health promotion for KHS on Kalamunda Community Radio Station;
- Production of three newsletters by SMHS – *Almanac, Artery* and *Armadale Newsletter;*
- Fremantle Hospital continued its liaison with the Fremantle Football Club (Fremantle Dockers) in support of the Children's Ward and the Fremantle Medical Research Foundation, with major coverage being given to the annual Docker's Bravery Awards;
- A campaign to promote Australia's first tissue bank, the WA Research Tissue Network (WARTN) being located at SCGH;
- Dental Health Services assisted the Australian Dental Association in Oral Health Promotion Week;
- Media coverage about SCGH Wound Management Clinical Nurse Consultant, Pam Morey, who won the inaugural 2003 WA Nursing Excellence Award and was named the 2003 WA Nurse of the Year;
- Media coverage about Fremantle Hospital's success in winning the National Training Award for Excellence in Training in Community Services and Health;
- Media coverage when Fremantle Hospital won the State Award as Large Employer of the Year in the Annual State Training in Excellence Awards; and
- Media coverage on world-renowned WA artist and former patient Robert Juniper who designed a therapeutic garden at the RPH Shenton Park campus.

There were also hundreds of newspaper stories and a number of Special Television Features including:

- ABC TV – *New Dimensions with George Negus* - "Working in the Extreme" – a profile on the Director of RPH's Cardiac Transplant Unit, Mr Robert Larbalestier;
- ABC TV – *New Dimensions with George Negus* - Story about RPH patient Paul Berry who contracted polio in 1956 epidemic and is the only remaining polio survivor in WA - living in an iron lung;
- ABC TV – *Catalyst* – filming began at WCHS of a four-part series based on the science of medicine, focusing on oncology, burns, neonates and rural health; to be screened in 2004;
- Two of Australia's top ranking Current Affairs programs ran stories on a new Zero Tolerance Policy developed by RPH Emergency Department staff to reduce incidents of aggression by members of the public;
- ABC TV – *New Dimensions with George Negus* –. Presented a story about the Director of the RPH Burns Unit, Fiona Woods, who headed the surgical emergency team and coordinated the treatment of over 30 badly burned Bali patients; and
- Channel 7 – *Today Tonight* – ran a story about a relatively new surgical procedure known as 'awake craniotomy'.

PUBLICATIONS

During 2002/2003, many publications were produced by the Metropolitan Health Service (MHS) to provide patients and the community with information on the services provided and on specific medical treatments. The MHS publications, which took the form of pamphlets, brochures, posters, newsletters and booklets, included:

- An Annual Report;
- Patient information guides;
- Hospital newsletters;
- Department newsletters and brochures;
- Brochures on specific conditions and treatments;
- Consumer Charter/patient's rights and responsibilities brochures; and
- Customer Feedback Brochures (including complaint procedures).

Metropolitan Health Service staff also contributed to a wide range of local, national and international publications. These included medical and other professional journals, textbooks and tertiary institution and academic material.

TEACHING AND RESEARCH

Teaching Activities

One of the key responsibilities of the Metropolitan Health Service (MHS), in partnership with the universities and other tertiary teaching institutions, is to ensure that there is an ongoing supply of health professionals with the skills and knowledge to provide best practice healthcare to the people of Western Australia.

While the teaching role is mainly undertaken in the Teaching Hospitals and (to a lesser extent) the Secondary Hospitals, extensive teaching programs also exist in a large number of the MHS's smaller agencies. The MHS also recognises that it has a responsibility to support high standards of health care delivery across the entire Western Australian Health Service and it therefore makes available to other WA Health Services and the private sector, many of its courses and educational material.

Teaching and Research cont.

Table 10: Teaching and Research – Major Clinical Education Programs provided in 2002/2003

Medical	**Nursing**
Clinical placements for undergraduate medical students	Clinical placements for undergraduate nursing students
Workplace re-entry Programs (Refresher courses)	Refresher/ Renewal of Registration courses: Registered nurses Paediatric nurses Midwives Enrolled nurses
Post Graduate Year 1 (Intern) Programs	
Post Graduate Year 2 Programs	
Post Graduate Specialist Training (about 20 specialties) - so doctors may gain Specialist qualifications	
Clinical Training and Education Centre (CTEC) training: Advanced Life Support Anaesthesia Neonatal Resuscitation Minimally invasive surgery skills eg laparoscopy	Professional Development for RNs
	Graduate Programs include 1st Year Registered Nurses 2nd Year Registered Nurses Medical/Surgical
Skills courses: Surgical skills Foetal monitoring Basic Life Support/CPR Defibrillators Emergency Management of Severe Trauma Care of the Critically Ill Surgical Patient CCrISP	Paediatrics Gynaecology Midwifery Perioperative nursing Orthopaedics Emergency Critical Care
Departmental clinical meetings (education, case-studies)	Neonatal Intensive Care
Outreach Assistance Programs: Obstetrics and Gynaecology for rural GPs Diabetes, etc	Paediatric Intensive Care Rehabilitation
Overseas Trained Doctors (OTD) program	Enrolled Nurse Programs: Clinical/Professional Development Medication
Prevocational training program	
Allied Health Clinical placements for undergraduate A/Health students Intern programs (pharmacists, radiation therapists) CPR	Skills Courses/Workshops include: 1st Year skills workshop for RNs Continence, ostomy & wound care ECG skills Basic Life Support/CPR Defibrillators Wound management Neuroscience High dependency nursing Pressure area care Multiple Sclerosis Certificate
	Clinical Training and Education Centre (CTEC) training
	Telehealth Education for Country Nurses - a wide variety of education topics provided to nurses who work in health services around the State

Teaching and Research cont.

Research Activities

The Metropolitan Health Service continued its outstanding growth in clinical/medical research during 2002/2003, culminating in numerous works being published in a variety of internationally recognised professional journals and papers presented at international conferences. Most of the research was undertaken in collaboration with the Teaching Hospital linked Research Foundations, the Universities and the Telethon Institute for Child Health Research. On many occasions, researchers undertook projects in collaboration with prestigious national and international research entities.

A large proportion of 2002/2003 research was fully or partially funded from grants received from external research funding bodies, including the National Health and Medical Research Council (NHMRC), National Heart Foundation, Cancer Foundation of WA, National Breast Cancer Foundation and the Raine Foundation.

Research undertaken within the Metropolitan Health Service covered an extensive range of topics. Key highlights and achievements are outlined below:

- 18 young medical and scientific researchers participated in the 13th RPH Young Investigators Day held on 11th September 2002;
- Professor David Ravine was appointed to the new Chair of Medical Genetics, and will be based at the RPH campus with links to the Western Australian Institute for Medical Research (WAIMR), the Department of Health and Genetics Services of WA. He will be involved in research, teaching, clinical genetics and strategic issues in the provision of genetics for WA;
- Professor Lyle Palmer was appointed to the Chair of Genetic Epidemiology and is located at the RPH campus of WAIMR. Professor Palmer has an international reputation for his work in the genetic epidemiology of asthma and respiratory disease;
- The RPH Research Administration Centre commenced a major new initiative to develop a new web-based research data-base;
- RPH had a very successful booth at the Medical Research Week Expo held at Scitech in June 2003. A variety of areas of research were presented, including virtual colonoscopy, stroke and the VITATOPS study, deep venous thrombosis and air travel, breast cancer and burns;
- Associate Professors George Yeoh and Lawrence Abraham relocated their molecular biology laboratories from Biochemistry at UWA to the WAIMR. Both are funded by NHMRC and the Cancer Foundation of WA. Professor Yeoh is a world expert in liver stem cell research, involved in identification and characterisation of these cells. Professor Abraham, who is equally well known for his studies of gene expression, was recently awarded a Cancer Foundation grant to study the regulation of genes in anaplastic large cell lymphoma;

Teaching and Research cont.

- Professor Graeme Hankey was a part of a Melbourne-based group who received approximately $1.25 million NHMRC 5 year grant. Professor Hankey is collaborating with Professors Donnan and Davis (in Melbourne) researching stroke - with a focus on translation of new biological findings into therapies;
- The ABC profiled Mark Davis, a senior medical scientist from the Department of Neuropathology, who researches malignant hyperthermia - a disease characterised by uncontrollable high temperature often triggered by anaesthetics. Mark is one of a handful of researchers, world-wide, who is endeavouring to find a genetic cause for the disease. Twenty-three WA families are known to have the genetic susceptibility to malignant hyperthermia;
- Professors Mallal and Christiansen and their research teams in the RPH Clinical Immunology Department and Murdoch University made a major discovery regarding the role of genetic factors and the response to treatment in HIV. Remarkably, when they investigated the first 200 patients in the WA HIV Cohort Study exposed to abacavir, they found that hypersensitivity to the drug (18 cases) was linked to a specific sequence in the genome, an ancestral gene sequence. Their outstanding work was recently published in the prestigious medical research journals *Science* and the *Lancet*;
- Professor Ian Puddey, Head of Internal Medicine at RPH, was awarded an NHMRC Centre of Clinical Research Excellence renewal grant of $2 million over 5 years (2003-2008). The renewal was a validation of the high quality clinical research that Professor Puddey and his team performed in the area of cardiovascular disease. The funding will provide scholarships for Masters and PhD students and support ongoing research projects;
- Dr Fiona Wood, Head of the RPH Burns Unit, who led the team of plastic surgeons that treated numerous patients from the Bali bombing, has been funded to perform research into optimising outcomes in burns patients. These studies aim to provide best-practice evidence for treating these severe injuries;
- Professor Peter Leedman, Professor of Medicine at UWA and Endocrinologist, was appointed Director of Research at RPH for a two-year period;
- An international authority in respiratory physiology, Dr Gain, arrived in August 2002 to take up a position as the Department of Respiratory Medicine’s first medical scientist and RPH’s new Chief Pulmonary Physiologist. Dr Gain has a broad background in clinical biochemistry and physiology and is actively developing a sleep clinic with a major emphasis on research into sleep disorders;
- Researchers investigating wine won both Divisions of the Young Investigator awards in 2002. Science Investigator winner, Emma Waddington, found after three years studying the effect of red wine on heart disease and cholesterol that red wine did change the progression of heart disease but her findings dashed the hopes of people who thought its anti-oxidant levels were an excuse to drink more. Clinical Investigator winner Renate Zilkens studied the effect of red wine and beer on endothelial function and oxidative stress;

Teaching and Research cont.

- RPH Senior Scientist Sandra Sjollema travelled to Thailand to educate the local clinical laboratory research staff about vitamin assay testing. The Thai researchers asked RPH for assistance in developing the methods for testing after reading about their work in the medical literature;
- Associate Professor Martyn French and Dr Patricia Price have been awarded an NHMRC grant of $400,000, to investigate the cause of Immune Restoration Disease - which can affect people being treated for HIV. These patients (approximately 10% of all treated) respond to the anti-HIV treatment, but their immune system responds adversely, causing tissue inflammation. Their research aims to identify patients who are at risk of developing the disease and lead to new therapies for its treatment;
- Clinical lipid expert, Dr John Burnett, and his team in Clinical Biochemistry and collaborators in Canada, have discovered a new gene mutation responsible for producing a rare disorder of lipid metabolism, called familial hypobetalipoproteinemia. These patients have almost no trace of LDL (the cholesterol that causes heart disease) and multiple other family members had similar lipid profiles. Dr Burnett analysed the genome sequence of these individuals to find that they all had a mutation in the APOB gene (called R463W), which produced a significant change in the amino acid content of the protein apoB. In collaboration with A/Professors Frank van Bockxmeer and Hugh Barrett, Dr Burnett's team is investigating several WA families with this same condition. Funding is partly from a RPH MRF grant. Dr Burnett delivered a paper on the research at the November 2002 Scientific Sessions of the American Heart Association in Chicago, and his findings were recently published in the distinguished Journal of Biological Chemistry;
- Christine Nathan, a respiratory scientist from the Department of Respiratory Medicine, won the Young Investigator Prize at the annual meeting of the Australian and New Zealand Society of Respiratory Science (ANZSRS). It was the first time that RPH had been represented at the meeting in its 23-year history. Christine won for her poster, which outlined her research into the adherence to standards for 'bronchial provocation testing' (asthma challenge testing) throughout Australia and New Zealand. Her findings will affect the way asthma testing is reported around the Australasian region. Kevin Gain, RPH's new Respiratory Medicine Chief Pulmonary Physiologist, also presented at the meeting. He is the web-site coordinator for the ANZSRS web-site (www.anzsrs.org.au) and his poster related to the way the web-site may be accessed and used - in the past year, hits per-month have risen from 2,000 to 18,000;
- Professor Peter Leedman, Professor of Medicine and Endocrinologist, was awarded a 2 year grant, co-funded by the Cancer Foundation of WA and the National Breast Cancer Foundation, to study novel regulators of hormone action in cancer cells. His team in the Laboratory for Cancer Medicine (based in the WAIMR) discovered a novel protein that targets a recently discovered regulator of steroid hormone action;

Teaching and Research cont.

- Dr Geoffrey Forbes, Head of Gastroenterology, leads a national team of collaborators that was awarded a two-year Cancer Foundation of WA grant to perform a clinical trial that will compare screening tests for colorectal neoplasia in average risk asymptomatic subjects. Bowel cancer is common, affecting one in twenty Australians. Screening aims to prevent bowel cancer or detect it at an early curable stage. This study will compare four different screening tests and provide information about how and why individuals participate in screening, and a comparison of the acceptability of these tests and their effectiveness in the general community. The tests range from a simple stool test performed at home to the latest in fibre-optic endoscopy examinations and x-ray technology. This research will determine which test people prefer and why, and whether offering a choice of tests improves participation in screening;
- The Department of Clinical Immunology and Biochemical Genetics participated in eleven national and international HIV-related drug trials. These trials were subsidised by either the National Centre in HIV Epidemiology and Clinical Research or by private drug companies;
- The Department of Occupational Therapy at RPH researched and developed a “Quality of Life Tool” for clients attending Living Skills Centre Inner City Mental Health;
- Associate Professor Kevin Singer, in the RPH Department of Physiotherapy, pursued collaborative research with UWA Department of Surgery, in the Centre for Musculoskeletal Studies. The research investigated back muscle function in chronic back pain patients;
- The Department of Physiotherapy participated in a Multi-Centre Study on Outcome Post Extensor Tendon Surgery - RPH/SCGH/FH Hand Therapy Physiotherapists will be collating this data as part of a Masters Thesis;
- The Department of Podiatry at RPH continued its research on determining the validity, predictive value and reliability of the ‘Basic Foot Assessment Checklist’ – a primary care screening tool for identifying foot ulcer risk in people with diabetes;
- In January 2003, Nursing Services established a Centre for Nursing Evidence-Based Practice, Education and Research by combining the existing Nursing Professional Development Unit (responsible for education, training and research) and adding two new programs – Evidence-Based Practice and Clinical Audit.
- The Clinical Audit Program conducted a hospital wide audit examining the context and content of nursing practice standards. This audit was conducted using the nursing clinical governance standard which stated that “all documented policies, standards of practice, procedures and procedural competencies that direct nursing practice are authorised, developed using a standardised format, and are reviewed, validated as best practice and made available to all staff”;

Teaching and Research cont.

- The RPH Foundation for Nursing Research awarded grants - for research into identification of high-risk patients, assessment skills for pressure ulcer development and a systematic review of interventions to reduce manual handling;
- A randomised controlled trial measured the efficacy of intranasal fentanyl with oral morphine for pain relief in burns patients during procedural wound care. This study was prematurely terminated as the routine wound care was superseded following the introduction of a new type of dressing that remained in situ for three days;
- A pilot study commenced to examine issues associated with wound infection in burns patients at RPH Burns Unit;
- A prospective cohort study of the incidence of urinary catheterisation and rate of catheter-associated complications in-patients was commenced at RPH (Wellington Street Campus);
- The sixth annual audit of the prevalence of pressure ulcers in inpatients was undertaken in March 2003 in 612 multi-day patients. The prevalence of hospital acquired pressure ulcers was 8.82%;
- A process commenced for the establishment of a EMHS nursing research review group, to be chaired by Associate Professor Gavin Leslie (who has a joint appointment with RPH and ECU for Critical Care Nursing);
- A study commenced to compare the efficacy of two different types of post-operative analgesia after laparoscopic surgery, an important area for hospitals as there is an increasing emphasis on same day surgical procedures. Dr Andrew Imison is investigating how useful specific analgesics are with combinations of intra-operative anaesthetics. The study aims to result in substantially improved postoperative analgesia at minimal cost and risk to the patient;
- Investigators from the UWA School of Surgery and Pathology have taken a novel approach to treating cancer by using antisense gene therapy. Dr Rosalie McCauley has found that levels of glutaminase are elevated in a variety of cancer cells. Their studies have shown that deprivation of glutamine to the cancer cells, kills them rapidly. The team is now investigating ways of delivering gene therapy to knock out the glutaminase in tumour cells to facilitate killing of breast and prostate tumours;
- Studies progressed in the Laboratory for Neuroscience to understand the mechanisms governing cell death observed in neurodegenerative diseases such as Alzheimer's and Parkinson's disease, and after brain or spinal cord injury. Dr Sam Busfield, a recipient of one of the prestigious Career Development Awards from the NHMRC, has identified a molecule (DR6) that is expressed in the brain and spinal cord, and is capable of inducing cell death;

Teaching and Research cont.

- The SCGH Office of Research Development developed and commenced implementation of a Strategic Plan for Research Development aiming to:
  - increase external funding for research;
  - develop a major research facility on the QEII Medical Centre campus;
  - encourage junior medical staff to become familiar with medical research techniques;
  - facilitate opportunities for senior medical staff to participate in medical research;
  - integrate medical research activities between hospital institutes, university and the NMHS; and
  - develop measurable outcomes to assess the success of these initiatives;
- The SCGH Research Advisory Committee supported research by hospital staff and encouraged participation in a large number of research projects. During 2003, 17 research projects and one PHD project were funded from this source. Hospital-based projects are valuable seed funding for application for external NMHRC grants and for research training;
- The SCGH Office of Research Development has developed a website (accessible through the SCGH Intranet and websites), a researchers' communication network and a regular research newsletter as strategies to improve communication between research groups in the hospital, university departments and the institutes on the QEII Medical Centre campus;
- The development of the Western Australian Institute of Medical Research (WAIMR) Laboratories in SCGH B Block advanced research on the hospital site attracting a large number of new research teams working in a vibrant and collaborative environment;
- SCGH supported a large number of externally funded clinical trial projects. 125 clinical research projects being coordinated by SCGH. A working group was established to support the standardization of operating procedures and to encourage group clinical research practice for the projects;
- On 7 October 2002, the Minister for Health, Mr Bob Kucera, launched the Centre for Nursing Research - a new approach to collaborative research between SCGH and Edith Cowan University;
- Professor Richard Prince and colleagues at SCGH research the role of genes in predicting osteoporosis;
- Dr Nigel Laing and his research team at SCGH, in collaboration with the Australian Neuromuscular Research Institute, researched the role of genes in the cause of nerve and muscle disorders. The team has been investigating a key gene which indicates a susceptibility to adult forms of myopathy. Related work on the genetics of Duchenne's muscular dystrophy has led to recognition of the defect in dystrophin gene with the future potential for modification of the gene by injection of modified genes in affected patients. This work also has important implications for understanding the mechanisms of muscle regeneration after injury and degenerative diseases;

Teaching and Research cont.

- Dr Nick Zeps became the supervisor of the WA Research Tissue Network (WATRN), at SCGH. The WATRN has samples of tumors and other tissues collected over the last decade. It is an invaluable resource in allowing the molecular composition of the tumor and other tissue to be restudied at a later date;
- In collaboration with the pharmaceutical industry and some Sydney academic centres, Associate Professor Phillip Thompson investigated the genetic and environmental influences on asthma at the (SCGH) Asthma and Allergy Research Institute. The project, which is funded through the Commonwealth Government, is developing new drugs for the treatment of asthma;
- Research by Dr David Hillman's group in the SCGH Sleep Disorders Research Institute revealed that a tendency for the upper airway to collapse during sleep may be a significant factor in the common sleep apnoea;
- The WA Heart Research Institute (WAHRI) (which is a collaboration of heart researchers at Royal Perth Hospital and SCGH, affiliated with the WAIMR) recently published an article authored by Drs Brendan McQuillan, Joe Hung, Peter Thompson and John Beilby showing that some genes can predict osteoporosis. They have also shown that some new markers of inflammation can predict osteoporosis;
- Dr Bronwyn Stuckey and colleagues in the Keogh Reproductive Medicine Research Institute investigated the treatment of male erectile dysfunction (ED) to assess newer alternatives to Sildenafil (Viagra). They found that ED was often a sign of generalised vascular disease and was more common than previously thought;
- The NMHS Population Health Program, in conjunction with the Telethon Institute for Child Health obtained $400,000 from Healthway and the WA Lotteries Commission to evaluate the Preconception Intervention Program utilising a clustered randomised controlled trail design. The trial will be conducted over three years from June 2003;
- In January 2003, Professor Assen Jablensky, Director of the NMHS Mental Health Service's Centre for Clinical Research in Neuropsychiatry, was invited to join the Prime Minister's Science, Engineering and Innovation Council. He is one of the ten members of the Neuroscience Working Group whose purpose is to present a report to the Prime Minister and Cabinet outlining the prospects for Australian neuroscience research in the next decade;
- DRAC Consultant, Dr Irene Boyatzis, researched pain control in the elderly in nursing homes. Her study into perceptions of bereavement care in consultant geriatricians and advanced trainees in geriatric medicine has been accepted for publication in the *Australasian Journal on Ageing*;
- Supervised by Associate Professor Dr Mathew Martin-Iverson at Graylands Hospital, Emma Savery, a PhD student from the School of Psychiatry and Clinical Neurosciences UWA, conducted a study into affective modulation of the startle response to child-related stimuli in child sex offenders;

Teaching and Research cont.

- Dr's Joseph Lee, Babu Mathew and Adam Brett of Graylands Hospital conducted an observational study to examine cardiovascular risk reduction in patients with schizophrenia, recently changed to Risperdal. This study was designed to determine if this anti-psychotic medication is associated with decreased risks of cardiovascular disease;
- Fremantle Hospital continues to play an important role in research into medical, surgical and psychological conditions, and in nursing and public health evaluation projects. With the completion of The University of Western Australia's $1.67 million research laboratories on the Fremantle Hospital site, the University Departments of Medicine and Surgery stepped up programs in Fremantle;
- Professor John Olynyk's research into haemochromatosis has attracted more than $2M from the NHMRC and the Cancer Foundation of WA to finance projects for the next three years. The Australian Academy of Science has also awarded him a visit to the USA next year to set up a collaborative project with the University of St Louis. This will study the level of hepcidin in the blood to predict iron load in patients with hereditary haemochromatosis and hepatitis C;
- Cardiothoracic researchers at Fremantle Hospital, led by Andrew Hodge and Leon Neethling, are in the process of developing a new anti-calcification treatment for pig heart valve tissue which mitigates post-implant calcification to almost 96%. This process is unique in the sense that it reduces calcification not only of the valve leaflets but also the calcification of the aortic wall which forms part of stentless bioprostheses. They are also investigating possible pharmacological mechanisms to counter the pathophysiology of Systemic Inflammatory Response Syndrome;
- Research into antibody targeted radiotherapy combined with chemotherapy to kill lymphoma cells in patients having bone marrow transplants is continuing through a grant by Fremantle Hospital's Medical Research Foundation. The work is being carried out by Dr J Cooney, Dr J Harvey Turner and Dr M Leahy;
- Consultant psychiatrist Dr Steve Addis and mental health nurse Dianne Sherwood, working with Dr Stampfer and Zaza Lyons, of UWA and Sir Charles Gairdner Hospital, developed a simple device to measure circadian heart rhythms in mental health patients. The research was shared during visits to England, America and India, where monitoring is now carried out in two hospitals in Bangalore. Seed funding on the best ways to repair such injuries has been awarded by the Fremantle Hospital Medical Research Foundation (FHMRF);

Teaching and Research cont.

- Other FHMRF awards were made to Dr Ian Lawrance to investigate intestinal scarring in Crohn's Disease, to Dr Bu Yeap to investigate factors affecting cells involved in prostate cancer, to Drs A McCutcheon and M Huckabee for rehabilitation of stroke victims, and Dr H Wallace and A/Professor Michael Stacey for the genetic profiling of patients with leg ulcers;
- Cognitive impairment in older diabetic people is under investigation by A/Professor David Bruce, Genevieve Casey, Dr F Ives and Professor Tim Davis. Preliminary results indicate brain lesions, identified through MRI scanning, may be important factors in memory loss which affects lifestyle and independence;
- Professor Markus Kuster, of Fremantle's new Department of Orthopaedics is investigating the biology of bone healing and the use of new plates which do not put pressure on bones;
- Dr Mallon and Dr Beckman from the Immunology Department have an interest in understanding why the immune system declines with advancing age. They are also investigating the intriguing question why 30-40% of the aged fail to make protective antibody to flu vaccines;
- Princess Margaret Hospital researchers conducted 66 new research projects last year and continued a number from previous years. Much of the research was undertaken in the departments of Respiratory Medicine, Immunology, Oncology and Haematology, Endocrinology and Physiotherapy. The Cranio-Maxillo Facial & Plastic Surgery Department expanded their research last year;
- PMH awarded two clinical research training fellowships and a career development award last year as an encouragement to the clinical staff to become involved in research;
- KEMH researchers collaborated with the Women's and Infants Research Foundation to conduct research across a wide range of fields. Projects were undertaken to determine the benefits of different interventions (performed before and after birth) in preventing conditions that effect newborn babies, such as pre-term birth, cerebral palsy, foetal medicine and surgery; and newborn intensive care. Other research projects were aimed at improving the health of women of all ages, in particular gynaecology and menopause research;
- The Dental Health Service's Child and Adult Dental Health research continued last year utilising their on-going surveys. Each year the survey results are used to review and update the dental Performance Indicators;
- The Dental Health Service completed an aged-care residents research project and the results have been published: Stubbs CM, Riordan PJ. Dental survey of elderly residents in nursing homes and hostels in Perth. *Australian Dental Journal*, *2002;47(4):321-326;* and
- A research project to evaluate Pulpotomies in Deciduous Teeth was almost completed. A total of approximately 600 children were followed for up to 4 years to determine the outcome of this treatment method. The data has been analysed and recommendations are being considered.

EVALUATIONS

The Metropolitan Health Service ensures that its programs meet the high standards required by participating in a comprehensive program of continuous evaluation leading to accreditation and by undertaking one-off reviews as necessary.

Each hospital within the MHS participates in the Australian Council of Healthcare Standards (ACHS) accreditation program which is a four year cycle of review. To achieve ACHS accreditation, hospitals have to demonstrate that they meet stringent standards across the entire range of services provided, clinical and non-clinical. The process involves detailed inspections over several days - undertaken by health service experts, usually from the Eastern States. During 2002/2003 all hospitals were accredited.

Many services provided by hospitals cannot operate without some form of current accreditation. All areas that offer training to medical specialists have to be accredited with the Medical Colleges eg Emergency Department and Surgical services. Pathology laboratories also require accreditation by the National Association of Testing Authority (NATA) to be able to operate.

There is also a requirement for other services provided within the MHS to meet appropriate standards. Some of the audited standards are established by the following organisations:

- Therapeutic Goods Administration
- Occupational Safety and Health Services
- Breast Screen Australia
- SAI Global Ltd
- Worksafe
- Foodsafe
- International Standards Organisation (ISO)
- FESA

Apart from the ACHS and other accreditation programs which form the major part of MHS evaluations, the Health Services conducted numerous other reviews ranging from the delivery of whole programs to the delivery of small components of health services. Findings were used to improve services where needs were identified.

Evaluations cont.

Table 11: Summary of Evaluations 2002/2003 Reviews

Service Evaluated	Evaluation Done by	Outcome
Clinical Review of Graylands Selby Lemnos – program and policy	Chief Psychiatrist	A dedicated multidisciplinary committee established to implement recommendations.
SMHS Mental Health Program for Seniors – Day Therapy Services (Melville)	Internal evaluations in partnership with The Centre for Research for Aged Care at Curtin University.	Development of a clinical service model.
FHHS Staff Development Department	WA Department of Training – Training Accreditation Council	Accredited and winner of State Training Excellence Award 2002 ("Large Employer of the Year" category)
FHHS Staff Development Department	Australian National Training Authority (ANTA)	Winner of an Industry award for Excellence in Training in Health and Community Services
FHHS Postgraduate Medical Education	Pre-vocational Training Accreditation Committee	Accredited

INTERNAL AUDIT CONTROLS

The Internal Audit Branch was established in July 2002 and has the role of accountability adviser and independent appraiser, reporting directly to the Director General of Health, Mike Daube. Audits conducted were generally planned audits, however on occasion, management initiated audits or special audits were also conducted. Predominantly the reviews were compliance based, however, a number of operational (performance-based) reviews have also been conducted. All audits conducted aim to assist senior management in achieving sound managerial control.

Specific internal audits conducted over the period include:

- FAAA Health Checks:
  - South Metropolitan Health Service (Fremantle Hospital)
  - Dental Health Services
  - Health Care Division
- Payroll Audits:
  - Women's & Children's Health Service
  - East Metropolitan Health Service (Royal Perth Hospital and Swan Health Service)

Internal Audit Controls cont.

- Country Audits:
  - Midwest & Murchison Health Region
  - Pilbara Gascoyne Health Region

- Operational Audits:
  - Waitlist Management

- Special Audits:
  - Douglas Review (Implementation of Recommendations from Inquiry into Obstetric and Gynaecological Services at King Edward Memorial Hospital)
  - Office of Aboriginal Health (Funding to Non-Government Organisations)
  - Audit of Financial Returns (Sir Charles Gairdner Hospital, Fremantle Hospital, Women's & Children's Health Service, Royal Perth Hospital and the Royal Australian College of Medical Administrators)
  - Grievance Procedures (management initiated)

Additionally, under the direction of the Director Corporate Governance, a number of audits have also been conducted by external consultants.

PRICING POLICY

Except where a public service obligation existed, the Metropolitan Health Service raised a number of fees and charges to recover the estimated cost of providing certain services. A daily bed fee was raised against all inpatients other than public patients. An annual review of fees and charges was conducted in accordance with the FAAA Section 55(b).

Dental Health Services charged fees based on the Department of Veterans' Affairs Schedule of Fees with patients charged:

- 50% of the fee if the patient was a Health Care or Pensioner Card holder; and
- 25% of the fee if the patient was a holder of one of the above cards and was in receipt of a near full pension or benefit from Centrelink.

RISK MANAGEMENT

Our Policy

The Metropolitan Health Service aims to achieve best possible practice in the management of all risks that threaten to adversely impact upon the health service itself, its customers, staff, assets, function, objectives, operations, or upon members of the public.

Strategies and Initiatives

The Metropolitan Health Service is incrementally implementing integrated risk management systems that underpin all organisational activities and address both corporate and clinical governance issues. The traditional risk management tools are being integrated into a more integrated framework, providing a holistic approach to governance issues and ensuring completion of the risk management cycle of risk identification, recording, assessment, treatment and ongoing monitoring and review. This has also been structured to meet the requirements of the new WAGHS model for Clinical Governance and the relevant Treasurers Instruction.

Health Services have made significant progress with the integrated risk management strategies with the larger hospitals having in place appropriate governance structures (clinical and corporate) including governance committees, databases and monitoring and reporting systems. The Services have also had to update policies and ensure that appropriate appointment processes, credentialing and accreditation standards are in place. Most importantly, hospital executives and senior clinicians are committed to clinical and corporate governance and the processes involved with achieving best practice. A major challenge for the services is to ensure that a culture of clinical and corporate governance is enshrined throughout the organisations and that the integrated risk management framework is implemented across all the smaller organisations within each area.

ENERGY SMART GOVERNMENT PROGRAM

In accordance with the Energy Smart Government policy the Department of Health is required to achieve a 12% reduction (relative to 2001/2002) in non-transport related energy use by 2006/2007 with a 5% reduction targeted for 2002/2003. The full Energy Smart Government Program report and interpretations – for the whole Department of Health – is reported in the Department of Health (Royal Street) Annual Report 2002/2003. Actual performance figures for the Metropolitan Health Service (excluding the Dental Health Service) are as follows:

Table 12: Energy Smart Government Program

Comparative Energy Performance				
Area	**Parameter**	**2001/2002**	**2002/2003**	**Variation %**
East Metropolitan Health Service	GJ/y	287,103	283,775	-1.16%
	$/y	$4,591,951	$4,193,304	-8.68%
	GJ/m^2	1.15	1.17	1.74%
North Metropolitan Health Service	GJ/y	332,460	336,369	1.18%
	$/y	$5,617,776	$5,437,744	-3.20%
	GJ/m^2	1.09	1.10	0.92%
South Metropolitan Health Service	GJ/y	173,149	180,690	4.36%
	$/y	$2,977,262	$3,238,416	8.77%
	GJ/m^2	0.87	0.91	4.60%
Women's and Children's Health Service	GJ/y	117,886	122,598	4.00%
	$/y	$2,098,539	$2,113,589	0.72%
	GJ/m^2	1.07	1.11	3.74%

Notes:
Excludes residential accommodation where separately metered.
Excludes heath services in buildings where energy is paid for by others.
Includes site co-users where co-users are not totally separately metered.
GJ = Giga Joules; m = metres; y = year; FTE = Full time equivalent; OBD = Occupied bed days

Some factors pertinent to the above figures for the Metropolitan Health Service include:

- The increased energy consumption at North Metropolitan Health Service is due to added facilities and full year operation of added facilities;

Energy Smart Government Program cont.

- Other increases are partly due to increased accuracy in information collected but detailed explanation of the variability requires more information than was collected in 2002/2003. The Department is in the process of improving asset performance reporting, including energy reporting, and expects to be able to better explain energy variation in future reporting periods.

The GJ/Staff FTE and GJ/OBD indices reported were required by the ESGP. The Department considers these indices to be unsuitable as a measure of productivity against which energy efficiency can be assessed.

During the year the following energy saving initiatives were undertaken within the Metropolitan Health Service:

- Energy Managers nominated and briefed;
- Energy consumption and cost database established;
- Process for identification, analysis, and management of energy saving initiatives established;
- Application made for ESGP funding of support consulting services to assist Health Services identify and prepare business case analysis of energy saving initiatives; and
- New improved price contracts for the supply of natural gas were negotiated.

WASTE PAPER RECYCLING

Waste paper recycling is actively encouraged within the Metropolitan Health Service. The organisations regularly review their recycling programs and explore options that offer a better service and/or are more cost-effective. Some of the Health Services collect paper separately for recycling, other organisations subscribe to co-mingled recycling programs whereby paper is collected together with other recyclables (glass and aluminium) and is taken off site for sorting by the recycling contractors. Because of the use of the comingling programs it is not possible to estimate the tonnage of paper recycled in 2002/2003.

THE MINISTER FOR HEALTH IN HIS CAPACITY AS THE DEEMED BOARD OF METROPOLITAN PUBLIC HOSPITALS CERTIFICATION OF PERFORMANCE INDICATORS FOR THE YEAR ENDED 30 JUNE 2003

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 Minister for Health in his capacity as Deemed Board of Metropolitan Public Hospitals and fairly represent the performance of the Board for the financial year ending 30 June 2003.

Michael Daube
Director General of Health
Accountable Authority for The Minister for Health in his capacity as the Deemed Board of Metropolitan Public Hospitals

28th August 2003

INDEPENDENT AUDIT OPINION

To the Parliament of Western Australia

THE MINISTER FOR HEALTH IN HIS CAPACITY AS THE DEEMED BOARD OF METROPOLITAN PUBLIC HOSPITALS
PERFORMANCE INDICATORS FOR THE YEAR ENDED JUNE 30, 2003

Qualification
Key Effectiveness Indicators
The key effectiveness indicators reported for Outcome 3 are not key measures of the Health Service's achievement of the outcome "Improvement in quality of life of people with chronic illness and disability". As such, no opinion is provided on these indicators.

Qualified Audit Opinion
In my opinion, except for the matter referred to in the qualification, The Minister for Health in his capacity as the Deemed Board of Metropolitan Public Hospitals' key effectiveness and efficiency performance indicators reported are relevant and appropriate and fairly represent indicated performance.

Scope
The Director General, Department of Health's Role
The Director General, Department of Health is responsible for developing and maintaining proper records and systems for preparing performance indicators.

The performance indicators consist of key indicators of effectiveness and efficiency.

Summary of my Role
As required by the Financial Administration and Audit Act 1985, I have independently audited the performance indicators to express an opinion on them. This was done by looking at a sample of the evidence.

An audit does not guarantee that every amount and disclosure in the performance indicators is error free, nor does it examine all evidence and every transaction. However, my audit procedures should identify errors or omissions significant enough to adversely affect the decisions of users of the performance indicators.

D D R PEARSON
AUDITOR GENERAL
November 19, 2003

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

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

100A Rate of screening in children
100B Rate of referral as a result of childhood screening schedule
101 Rate of childhood immunisation
102 Rate of hospitalisation for tonsillectomies (0-12 years)
103 Rate of hospitalisation for gastroenteritis in children (0-4 years)
104 Rate of hospitalisation for respiratory conditions
106 Rate of childhood dental screening
107 Dental health status of target clientele

Output 1 Prevention and promotion

105 Cost of service for community health services
108 Average cost of service for school dental service

Outcome 2 Restoration to health of people with acute illness

200 Elective surgery waiting times for public patients
201 Proportion of Emergency Department patients seen within recommended times
204 Rate of unplanned hospital re-admissions within 28 days, to the same hospital, for a related condition
205 Rate of unplanned hospital re-admissions within 28 days, to the same hospital, for a mental health condition
206 Rate of post operative pulmonary embolism
207 Discharge home rate of babies with an APGAR score of 4 or less five minutes after delivery
208 Survival rates for sentinel conditions
209 Survival rate of patients following coronary artery bypass grafts
210 Survival rate of patients following coronary angioplasty
219 Access to dental treatment services for eligible people

Output 2 Diagnosis and treatment

211 Average cost per casemix adjusted separation for teaching hospitals
212 Average cost per casemix adjusted separation for non-teaching hospitals
213 Average cost per Emergency Department presentation for Metropolitan Health Services hospitals
214 Average cost per doctor attended outpatient episode for Metropolitan Health Services
215 Average cost per non-admitted occasion of service for Metropolitan Health Services hospitals (excludes emergency occasions and doctor attended outpatient occasions)
221 Average cost of completed courses of adult dental care

Outcome 3 Improvement in the quality of life of people with chronic illness and disability

300 Waiting time to first outpatient appointment for chronic illness
301 Median waiting time for community and allied health services (hospitals and community based)
302 Median bed-days for persons under mental health community management who were admitted to hospital
304 Aged Care Assessment Team (ACAT) assessments

Output 3 Continuing care

303 Average cost per person with mental health illness under community management
305 Average cost per care awaiting placement (CAP) day

The Metropolitan Health Services (MHS) is required, under the Financial Administration and Audit Act 1985 (FAAA) and the Treasurer's Instruction TI 904, to present to Parliament annual indicators of efficiency and effectiveness. The Key Performance Indicators (KPIs) presented in this report address the extent to which the Department of Health's three desired outcomes have been achieved.

A key aim in presenting this information, and that reported by all the separate legal reporting entities of the DOH is to assist the public to understand the complex and diverse nature of the services and activities of the health system and how these contribute to its performance.

The performance indicators reported in the following pages address the extent to which the strategies and activities of the Metropolitan Health Services have contributed to the DOH's 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)

OUTCOME 2
Restoration to health of people with acute illness.
(Output 2 - Diagnosis and Treatment)

OUTCOME 3
Improvement in the quality of life of people with chronic illness and disability.
(Output 3 - Continuing Care)

While some of the indicators reported are similar to those in previous Metropolitan Health Services Annual Reports, some are new indicators reported for the first time. Where possible comparisons with previous years' data have been provided.

CPI INFLATOR SERIES (CPI)

The index figures are derived from the CPI all groups, weighted average of the 8 capital cities index numbers. For the financial year series the index is the average of the December and March quarter and is rebased to reflect a mid year point of the 5 year series that appears in the annual reports. The average of the December and March quarter is used, because the full year index series is not available in time for the annual reporting cycle. The calendar year series uses a similar methodology but is based on the average of the June and September quarter.

The financial year costs for the annual report can be adjusted by applying the following formula, the results will be all financial data will be converted to 00/01 dollars:

Cost_n x (100/Index_n) where n is the financial year or calendar year where appropriate

The index figures for the financial years and calendar years to be applied are provided below:

Calendar year	1998	1999	2000	2001	2002
Index (base 2000)	94.24	95.57	100.00	104.24	107.39
Financial year	1998/99	1999/00	2000/01	2001/02	2002/03
Index (base 2000/01)	92.31	94.43	100.00	103.03	106.36

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

The services (outputs) of all parts of the Department of Health contribute to the outcome above. The achievement of this component of the health objective includes activities that reduce the likelihood of disease or injury and reduce the risk of long term disability or premature death. Strategies include prevention, early identification and intervention and the monitoring of the incidence of disease in the population to ensure primary health measures are working. The impact of drug abuse is also monitored.

The services (outputs) of the Metropolitan Health Service as well as the other divisions of the Department of Health are contained on the table below. The greatest proportion of the services provided by the Metropolitan Health Service in this outcome is directed to children. Other health service divisions for example the Royal Street Division and the Drug and Alcohol Authority provide more services directed to the prevention of injury and illness and the impact of drug abuse.

Table 13: Respective Indicators by Health Sector

Outcome 1: Reducing the incidence of preventable disease, injury, disability and premature death and the impact of drug abuse.	**Metropolitan Health Service**	**Peel Health Services**	**South West Area Health Service**	**WA Country Health Service**	**Royal Street Division**	**WA Drug & Alcohol Authority**
The achievement of this component of the health objective involves activities which:						
1. Reduce the likelihood of onset of disease or injury by:						
• Immunisation programs	101	101	101	101	R107	
• Childhood screening & appropriate referrals	100A 100B 106 107 108	100A 100B	100A 100B	100A 100B	R113	
• Safety program					R101	
• Encouraging healthy lifestyles (examples diet and exercise)		109			R110 R111	
2. Reduce the risk of long term disability or premature death from injury or illness through:						
• Early identification of breast, cervical screening cancer (screening & referral if positive results)					R104 R105A R105B	
• Surveillance	105	105	105	105	R103 R106 R108 R109 R112 R114	
3. Monitoring the incidence of disease in the population to ensure primary health measures are effective	102 103 104	102 103 104	102 103 104	102 103 104		
4. Monitoring and surveillance of suicide rates and drug & alcohol use					R102	See D&AA Report

100A: Rate of screening in children

This indicator reports screening rates per 1,000 of population, for children who reside in the Metropolitan Health Services catchment area.

Rationale

Screening programs for children are carried out to ensure early identification and intervention of developmental delays or other health problems. The early identification and management of problems improves the life and health outcomes for children. Different screening methods are used to determine if children have a developmental delay or issue, or are at increased risk of poor health outcomes due to factors impacting on their physical, social or emotional development. The National Health & Medical Research Council (NH & MRC) recommends screening protocols for certain age groups to ensure that disabilities such as poor hearing, sight problems and congenital disabilities are recognised at an early age.

In most circumstances, the recognition of a problem leads to intervention which will address the issue and improve the child's quality of life.

Results

Screening rates were measured in two age groups (0 to 4) and (5 to 12) and across two ethnic groups - Non-Aboriginal and Aboriginal children:

Table 14: Rate of screening per 1,000 population in children

	2000		2001		2002	
	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal
0 - 4 Years	935.9	537.0	869.7	551.1	799.8	524.2
5 – 12 Years	319.8	78.4	288.2	89.4	193.6	121.4

Data Sources:
HCare Community Health data.
Health Service Population data.

Comments

With new knowledge about the importance of a child's social and emotional development in their early years of life, the focus of universal screening of physical development has shifted. The adoption of a more holistic and family-centred approach to supporting children in the early years has led to a shift from universal screening programs to the screening of those children deemed to be at higher risk. This has led to a reduction in the number of formalised screenings of all children in a certain age-group and an increased focus on those identified as being at higher risk.

In some parts of the metropolitan area, the screening of Year 6 students for vision was carried out only for those children who were identified as having vision difficulties (in line with the most recent NH&MRC recommendations).

100B: Rate of referral as a result of childhood screening schedule

This indicator reports post-screening referral rates per 1,000 of population, for children who reside in the Metropolitan Health Services catchment area.

Rationale

Once children have been through screening programs, it is important that those who have failed to meet the screening criteria are referred on to an appropriate specialist to receive more detailed assessments and, where it is needed, therapy. Variations in post-screening referral rates are examined on an ongoing basis and year to year comparisons are used to alert health service planners to potential problems.

Results

Post screening referral rates (per 1,000 of population) were measured in two age groups (0 to 4) and (5 to 12) and across two ethnic groups - Non-Aboriginal and Aboriginal children:

Table 15: Rate of referral per 1,000 population of children as a result of childhood screening schedule

	2000		2001		2002	
	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal
0 - 4 Years	29.1	21.2	28.7	21.4	26.6	21.8
5 -12 Years	21.0	16.8	24.6	13.1	17.1	20.6

Data Sources:
HCare Community Health data.
Health Service Population data.

Comments

With the shift towards reduced screening for children not deemed to be “at risk” and more screening of “at risk” children, fewer Non-Aboriginal children were referred. The improved rate of screening for Aboriginal children has resulted in an increase in the number of children referred in both the 0-4 and 5-12 age groups.

There was also an increased emphasis on multidisciplinary early intervention approaches with screening staff providing the necessary early intervention resources to the families of many of the children, thus reducing the number of referrals for more specialised intervention.

101: Rate of childhood immunisation

This indicator reports immunisation rates per 1,000 of population, for children who reside in the Metropolitan Health Services catchment area.

Rationale
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 their full potential. One of the key components of this is to ensure that the majority of children are immunised according to internationally recognised vaccination practices.

Immunisation of the individual is important not only for that individual, but also for the entire community – if the majority of people are immunised the community benefits from "herd immunity" which prevents epidemics.

Without access to immunisation the consequences of any illness or disability are likely to be more disabling, lead to a higher hospitalisation rate and contribute to a higher rate of premature death.

This indicator measures the rate of immunisation against particular diseases (by age group) of the resident child population in the metropolitan catchment area. It also measures the hospitalisation rate for children who need treatment for the infectious diseases in question.

Results
Immunisation rates (per 1,000 of population) were measured in three age groups (12 to 15 months), (24 to 27 months) and (72 to 75 months) and across two ethnic groups - Non-Aboriginal and Aboriginal children:

Table 16: Rate per 1,000 of population for childhood immunisation

	2001 (Mar Quarter)		2002 (Mar Quarter)		2002 (Dec Quarter)	
	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal
12 – 15 months	906.8	783.8	886.0	676.1	903.6	777.8
24 – 27 months	843.1	817.6	849.4	662.5	872.7	790.1
72 – 75 months	N/A	N/A	773.0	687.0	784.8	766.0

Data Source:
Australian Childhood Immunisation Register (ACIR).

101: Rate of childhood immunisation cont.

This part of the indicator reports hospitalisation rates per 1,000 of population, for children who reside in the Metropolitan Health Services catchment area.

Table 17: Rate of hospitalisation per 1,000 of population for children with infectious diseases

	2000		2001		2002	
	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal
Diptheria	0.0	0.0	0.0	0.0	0.0	0.0
HepatitisB	0.0	0.0	0.0	0.0	0.0	0.0
Measles	0.0	0.0	0.004	0.0	0.004	0.0
Pertussis	0.05	0.0	0.07	0.13	0.08	0.26
Polio	0.0	0.0	0.0	0.0	0.0	0.0
Tetanus	0.0	0.0	0.0	0.0	0.0	0.0

Data Sources:
Hospital Morbidity Data System.
WA Population Estimates, HIC.

Comments – Immunisation rates
There were slight improvements in immunisation rates for the population within the MHS area. Immunisation programs were delivered by community health services, GPs and local government authorities. The area health services played a key role in the coordination of efforts.

It is a concern that the Aboriginal rate of immunisation is still much lower than the wider population. This may be due, in part, to reporting anomalies whereby clients attending different service providers may not always have their demographic details recorded appropriately. Full immunisation of all children remains a priority for the MHS.

Comments - Hospitalisation rates
The rates for hospitalisation with this group of infectious diseases is extremely low (bearing in mind rates are presented per 1,000 of population) indicating that the immunisation program is very successful. The higher rate for pertussis in 2002 was driven by a cluster of cases in a single school in the hills area.

102: Rate of hospitalisation for tonsillectomies (0 - 12 years)

This indicator reports hospitalisation for tonsillectomy rates per 1,000 of population, for children who reside in the Metropolitan Health Services catchment area.

Rationale

Surgical removal of tonsils (tonsillectomy) is a treatment for children who have recurrent tonsillitis. Treatment of tonsillitis can be undertaken either in the community or in hospital. It would be expected that the number of hospital admissions will decrease as performance and quality of service in the primary health care area (prevention and promotion) improves. The number of children who are admitted to hospital per 1,000 population for tonsillectomies may be an indication of improved primary care or community health strategies – for example, health education by a primary health care professional ie general practitioner, community health or school health nurse.

Note

While this indicator uses hospital separations, it is a measure of primary health care performance and not a measure of the performance of the Health service providing the hospitalisation.

Results

Hospitalisation for tonsillectomy rates (per 1,000 of population) were measured over 3 years, across two ethnic groups - Non-Aboriginal and Aboriginal children:

Table 18: Rate of hospitalisation per 1,000 of population for tonsillectomies (0 - 12 years)

2000		2001		2002	
Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal
6.1	1.0	6.4	1.2	6.9	1.4

Data Sources:
Hospital Morbidity Data System.
WA Population Estimates, HIC.

Comments

The tonsillectomy rates have remained fairly constant over the last 3 years.

103: Rate of hospitalisation for gastroenteritis in children (0 - 4 years)

This indicator reports hospitalisation for gastroenteritis rates per 1,000 of population, for children (0 to 4 years) who reside in the Metropolitan Health Services catchment area.

Rationale

Gastroenteritis is a condition for which a high number of patients are treated either in the hospital or in the community. It would be expected that hospital admissions for this condition would decrease as performance and quality of service in many different health areas improves. The number of children who are admitted to hospital for treatment of gastroenteritis 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 environmental issues will also have an impact on the prevalence of transmissible diseases like gastroenteritis.

Note

While this indicator uses hospital separations, it is a measure of primary health care performance and not a measure of the performance of the Health service providing the hospitalisation.

Results

Hospitalisation rates for gastroenteritis in children (0 to 4 years) per 1,000 of population, were measured over 3 years, across two ethnic groups - Non-Aboriginal and Aboriginal children:

Table 19: Rate of hospitalisation per 1,000 of population for gastroenteritis in children (0 - 4 years)

2000		2001		2002	
Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal
8.0	14.3	12.0	18.0	9.6	20.7

Data Sources:
Hospital Morbidity Data System.
WA Population Estimates, HIC.

104: Rate of hospitalisation for respiratory conditions

This indicator reports hospitalisation for respiratory conditions rates per 1,000 of population, for people who reside in the Metropolitan Health Services catchment area.

Rationale
A reduced number of people who are admitted to hospital for treatment of respiratory conditions such as acute bronchitis, bronchiolitis, croup and acute asthma may be an indication of the effectiveness of primary care or community health strategies - for example, health education.

It is important to note however, that other factors may influence the number of people hospitalised with these conditions. These conditions are ones which have a high number of patients treated either in hospital or in the community.

Note
While this indicator uses hospital separations, it is a measure of primary health care performance and not a measure of the performance of the Health service providing the hospitalisation.

Results
Hospitalisation rates for respiratory conditions per 1,000 of population were measured over 3 years, across two ethnic groups - Non-Aboriginal and Aboriginal people. Because some of the respiratory conditions affect only the very young, different age groups were used for the different conditions.

Table 20: Rate of hospitalisation per 1,000 of population for acute asthma

	2000		2001		2002	
	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal
0 - 4 Years	10.8	11.9	11.1	11.4	11.0	18.7
5 - 12 Years	3.7	3.1	3.4	3.1	3.4	4.6
13 - 18 Years	1.6	0.7	1.3	1.6	1.2	1.2
19 - 34 Years	1.0	1.5	0.7	1.6	0.8	1.4
35 + Years	0.8	3.9	0.8	4.7	0.9	6.9

Data Sources:
Hospital Morbidity Data System.
WA Population Estimates, HIC.

104: Rate of hospitalisation for respiratory conditions cont.

Table 21: Rate of hospitalisation for acute bronchitis per 1,000 of population

	2000		2001		2002	
	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal
0 - 4 yrs	0.2	1.7	0.2	0.3	0.2	0.3

Data Sources:
Hospital Morbidity Data System.
WA Population Estimates, HIC.

Table 22: Rate of hospitalisation for bronchiolitis per 1,000 of population

	2000		2001		2002	
	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal
0 - 4 yrs	10.4	37.8	8.6	28.4	10.3	37.3

Data Sources:
Hospital Morbidity Data System.
WA Population Estimates, HIC.

Table 23: Rate of hospitalisation for croup per 1,000 of population

	2000		2001		2002	
	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal
0 - 4 yrs	4.7	4.3	2.6	1.7	4.5	4.5

Data Sources:
Hospital Morbidity Data System.
WA Population Estimates, HIC.

Comments

The fluctuations occurring over the three years may be due to environmental factors.

106: Rate of childhood dental screening

This indicator reports the rate of screening within the school dental program.

Rationale

Dental screening programs for school children are undertaken to ensure early identification of dental problems and, where appropriate provide treatment. The early identification and management of dental problems improves the life and health outcomes for children.

This indicator examines the disease prevention and health promotion effectiveness of the school dental service by measuring the enrolment and screening rates for school children who are eligible for the service. It also measures the 'free of active dental caries' rate at the time of patient recall, because if the preventative program has been effective, children will have a low level of active caries.

While the outcomes for these dental programs include 'restoration of health' it is considered that their primary outcome is prevention of disease and promotion of health – hence their inclusion with the Outcome 1 indicators.

Results

The percentage of school children enrolled in the School Dental Service and the percentage of children receiving dental care, were measured across three groups: pre-primary school children, primary school children and secondary school children. The 2002/2003 rates were compared to the four previous years:

Table 24: Rate of screening of pre-primary school children

	1998/99	1999/00	2000/01	2001/02	2002/03
Enrolled in program	84.5%	83.6%	83.9%	84.2%	82.6%
Under care	84.5%	83.6%	83.9%	84.2%	82.6%

Data Source:
School Dental Health.

Table 25: Rate of screening of primary school children

	1998/99	1999/00	2000/01	2001/02	2002/03
Enrolled in program	87.06%	86.8%	86.3%	85.9%	85.2%
Under care	87.06%	86.8%	86.3%	85.9%	85.2%

Data Source:
School Dental Health.

106: Rate of childhood dental screening cont.

Table 26: Rate of screening of secondary school children

	1998/99	1999/00	2000/01	2001/02	2002/03
Enrolled in program	77.3%	76.3%	75.9%	77.2%	82.6%
Under care	58.0%	57.8%	60.1%	58.9%	58.9%

Data Source:
School Dental Health.

The 'free of active dental caries' rate at the time of patient recall is measured below and compares results with previous years.

Table 27: Rate of children free of dental caries when recalled

	1998/99	1999/00	2000/01	2001/02	2002/03
Children free of active dental caries on recall	67.7%	67.9%	67.0%	67.1%	67.2%

Data Source:
School Dental Health.

Comments

Percentage of Children in the School Dental Service: The percentage of school children enrolled in and receiving care from the service dropped slightly in 2002/2003. However, it still remains at a high level and is confirmation that the School Dental Service is an effective means of delivering disease prevention and health promotion programs. As in previous years, the 'under care' figures for the secondary school group vary from the enrolment figures because the older children are expected to take more responsibility for their own care i.e. missed appointments are not followed up by the service. Until such time that those students make further contact, they are not 'under care'.

Free of Active Caries Rate: The 'Free of Active Caries on Recall' rate has remained relatively constant even though the average recall interval has increased from 13.8 months to 14.4 months over the past five years.

107: Dental health status of target clientele

This indicator reports dental health status of school children and adults eligible to use the state government Dental Health Service.

Rationale

A major role of the Dental Health Service is to prevent dental disease. To gauge the effectiveness of the service, the rate of decayed, missing or filled teeth (DMFT) of its target clientele may be measured.

This indicator measures the effectiveness of the School Dental Service and the adult dental program by measuring the 2002/2003 rate of decayed, missing or filled teeth (DMFT) and comparing it with previous years.

Results

The rate of decayed, missing or filled teeth (DMFT) per person was measured in two groups - the children enrolled and under the care of the School Dental Service and a target group of financially disadvantaged adults (aged 35 to 44 years). Results were compared to previous years.

Table 28: Average number of decayed, missing or filled teeth for school children

	1998/99	1999/00	2000/01	2001/02	2002/03
5 year olds (deciduous DMFT)	1.32	1.48	1.51	1.59	1.54
8 year olds	0.33	0.27	0.37	0.34	0.35
12 year olds	0.79	0.81	0.91	0.84	0.93
15 year olds	1.55	1.50	1.68	1.51	1.57

Data Source:
School Dental Health.

Table 29: Average number of decayed, missing or filled teeth for adults

1998/99	1999/00	2000/01	2001/02	2002/03
13.4	13.9	13.7	13.8	12.5

Data Source:
School Dental Health.

107: Dental health status of target clientele cont.

Comments

School Dental Service: The number of DMFTs in children has remained constant over the past five years. The Western Australian results for the 12 year old compare favourably with international benchmarks:

Austria	1.70 (1997)	Denmark	0.80 (2001)
Finland	1.10 (1997)	Germany	1.20 (2000)
Italy	2.10 (1996)	Norway	1.50 (2000)

These data are provided from the WHO Oral Health Country/Area Profile Program. Data are updated through the Oral Health Collaboration and the collection protocol is standardised, making the data comparable.

Adult Dental Service: The number of DMFTs, while having remained consistent over the past four years, showed a slight improvement in 2002/03.

105: Cost of service for community health services

This indicator reports the average cost per community health service.

Rationale

The efficiency of community health services may be gauged by measuring the average cost per occasion of service, over a number of years.

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.

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 community. These interventions are quantified as occasions of service but can cover a wide range in terms of time and complexity.

Table 30: Cost of service for community health services

	2000/2001	2001/2002	2002/2003
Average cost (actual) of a Community Health Occasion of Service	$30	$36	$46
CPI adjusted	$30	$35	$43

Data Sources:
HCARe Community Health.
Health Services Financial Data.

Note 1

Inner City Community Health programs are not included in this KPI.

Note 2

This is not a population-based indicator, it measures the average cost of an occasion of service in community health programs. It is useful for broad comparisons of trends and must be considered in conjunction with an understanding of current program delivery priorities.

Note 3

Increase in 2002/2003 is due to a change in methodology calculations. All calculations include notional overheads. These figures are not to be used for any other comparative purpose.

108: Average cost of service for school dental service

This indicator reports the cost per enrolled child in the care of the school dental service.

Rationale
The efficiency of health services may be gauged by measuring the average cost of its various services in comparison to previous years' average costs. This indicator, which is a measure of the efficiency of the School Dental Service, measures the average cost of providing a single dental service in the school program.

School Dental Service provides both 'prevention of disease' and 'restoration of dental health'. As the primary outcome of school dental care is the prevention of oral disease and the promotion of good dental health, this indicator has been included with the other Output 1 indicators.

Table 31: Average cost of service for school dental service

	1998/99	1999/00	2000/01	2001/02	2002/03
Actual cost	$70.51	$67.65	$75.57	$80.24	$79.86
CPI adjusted	$76.38	$71.64	$75.57	$77.88	$75.08

Data Source:
School Dental Health Service Data.

Restoration of the health of people with acute illness

The achievement of this component of the health objective involves activities in the Metropolitan Health Services which:

- Ensure that people have access to acute care services when they need them so that intervention occurs as soon as possible. Timely and appropriate access ensures that acute illnesses do not progress.
- Provide quality diagnostic and treatment services to ensure the maximum restoration to health after an acute injury or illness.
- Provide appropriate after-care and rehabilitation to ensure physical and social functioning is restored.
- Provide appropriate obstetric care during pregnancy and the birth episode to both mother and child.

Outcome 2 indicators report the largest proportion of Metropolitan Health Services activities.

Table 32: Respective Indicators by Health Sector

Outcome 2: Restoration to health of people with acute illness.	**Metropolitan Health Service**	**Peel Health Services**	**South West Area Health Service**	**WA Country Health Service**	**Royal Street Division**	**WA Drug & Alcohol Authority**
The achievement of this component of the health objective involves activities which:						
1. Ensures that people have access to acute care services by:						
• Prioritising access to elective surgery	200 201		200 201	200 201	R207	See D&AA Report
• Providing timely transport to hospital		220	220	220	R206 R213 R214	
• Prioritising access to dental services	219 221				R202 R216	
2. Provide quality diagnostic services and treatment by:						
• Providing appropriate and quality admitted patient services when people are ill or injured.	204 205 206 208 209 210 211 212	204 205 208	204 205 206 208 212	204 205 206 208 212	R201 R203 R204 R205 R208 R209 R211 R212 R215	See D&AA Report
• Providing timely and appropriate ambulatory services for people who do not require admitted patient care.	213 214 215	216 217	202 216 217	202 216 217	R210	See D&AA Report
• Providing appropriate obstetric and neonatal care.	207			207		
• Providing appropriate treatment in hospital of patients who require long term nursing care.		218	218	218		

200: Elective surgery waiting times for public patients

This indicator reports waiting list information.

Rationale

For health services to be effective, access to them needs to be provided on the basis of clinical need. In general terms, surgical procedures are performed to either restore a person to good health, or to improve the quality of life. If patients requiring surgical procedures are required to wait for excessively long periods of time, they may have to tolerate ongoing pain, dysfunction or disability. It is also possible that their condition might worsen.

This indicator measures the waiting times for people who are booked in for elective surgical procedures. It reports:

- The number of people who were on the waiting list at the end of the financial year.
- The number of people admitted from the waiting list during the whole of the financial year, compared to previous financial year.

The Australian Institute of Health and Welfare (AIHW) has identified a suite of surgical procedures (indicator procedures) which, typically, are of high volume and are often associated with long waiting periods. This performance indicator reports the following for the indicator procedures:

- For the people who had been admitted from the waiting list during the financial year for an indicator procedure – the average length of time they had waited for their surgical procedures. This was compared to previous financial years.
- For the people who remained on the waiting list at the end of the financial year for an indicator procedure – the average length of time they had waited for their surgical procedures. This was compared to previous years.

Results

The following table identifies the number of people who were on the waiting list at the end of each month during 2002/2003.

Table 33: Number of people on waiting list at 30 June

	2001/2002	2002/2003
30 June	13,960	14,050

Data Source:
Central Wait List Bureau.

200: Elective surgery waiting times for public patients cont.

Table 34: Number of people admitted from the waiting list

Month	2001/2002	2002/2003
July	3,151	3,570
August	3,579	3,466
September	3,244	3,168
October	2,996	3,469
November	3,467	3,478
December	2,383	2,577
January	2,284	2,483
February	3,495	3,448
March	3,104	3,462
April	3,168	3,271
May	3,743	3,499
June	3,130	3,290
Total	37,744	39,181

Data Source:
Central Wait List Bureau.

Table 35: Number of people admitted from the waiting list during 2002/2003 with mean and median waiting times (in weeks)

Type of Operation	Number of people admitted from waiting list	Mean waiting times (weeks)	Median waiting times (weeks)
Cataract extraction	3,915	18.95	13.86
Cholecystectomy	888	8.67	4.00
Coronary artery bypass graft	367	3.48	2.29
Cystoscopy	2,221	5.73	2.43
Haemorrohoidectomy	277	6.96	3.57
Hysterectomy	1,048	5.45	3.86
Inguinal herniorrhaphy	985	7.33	3.71
Myringoplasty	188	29.15	18.79
Myringotomy	813	10.08	6.86
Other	22,840	9.28	3.14
Prostatectomy	392	6.66	2.71
Septoplasty	413	25.35	10.29
Tonsillectomy	1,008	19.36	11.71
Total hip replacement	456	21.43	10.71
Total knee replacement	423	28.30	16.86
Uncoded	2,746	5.16	1.14
Varicose vein ligation & stripping	199	17.56	5.71
Total	**39,179**	**10.42**	**3.71**

Data Source:
Central Wait List Bureau.

200: Elective surgery waiting times for public patients cont.

Table 36: Average length of stay for people remaining on the waiting list at the end of the financial year with mean and median waiting times (in weeks) by indicator procedure

Operation	June 2000		June 2001		June 2002		June 2003	
	mean	median	mean	median	mean	median	mean	median
Cataract extraction	18.94	14.57	20.25	15.43	22.69	16.00	22.75	15.71
Cholecystectomy	28.03	14.14	28.35	14.71	27.28	13.71	23.53	13.00
Coronary artery bypass graft	8.21	2.79	10.93	2.57	20.50	3.43	7.44	5.00
Cystoscopy	22.62	8.86	28.99	9.21	20.83	7.14	22.15	11.64
Haemorrohoidectomy	35.52	31.14	41.67	32.79	41.03	21.93	42.22	37.79
Hysterectomy	12.93	7.29	13.70	6.50	15.15	4.71	12.04	5.79
Inguinal herniorrhaphy	28.18	16.14	34.48	18.64	21.48	11.43	23.05	12.86
Myringoplasty	58.64	42.43	66.50	49.29	71.18	52.43	75.10	46.36
Myringotomy	29.51	21.14	41.61	32.57	27.87	13.43	24.78	12.00
Other	40.85	24.29	43.21	28.57	42.61	22.57	42.43	21.86
Prostatectomy	15.21	11.57	11.62	7.29	15.44	9.21	25.75	4.86
Septoplasty	54.35	33.14	51.45	31.71	59.40	40.57	67.00	42.07
Tonsillectomy	38.02	23.43	47.59	35.14	44.54	30.43	45.92	23.00
Hip replacement	30.32	23.14	29.95	19.86	32.65	19.71	31.05	18.21
Knee replacement	33.91	28.64	34.98	27.43	38.32	27.43	36.05	28.00
Uncoded	14.46	4.43	13.34	5.71	16.61	5.57	23.52	4.64
Varicose vein	54.28	35.71	68.20	52.29	80.46	61.14	60.53	51.86
Total	**35.34**	**19.86**	**37.32**	**21.29**	**37.69**	**19.29**	**38.38**	**19.57**

Data Source:
Central Wait List Bureau.

201: Proportion of Emergency Department patients seen within recommended times

This indicator reports the proportion of Emergency Department patients seen within recommended times.

Rationale

When patients first enter an Emergency Department, they are assessed by specially trained nurses, who judge how urgently treatment should be provided. This process, which is known as triage, is to ensure that treatment is given within the appropriate timeframe. This lessens the likelihood that the sicker patients will deteriorate. Treatment within recommended times facilitates restoration to health - either during the emergency visit or, if the patient is admitted to hospital, during the hospital stay.

The triage process and scores are recognised by the Australasian College for Emergency Medicine (ACEM) and are recommended for prioritising all patients who present to an Emergency Department. In a busy Emergency Department, where several people present at the same time, the service aims for the best outcome for all.

The triage code indicates how quickly patients should be reviewed by medical staff. A patient is allocated a code between 1 and 5, with category 1 patients being the sickest. This indicator measures the percentage of patients in each triage category who were seen within the time periods recommended by ACEM.

Table 37: Proportion of Emergency Department patients seen within recommended times

	TARGET	2000/01*	2001/02	2002/03
Triage category 1 (immediately)	**100%**	99.07%	99.96%	99.92%
Triage category 2 (within 10 minutes)	**80%**	76.50%	82.90%	72.09%
Triage category 3 (within 30 minutes)	**75%**	68.43%	59.70%	56.81%
Triage category 4 (within 60 minutes)	**70%**	58.66%	52.05%	49.95%
Triage category 5 (within 2 hours)	**70%**	80.24%	71.87%	68.15%

Data source:
Emergency Department Information System.

***Note:** The 2000/2001 does not include data from South Metropolitan Health Service.

Comments

The non achievement of the targets for categories 2, 3, 4 and 5 are attributed to increasing workloads in the Emergency Departments with minimal changes to staffing levels and reduced efficiency due to increasing access block. The refurbishment of some of the Departments has also caused some inefficiency, however, it is hoped that with the completion of capital works programs the Departments will operate more effectively.

204: Rate of unplanned hospital re-admissions within 28 days, to the same hospital, for a related condition

This indicator reports the rate of unplanned hospital re-admissions within 28 days, to the same hospital, for a related condition.

Rationale
An unplanned re-admission is an unplanned return to hospital as an admitted patient for the same, or a related condition, as the one for which the patient had most recently been discharged.

A high percentage of re-admissions may indicate that improvements could be made to discharge planning or to aspects of the inpatient treatment. Appropriate medical and/or surgical intervention, together with appropriate discharge arrangements will decrease the likelihood of unplanned hospital re-admissions. Unplanned re-admissions necessitate patients spending additional periods of time in hospital as well as utilising additional hospital resources.

Although there are some conditions that may require numerous admissions to enable the best level of care to be given, in most of these cases, re-admission to hospital would be planned.

Table 38: Rate of unplanned hospital re-admissions within 28 days, to the same hospital, for a related condition

	2000/2001	2001/2002	2002/2003
Unplanned Re-admissions Rate	1.72%	1.04%	1.48%

Data Source:
Hospital Morbidity Data System.

Note 1
Excludes re-admission for renal dialysis and chemotherapy.

Note 2
The 2000/2001 and 2001/2002 years do not include data from Armadale Health Service.

Comments
The re-admission percentages for all Metropolitan Health Services hospitals are low. These results suggest that good clinical practice and discharge planning are in place.

205: Rate of unplanned hospital re-admissions within 28 days, to the same hospital, for a mental health condition

This indicator reports the rate of unplanned hospital re-admissions within 28 days, to the same hospital, for a mental health condition.

Rationale

An unplanned re-admission for a patient with a mental health condition is an unplanned return to hospital, as an admitted patient, for the same condition as the one for which the patient had most recently been discharged.

While it is inevitable that some patients will need to be readmitted to hospital within 28 days, in an unplanned way, a high percentage of re-admissions may indicate that improvements could be made to discharge planning or to aspects of the inpatient therapy protocols. Appropriate therapy, together with good discharge planning will decrease the likelihood of unplanned hospital re-admissions. Unplanned re-admissions necessitate patients spending additional periods of time in hospital as well as utilising additional hospital resources.

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

Note

The numbers of patients who receive inpatient mental health care are very low, hence small numbers of patients who have unplanned re-admissions can result in large variations to the annual percentage. The Australian Council on HealthCare Standards (ACHS) considers that a threshold of 10% is an acceptable rate of unplanned re-admissions within 28 days, for patients receiving inpatient mental health services.

Results

In 2002/2003 the rate of unplanned re-admissions within 28 days, for patients receiving inpatient mental health services, was 3.5%. There are no comparative Metropolitan Health Services results for previous years.

Comments

The re-admission rate of 3.5% is well below the ACHS threshold of 10%. This result suggests that good clinical practice and discharge planning are in place.

206: Rate of post operative pulmonary embolism

This indicator reports the rate of post operative pulmonary embolism.

Rationale

Post operatively, patients can develop blood clots in the deep veins of the leg. These clots can travel to the lungs and cause circulatory problems. This is known as a pulmonary embolism and is one of the main causes of death in fit people undergoing elective surgery and it is often preventable.

This indicator measures the percentage rate of patients who underwent surgery and subsequently developed pulmonary embolism. Hospitals have in place protocols that minimise the risk of clots developing and, by monitoring the incidence of post operative pulmonary embolism, can improve the protocols as necessary. A low percentage of patients developing pulmonary embolism post operatively suggests that the appropriate precautions have been taken.

The monitoring of post operative complications is important in ensuring the optimum recovery rate for people with acute illness.

Cases are selected for reporting using the criteria as defined by the Australian Council on Health Care Standards (ACHS). The ACHS standard for good practice is a rate less than 0.8%. Cases are reported for pulmonary embolisms if the post operative length of stay is greater than or equal to 7 days.

Table 39: Rate of post operative pulmonary embolism

	ACHS Threshold	2001*	2002
Post operative pulmonary embolism rate	**0.2% - 0.8%**	0.15%	0.30%

Data Source:
Hospital Morbidity Data System.

Comments

The post operative pulmonary embolism rates are within the ACHS parameters, suggesting that Metropolitan Health Services protocols represent good clinical practice.

207:	**Rate of discharge directly home from birth hospital for babies with an APGAR score of 4 or less five minutes after delivery**

For babies with an APGAR score of 4 or less at five minutes after delivery, this indicator measures the rate being discharged directly to home from the hospital of birth.

Rationale

This indicator looks at all live-born babies with an APGAR score of 4 or less, five minutes after delivery. The rate per 100 births is based on those babies that have an outcome of “Discharged Home” from the delivering hospital.

APGAR scoring describes the condition of the newborn baby at 1, 5 and 10 minutes of age. APGAR scores: heart rate, breathing activity, colour, spontaneous movement and muscle tone. For the purposes of this indicator the scoring after 5 minutes of birth was used.

Babies who have been unwell in-utero (ie in the mother’s uterus) will often have low APGAR scores. Babies who have had difficulties with their oxygen supply in labour may, also, have low APGAR scores. Babies with low APGAR scores are, therefore, the group of live-born babies most likely to require more extended care or to not survive.

Note

This indicator only measures those ‘at risk’ babies who are **discharged home from their birthing hospital**, it does not measure survival. Many of the ‘at risk’ babies are not discharged home from their birthing hospital, but are transferred to another hospital (usually King Edward Memorial or Princess Margaret Hospital) for further care before discharge home – these babies are not measured in this indicator. **Thus, this indicator does not include those babies transferred to another hospital but ultimately are discharged home.**

Results

The following are the results based on all metropolitan births. The results have been broken into gestation weeks as this has been proven statistically to significantly impact on the number of babies discharged directly home from the birth hospital.

Table 40: Rate of discharge directly home from birth hospital for babies with an APGAR score of 4 or less five minutes after delivery

Metropolitan Health Services - 2000				
	Gestation	**Discharged Home**	**Total Births**	**Rate per 100 births**
	20-28w	4	23	17
	29-32w	2	7	29
Sub-total	**<33w**	**6**	**30**	**20**
	33-36w	1	8	13
	37-41w	17	19	89
Sub-total	**>=33w**	**18**	**27**	**67**
Total		24	57	42
%of <=4 APGAR to Total Births				**53%**
Metropolitan Health Services - 2001				
	Gestation	**Discharged Home**	**Total Births**	**Rate per 100 births**
	20-28w	1	22	5
	29-32w	1	4	25
Sub-total	**<33w**	**2**	**26**	**8**
	33-36w	0	5	0
	37-41w	7	15	47
Sub-total	**>=33w**	**7**	**20**	**35**
Total		9	46	20
% of <=4 APGAR to Total Births				**45%**
Metropolitan Health Services - 2002				
	Gestation	**Discharged Home**	**Total Births**	**Rate per 100 births**
	20-28w	0	6	0
	29-32w	2	3	67
Sub-total	**<33w**	**2**	**9**	**22**
	33-36w	1	7	14
	37-41w	9	15	60
Sub-total	**>=33w**	**10**	**22**	**45**
Total		12	31	39
% of <=4 APGAR to Total Births				**32%**

Data Source:
Midwives Statistics.

Note 1
All stillborns have been excluded.
Note 2
Although it is also preferable to exclude infants induced for congenital abnormalities, this would only be possible for KEMH data and not for any other metropolitan hospitals. Including these babies however is likely to have a minimal effect on the rate of low APGAR babies discharged home. This is further evidenced by reviewing the past six months of KEMH data in which 17 babies were induced for congenital abnormalities, 14 (82%) were stillborn and are therefore excluded anyway. The remaining 3 cases all had a recorded APGAR score >4, therefore would also not be included as part of this particular indicator.
Note 3
Logistic regression modelling was used to analyse the probability of a baby born in a Metropolitan hospital with a low APGAR score, being discharged directly home.

Comments

The probability of a baby born with a low APGAR score being discharged directly home varies from year to year and between metropolitan and the country hospitals. Within the metropolitan area, there is a significant effect on the probability if a baby was born at KEMH rather than another hospital. However, this effect is not significant when confined to babies born with low APGAR scores. This is almost certainly due to a residual effect of the additional pre-term (< 37 weeks) births. When the analysis is confined to those babies born at term (37-41w) there is no difference at all in the probability of being discharged directly home between those babies born at KEMH and those born at other metropolitan hospitals.

Analysis of information would be greatly improved if the babies who were not discharged directly home from the birth hospital, were followed in their progress through the entire hospital system. In Metropolitan hospitals, for example, KEMH is the hospital of birth of 95% of the babies born with an APGAR score of 4 or less and a gestation period of between 20-32 weeks. A large proportion of these and other pre-term babies (< 37 weeks gestation) are transferred to other hospitals for further care before eventually being discharged home.

Further analysis of live-born babies born at metropolitan hospitals reveals the proportion of babies born with an APGAR score of <=4 ranges from 53% in 2000 down to 32% in 2002. Unfortunately there are no like benchmark studies to compare against. The closest comparison relates to the AIHW published Perinatal Statistics which state: Nationally in 1990, 30% of live-born babies had an APGAR score of 3 or less.

Where it is realised that an unborn baby may have health problems it is usual practice to refer that woman to King Edward Memorial Hospital . Therefore, teaching hospitals expect a higher incidence of babies with low APGAR scores than non-teaching hospitals, and a higher incidence of live-born babies not surviving. Thus, the rates for the Metropolitan area are significantly influenced by the higher proportion of ‘at risk’ deliveries that are referred to the teaching hospital.

208: Survival rates for sentinel conditions

This indicator reports the survival rates for stroke, heart attack and fractured hip.

Rationale

The survival of patients in hospitals can be affected by many factors including the patient's diagnosis, the severity of the condition, the patient's age, co-morbid conditions and complications arising. The treatments given and/or procedures performed also contribute to whether or not the patient survives or succumbs to the illness or injury.

Reviewing survival rates is one way to determine if a health service is performing effectively. However, because all patients and their conditions and treatments are different, it is very hard to reach meaningful conclusions by across-the-board comparisons. To overcome this difficulty 'sentinel' conditions have been identified – these are conditions where there is a reasonable expectation that, given the appropriate hospital care, most (but not all) patients are likely to survive.

Three 'sentinel' conditions have been selected and survival rates are measured by specified age groups. For each of these conditions – stroke, heart attack and fractured hip, a good recovery is more likely when there is early intervention and appropriate care.

This indicator measures the Metropolitan Health Services' performance in relation to restoring the health of people who have had a stroke, myocardial infarction (heart attack) or fractured neck of femur (fractured hip) by measuring those who survive the illness and are discharged from hospital. Some may be transferred to another hospital for specialist rehabilitation or to a hospital closer to home for additional rehabilitation at the end of the acute admission.

Table 41: Rate of acute myocardial infarction (AMI) heart attack survival

	2000	2001	2002
0 – 49 Years	99.09%	97.27%	97.67%
50 – 59 Years	96.53%	98.92%	97.93%
60 – 69 Years	94.65%	95.88%	93.93%
70 – 79 Years	87.35%	86.26%	92.23%
80 Years +	79.62%	81.45%	79.18%

Data Source:
Hospital Morbidity Data System.

208: Survival rates for sentinel conditions cont.

Table 42: Rate of fractured neck of femur survival

	2000	2001	2002
70 – 79 Years	95.80%	97.24%	95.98%
80 Years +	94.37%	93.48%	92.03%

Data Source:
Hospital Morbidity Data System.

Table 43: Rate of stroke survival

	2000	2001	2002
0 – 49 Years	88.76%	87.76%	90.44%
50 – 59 Yeas	93.42%	85.29%	92.21%
60 – 69 Years	88.85%	85.37%	86.73%
70 – 79 Years	86.00%	85.08%	82.47%
80 Years +	73.57%	77.14%	73.89%

Data Source:
Hospital Morbidity Data System.

Comments

The survival rates for AMI and fractured neck of femur have remained fairly constant over the three years. Survival rates for stroke fluctuate across the 3 years and across age groups. Fluctuations in the younger stroke age groups could be explained by the small numbers of patients in the age groups – a single death would considerably increase the death rate for the category.

209: Survival rate of patients following coronary artery bypass grafts

This indicator reports the survival rate of patients following coronary artery bypass grafts.

Rationale

When new surgical techniques are introduced it is important for hospitals to monitor results of any new technique and compare the outcomes with other surgical methods. Until recently, all patients who underwent coronary artery bypass grafts were placed on a cardiopulmonary bypass (Heart Lung) machine.

For a number of patients, it is now possible for coronary artery bypass surgery to be undertaken without the use of cardiopulmonary bypass. This may lead to improved outcomes of surgery for those patients, however not all patients are suited to having the procedure without the bypass machine. Hospitals undertaking this type of surgery should measure the survival outcomes of new and unchanged methods of surgery and benchmark themselves against peer hospitals to ensure that appropriate standards are achieved.

This indicator measures the survival rate of patients undergoing coronary artery bypass surgery. The results will show survival rates with or without the use of the cardiopulmonary bypass machine.

Table 44: Survival rate of patients following coronary artery bypass grafts

	2000	2001	2002
Without bypass machine	99.2%	99.1%	98.7%
With bypass machine	95.2%	95.7%	95.0%

Data Source:
Hospital Morbidity Data System.

Comments

Survival rates for patients who receive coronary artery bypass grafts (with or without a bypass machine) remain very high and fairly constant over the three years measured.

210: Survival rate of patients following coronary angioplasty

This indicator reports survival rate of patients following coronary angioplasty.

Rationale

Hospitals that carry out complicated tertiary procedures should measure the survival outcomes and benchmark themselves against peer hospitals to ensure that appropriate standards are achieved.

Table 45: Survival rates across 3 years for patients undergoing coronary angioplasty

2000	2001	2002
99.15%	99.37%	98.62%

Data Source:
Hospital Morbidity Data System.

Comments

Coronary angioplasty survival rates, which are very high and have not fluctuated over the three year period and are in line with National Registry benchmarks.

219: Access to dental treatment services for eligible people

This indicator reports the access to dental treatment services for eligible people.

Rationale

The Dental Health Service provides financially disadvantaged people with access to non-specialist dental treatment services, both emergency and non-emergency. One of the key measures of the effectiveness of a service is the extent to which the service can be accessed by its clients.

Results report the number of eligible people who accessed the service in 2002/2003 in comparison to previous years. It also provides an indication of the emergency/non-emergency mix over the same time period.

Table 46: Access to dental treatment services for eligible people

	1998/99	1999/00	2000/01	2001/02	2002/03
Eligible persons who access Dental Health Services (adult)	16%	18%	18%	21%	19%

Data Source:
Dental Health Service Records.

The emergency and the non emergency completed courses of care were counted in 2002/2003 and each was expressed as a percentage of the total completed courses of care. Comparisons were made to previous years.

Table 47: Rate of completed dental care

	1998/99	1999/00	2000/01	2001/02	2002/03
Emergency completed courses of care	44%	45%	46%	49%	57%
Non Emergency completed courses of care	56%	55%	54%	51%	43%

Data Source:
Dental Health Service Records.

Comments

Eligible Persons who Access Services: Historically only about 20% of eligible persons access care in government dental facilities. While it appears that significantly fewer people accessed the dental services in 2002/2003, the results reflect the opening of an alternative care provider, the Oral Health Centre of WA (OHCWA) in mid 2001/2002. Since its opening, OCHWA has been treating patients needing specialised dental treatments – services that were previously provided by the Dental Health Service.

219: Access to dental treatment services for eligible people cont.

A substantial increase in the number of people eligible to access the government assisted Dental Health Service, as well as a significant shortage of dentists, has also contributed to the fall in the proportion of eligible persons accessing dental care. The shortage of dentists in particular is exacerbated by difficulties in recruiting qualified dentists.

Emergency/Non Emergency mix of services: There has been a major shift in the Emergency/non Emergency ratio over the last four years with a significant increase in the percentage of emergency cases in 2002/2003. As emergency care consumes greater resources than non emergency care this shift has had an impact on the agency's overall volume of care to eligible people.

211: Average cost per casemix adjusted separation for teaching hospitals

This indicator reports the teaching hospital average cost of a casemix adjusted separation.

Rationale

The efficiency of hospitals may be gauged by measuring the average cost of their various services in comparison to previous years' average costs. This indicator, which is a measure of the efficiency of teaching hospitals inpatient services, measures the average cost of providing a single hospital inpatient episode.

Because every hospital has a different mix of cases and every patient is different to every other one, there is a need to standardise the inpatient episodes. Casemix is used to standardise the inpatient activity measures. The use of casemix in hospitals is a recognised methodology for adjusting actual activity data to reflect the complexity of service provided against the use of resources. Hence, the number of separations in a hospital may be adjusted from the actual raw number by a casemix index to reflect the complexity of the services provided. Metropolitan Health Services hospitals utilise the Australian Refined National Diagnostic Related Groups (AR-DRGs) Version 4.2 to which cost weights are allocated.

Table 48: Average cost per casemix adjusted separation for teaching hospitals

	2000/2001	2001/2002	2002/2003
Average cost per casemix adjusted separation	$2,846	$3,248	$3,893
CPI adjusted	$2,846	$3,152	$3,660

Data Sources: Hospital Morbidity Data System, Health Services Activity Information.

Note

Increase in 2002/2003 is due to a change in methodology calculations. All calculations include notional overheads. These figures are not to be used for any other comparative purpose.

Comments

The 2002/2003 average cost per adjusted separation has increased, compared to the previous year. The increase in costs is a result of a different method of calculation and the following cost pressures:

- Cost of Award increases
- Employment of additional nurses and the implementation of Nursing Hours per Patient Day models
- Increased depreciation expenses
- CPI
- Increases in Riskcover premiums
- Flow-on costs relating to the implementation of Douglas Inquiry recommendations
- The Bali crisis
- Costs associated with Vancomycin-Resistant Enterococcus (VRE) testing
- The use of Drug Eluting Stents

212: Average cost per casemix adjusted separation for non-teaching hospitals

This indicator reports the non-teaching hospital average cost of a casemix adjusted separation.

Rationale

The efficiency of hospitals may be gauged by measuring the average cost of their various services in comparison to previous years' average costs. This indicator, which is a measure of the efficiency of non-teaching hospitals inpatient services, measures the average cost of providing a single hospital inpatient episode.

Because every hospital has a different mix of cases and every patient is different to every other one, there is a need to standardise the inpatient episodes. Casemix is used to standardise the inpatient activity measures. The use of casemix in hospitals is a recognised methodology for adjusting actual activity data to reflect the complexity of service provided against the use of resources. Hence, the number of separations in a hospital may be adjusted from the actual raw number by a casemix index to reflect the complexity of the services provided. Metropolitan Health Services hospitals utilise the Australian Refined National Diagnostic Related Groups (AR-DRGs) Version 4.2 to which cost weights are allocated.

Table 49: Average cost per casemix adjusted separation for non-teaching hospitals

	2000/2001	2001/2002	2002/2003
Average cost per casemix adjusted separation	$2,141	$2,400	$2,775
CPI adjusted	$2,141	$2,329	$2,609

Data Sources:
Hospital Morbidity Data System.
Health Services Financial Data.

Note

Increase in 2002/2003 is due to a change in methodology calculations. All calculations include notional overheads. These figures are not to be used for any other comparative purpose.

Comments

The 2002/2003 average cost per adjusted separation has increased, compared to the previous year. This is mainly due to the cost of award increases and change in methodology.

213: Average cost per Emergency Department presentation for Metropolitan Health Services hospitals

This indicator reports the Metropolitan Health Services hospitals' average cost of an Emergency Department presentation.

Rationale

The efficiency of hospitals may be gauged by measuring the average cost of their various services in comparison to previous years' average costs. This indicator, which is a measure of the efficiency of the Metropolitan Health Services' Emergency Department services, measures the average cost of providing a single Emergency Department service.

Table 50: Average cost per Emergency Department presentation for Metropolitan Health Services hospitals

	2000/2001	2001/2002	2002/2003
Average cost per Emergency Department presentation	$209	$251	$302
CPI adjusted	$209	$244	$284

Data Sources:
Emergency Department Information System (EDIS).
Health Services Financial Data.

Note
Increase in 2002/2003 is due to a change in methodology calculations. All calculations include notional overheads. These figures are not to be used for any other comparative purpose.

Comments

The 2002/2003 average cost per Emergency Department presentation has increased, compared to the previous year. This is due to the cost of award increases and change of methodology.

214: Average cost per doctor attended outpatient episode for Metropolitan Health Services hospitals

This indicator reports the Metropolitan Health Services hospitals' average cost of an outpatient department episode.

Rationale

The efficiency of hospitals may be gauged by measuring the average cost of their various services in comparison to previous years' average costs. This indicator, which is a measure of the efficiency of the Metropolitan Health Services' outpatient department services, measures the average cost of providing a single outpatient department service which was attended by a doctor.

Table 51: Average cost per doctor attended outpatient episode for Metropolitan Health Services hospitals

	2000/2001	2001/2002	2002/2003
Average cost per outpatient department episode (doctor attended)*	$126	$141	$160
CPI adjusted	$126	$137	$150

Data Sources:
The Open Patient Account System (TOPAS).
Health Services Financial Data.

Note 1
Increase in 2002/2003 is due to a change in methodology calculations. All calculations include notional overheads. These figures are not to be used for any other comparative purpose.

Note 2
Includes Royal Perth Hospital, Sir Charles Gairdner Hospital, Fremantle Hospital, Princess Margaret Hospital and King Edward Memorial Hospital.

215: Average cost per non-admitted occasion of service for Metropolitan Health Services hospitals (excludes emergency occasions and doctor attended outpatient occasions)

This indicator reports the average cost per non-admitted occasion of service for Metropolitan Health Services. It excludes emergency and doctor attended outpatient occasions of service.

This is the first year that teaching hospitals have reported this PI. The hospitals have yet to attain a consistent approach to counting the relevant occasions of service and of classifying the corresponding expenditure.

Rationale

The efficiency of hospitals may be gauged by measuring the average cost of their various services in comparison to previous years' average costs. This indicator, which is a measure of the efficiency of the services to non-admitted patients within the Metropolitan Health Services, reports the average cost of providing a single non-admitted occasion of service where a doctor does not provide the care.

Table 52: Average cost per non-admitted occasion of service for Metropolitan Health Services hospitals (excludes emergency occasions and doctor attended outpatient occasions)

	2000/2001	2001/2002	2002/2003
MHS Teaching Hospitals	$55	$75	$81
MHS Non-Teaching Hospitals	$43	$45	$50
Total Metropolitan Health Services cost (actual)	$51	$66	$75
Total Metropolitan Health Services cost CPI adjusted	$51	$64	$71

Data Sources:
Health Services Financial Data.
Health Services Activity Information Systems for Allied Health.
The Open Patient Accounting System (TOPAS).

Note 1
Increase in 2002/2003 is due to a change in methodology calculations. All calculations include notional overheads. These figures are not to be used for any other comparative purpose.

Note 2
Fremantle Hospital data not included in 2000/2001.

221: Average cost of completed courses of adult dental care

This indicator reports the average cost of completed courses of dental care for adults.

Rationale
The efficiency of health services may be gauged by measuring the average cost of their various services in comparison to previous years' costs.

As this is the first year that this measurement has been undertaken, comparative assessment cannot be made until future years.

Table 53: Average cost of completed courses of adult dental care

	2002/03
Average cost	$225.66

Data Source:
Dental Health Services Data.

Improvement in the quality of life for people with chronic illness and disability

The achievement of this component of the health objective involves provision of services and programs that improve and maintain an optimal quality of life for people with chronic illness, disability or terminal disease.

To enable people with chronic illness or disability to maintain as much independence in their everyday life as their illness permits, services are provided in clients' homes to enable normal patterns of living that are valued in the general community. Sometimes services are provided in residential facilities when the care needs of the clients exceed what can be provided in a normal home environment.

Indicators developed to measure performance of the Metropolitan Health Services in Outcome 3 link to the areas indicated in the framework table below.

Table 54: Respective Indicators by Health Sector

Outcome 3: Improving the quality of life for people with chronic illness and disability.	**Metropolitan Health Service**	**Peel Health Services**	**South West Area Health Service**	**WA Country Health Service**	**Royal Street Division**	**WA Drug & Alcohol Authority**
The achievement of this component of the health objective involves activities which:						
1. Supporting people with chronic illness by:						
▪ Providing palliative care services.					R304 R308 R310	
▪ Providing support services to people with chronic illnesses and disabilities.	300 301	301	301	301	R305 R309	
▪ Providing appropriate home care services for the frail aged.	304	304	304	304	R302 R306 R307	
• Providing community support for those with mental illness.	302 303	302 303	302 303	302 303	R311	
• Providing temporary care for those awaiting permanent nursing home care.	305		305			
• Providing appropriate rehabilitative care.					R301 R303	See D&AA Report

300: Waiting time to first outpatient appointment for chronic illness

This indicator reports the waiting time for clinics that treat patients with chronic illness or disability.

Rationale
In order to achieve and maintain an optimal quality of life, people with chronic illness and disability, require timely access to appropriate assessment and treatment services to ensure that their condition and its symptoms are managed.

This indicator measures the waiting time for people who were referred to an outpatient clinic to see a specialist consultant for the assessment or management of a chronic illness or disability. This indicator refers specifically to those people who are being referred for the first time, and excludes those who have previously seen a Consultant at the clinic and who are returning for a subsequent appointment.

The clinics specifically selected for this indicator were those Metropolitan Health Services clinics that predominantly treated patients with chronic illness or disability. They include:

- Three clinics conducted at Fremantle Hospital:
  - Renal clinic
  - Ophthalmology
  - Ulcer clinic
- Two State wide clinics conducted at Royal Perth Hospital:
  - Back disabilities clinic (Shenton Park campus)
  - Rheumatology clinic (Shenton Park campus)

Table 55: Mean and median waiting time to first outpatient appointment for chronic illness

	2001/2002			2002/2003		
	New cases	Mean in days	Median in days	New cases	Mean in days	Median in days
Ophthalmology	1,333	100	61	1,870	99	46
Renal	158	107	23	205	166	34
Ulcer	231	98	21	263	36	21
Back disability	236	84	91	209	118	122
Rheumatology	243	62	31	295	47	28

Data Source:
The Open Patient Accounting System (TOPAS).

300: Waiting time to first outpatient appointment for chronic illness cont.

Comments

Ulcer Clinic: Improved cooperation with community-based services made a significant reduction in follow-up visits leading to reduced mean wait times for new clients.

Ophthalmology Clinic: The appointment of an additional senior registrar resulted in reduced median wait times, indicative of fewer long wait cases.

Back Disability Clinic: The increase in the median waiting time for Back Disability Clinic at Shenton Park Campus was influenced by the number of consultants on long term leave compounded with the difficulty in recruitment. Consequently, a limited number of appointments were available for new cases.

301: Median waiting time for community and allied health services (hospitals & community based)

This indicator reports the waiting times for occupational therapy services (adults), speech pathology services (adults) and physiotherapy services (children). The services are provided at different sites in the Metropolitan Health Services.

Rationale
People with chronic illness and disability require timely access to appropriate on-going community and allied health treatment services to ensure that their condition and symptoms are managed, and to achieve and maintain an optimal quality of life. Without access to appropriate intervention or treatment, the consequences may be more disabling and may lead to a lesser quality of life

This indicator reports the time people wait for appointments at community and allied health services where they can access treatment for their chronic illness or disability. The clinics selected for this indicator were those Metropolitan Health Services community and allied health clinics that treated patients with chronic illness or disability. They include:

- Occupational Therapy Services (adults) at:
  - Kalamunda Health Service
  - Swan Health Service
  - Sir Charles Gairdner Hospital — On-site
  - Sir Charles Gairdner Hospital — Domiciliary
  - Fremantle Hospital and Health Service
  - Armadale Health Service
  - Rockingham/Kwinana Health Service
- Speech Pathology Services (adults) at:
  - Bentley Health Service
  - Sir Charles Gairdner Hospital — On-site
  - Sir Charles Gairdner Hospital — Domiciliary
  - Fremantle Hospital and Health Service
  - Armadale Health Service
  - Rockingham/Kwinana Health Service
- Physiotherapy Services (children) at:
  - Bentley Health Service
  - Swan Health Service
  - Clarkson Child Development Centre
  - Joondalup Child Development Centre
  - Koondoola Child Development Centre
  - Fremantle Hospital & Health Service
  - Rockingham/Kwinana Health Service

Results
This indicator measures the median waiting time (in days) for all clients seen during the 2002/2003 from the date of referral to the initial presentation for the first occasion of service. Where available, 2001/2002 waiting times are also presented for comparative purposes.

Table 56: Median waiting time for community and allied health services (hospitals & community based)

Occupational Therapy Services (adults):	2001/2002	2002/2003
Kalamunda Health Service	n/a	22
Swan Health Service	n/a	201
Sir Charles Gairdner Hospital - onsite	2	2
Sir Charles Gairdner Hospital - domiciliary	4	6
Fremantle Hospital & Health Service	0	25
Armadale Health Service	n/a	14
Rockingham/Kwinana Health Service	24	14

Speech Pathology Services (adults)	2001/2002	2002/2003
Bentley Health Service	n/a	10
Sir Charles Gairdner Hospital - onsite	39	11
Sir Charles Gairdner Hospital - domiciliary	42	43
Fremantle Hospital & Health Service	0	28
Armadale Health Service	n/a	10
Rockingham/Kwinana Health Service	54	17

Child Physiotherapy Services	2001/2002	2002/2003
Bentley Health Service	n/a	28
Swan Health Service	n/a	43
Clarkson Child Development Centre	n/a	9
Joondalup Child Development Centre	14	13
Koondoola Child Development Centre	12	7
Fremantle Hospital & Health Service	166	102
Rockingham/Kwinana Health Service	21	8

Data Sources:
The Open Patient Accounting System (TOPAS).
Health Services Allied Health Data System.

Comments

Adult Occupational Therapy Services: Long waiting times at Swan, Kalamunda and Fremantle Health Services were due to increased demand during 2002/2003 and to the referral of more complex cases. In the East Metropolitan Health Service alternate management strategies, such as parent education groups, were unable to significantly reduce waiting times.

Adult Speech Therapy Services: There have been improvements in many of the services' waiting times. These services have also been subject to increased demand in 2002/2003.

Child Physiotherapy Services: The opening of the Clarkson Child Development Centre in the North Metropolitan Health Service alleviated pressure on some of the other centres. Multidisciplinary work with Child Health Nurses has enabled effective preventative work and reduced the number of referrals at the Fremantle Hospital & Health Service.

302: Median bed-days for persons under mental health community management who were admitted to hospital

This indicator reports the median bed-days for persons under mental health community management who were admitted to hospital.

Rationale
Community management of people with mental illness aims to provide the treatment and support required to prevent the recurrence of acute episodes of illness requiring hospitalisation. If community management achieves this aim of reducing hospitalised care then the number of clients admitted to hospital and the length of stay should decrease.

By reducing the severity and frequency of mental health episodes the mental health status and thus quality of life of people with mental illness is improved. The indicator consists of all overnight psychiatric (mental health diagnosis) admissions to public hospitals.

Table 57: Median bed-days for persons under mental health community management who were admitted to hospital

Mental Health Units	1998	1999	2000	2001	2002
Armadale Kelmscott	23	14	13	11	11
Bentley	23	22	22	19	17
Fremantle	19	17	15	14	15
Graylands	27	31	25	27	24
Kalamunda*	3	4	15	17	0
North Metro	19	23	19	20	18
Rockingham Kwinana	14	14	13	13	12
RPH Inner City	34	27	22	21	18
Selby Lemnos	58	66	49	51	35
Swan District	21	24	20	18	19

Data Source:
Local Area Mental Health Information System (LAMHIS).

***Note**
In 2002 Kalamunda Health Service patients were managed at the Swan Health Service.

304: Aged Care Assessment Team (ACAT) assessments

This indicator is in four parts and reports the number of ACAT assessments, the number of first assessments, the waiting time for ACAT assessment for a first referral and the recommended care outcomes for aged care assessments.

Rationale

People within the targeted age groups (70 and over in the non Aboriginal group and 50 and over in the Aboriginal group) are at risk of experiencing a poorer quality of life because of frailty, chronic illness or disability reducing their capacity to manage their activities of daily living. A range of services are available to people requiring support to improve or maintain their optimal quality of life. There are supports available to people living in their own homes as well as supported accommodation options.

ACAT assess the support needs of people who may require services to improve or maintain their quality of life. Appropriate coverage of the 'at risk' population is a measure of ensuring that the needs of this population are adequately assessed and the plans for the provision of required levels of support are developed.

304A: Rate of ACAT assessments within targeted age groups per 1,000 population

This indicator reports the extent to which people within the targeted age groups are assessed by ACAT.

Table 58: Rate of ACAT assessments within targeted age groups per 1,000 population

Health Service	Ethnicity	Age group	2001 Assessment Rate per 1,000 population	2002 Assessment Rate per 1,000 population
East Metropolitan Health Service	Non-Aboriginal	70+ years	n/a	194
	Aboriginal	50+ years	n/a	36
North Metropolitan Health Service	Non-Aboriginal	70+ years	167	163
	Aboriginal	50+ years	10	11
South Metropolitan Health Service	Non-Aboriginal	70+ years	n/a	120
	Aboriginal	50+ years	n/a	22

Data Source:
University of WA, ACAT data.

304: Aged Care Assessment Team (ACAT) assessments cont.

304B: Rate of first ACAT assessments within targeted age groups per 1,000 population

This indicator reports the rate of first assessments by Aged Care Assessment Teams per 1,000 of population.

Table 59: Rate of first assessments by Aged Care Assessment Teams per 1,000 of population.

Health Service	Ethnicity	Age group	2001 Assessment Rate per 1,000 population	2002 Assessment Rate per 1,000 population
East Metropolitan Health Service	Non-Aboriginal	70+ years	n/a	77
	Aboriginal	50+ years	n/a	8
North Metropolitan Health Service	Non-Aboriginal	70+ years	58	61
	Aboriginal	50+ years	3	4
South Metropolitan Health Service	Non-Aboriginal	70+ years	n/a	51
	Aboriginal	50+ years	n/a	11

Data Source:
University of WA, ACAT data.

304C: Median waiting time (days) for ACAT assessment for a first referral

This indicator reports the median time people wait for a first assessment after their referral to an ACAT team.

Rationale

The first referral to an ACAT for assessment is a significant point in the planning and management of a person's care, in that this multi-disciplinary assessment ensures a full review of a person's current capabilities and needs. This is also an important entry point to accessing a range of community and residential support services.

304: Aged Care Assessment Team (ACAT) assessments cont.

Table 60: Median waiting time (days) for ACAT assessment for a first referral

Health Service Site	2001	2002
East Metropolitan Health Service	n/a	2
North Metropolitan Health Service	1	0
South Metropolitan Health Service	n/a	4

Data Source:
University of WA, ACAT data.

304D: Recommended care outcomes for aged care assessments

This indicator reports the 2002 outcomes achieved through the ACAT process.

Rationale

Aged Care Assessment Teams (ACAT) assess the support needs of people who may require services to improve or maintain their quality of life. The core objective of the service is to comprehensively assess the needs of frail older people to assist them to gain access to the services most appropriate to their needs.

The primary purpose of ACATs and the assessment role is underpinned by the principles of supporting people in their own homes, in their own communities and recommending residential care only where their support systems are not appropriate to meet their needs.

Table 61: Recommended care outcomes for aged care assessments

Outcome for 2002	Aboriginal 50 + years		Non Aboriginal 70 + years	
	Number	%	Number	%
Died before ACAT process completed	0	0%	273	1.5%
Transferred before ACAT process completed	3	6.4%	346	1.9%
Returned home with services	22	46.8%	5,507	29.6%
Returned home - no services	11	23.4%	5,941	32%
Admitted to a nursing home	4	8.5%	2,388	12.8%
Remained or returned to a nursing home	1	2.1%	430	2.3%
Admitted to a hostel	1	2.1%	1,834	9.9%
Remained or returned to a hostel	5	10.7%	1,686	9.1%
Other (eg Psychiatric extended care, palliative care)	0	0%	167	0.9%
Total	47	100.00%	18,572	100.00%

Data Source:
University of WA, ACAT data.

303: Average cost per person with mental health illness under community management

This indicator reports the Metropolitan Health Services' average cost per person for someone who is being treated for a mental health illness, under community management.

Rationale

The efficiency of health services may be gauged by measuring the average cost of their various services in comparison to previous years' average costs.

The majority of services provided by community mental health services are for people in an acute phase of a mental health problem or who are receiving post-acute care. This indicator gives a measure of the cost of treatment for a public psychiatric patient under community management (non-admitted/ambulatory patient).

Table 62: Average cost per person with mental health illness under community management

	1999/2000	2000/2001	2001/2002	2002/2003
Average cost per person with Mental Illness (under Community Care)	$2,390	$2,386	$2,497	$3,078
CPI adjusted	$2,531	$2,386	$2,424	$2,894

Data Sources:
Mental Health Information Systems.
Health Services Financial Systems.

Note 1
Increase in 2002/2003 is due to a change in methodology calculations. All calculations include notional overheads. These figures are not to be used for any other comparative purpose.

Note 2
1999/2000 results do not include Rockingham and Armadale Health Services' data.

305: Average cost per Care Awaiting Placement (CAP) day

This indicator reports the Metropolitan Health Services' average cost per CAP for those patients awaiting a permanent placement.

Rationale
The efficiency of health services may be gauged by measuring the average cost of their various services in comparison to previous years' average costs.

Some people with chronic illness or disability, even with regular respite care and HACC service, are not able to be cared for at home. They may need long term residential care to ensure that their quality of life is maintained and, in some instances, there may be a period of waiting before long term residential care becomes available.

The Department of Health manages a Care Awaiting Placement (CAP) program to ensure that those who need residential placement can remain in temporary care while awaiting more permanent placement.

Table 63: Average cost per Care Awaiting Placement (CAP) day

	2001/2002	2002/2003
Average cost per CAP day	$273	$273
CPI adjusted	$265	$257

Data Source:
DOH, contract papers.

Note
2001/2002 includes NMHS and SMHS only.

CERTIFICATION OF FINANCIAL STATEMENTS
for the year ended 30 June 2003

The accompanying financial statements of The Minister for Health in his capacity as the Deemed Board of Metropolitan Public Hospitals 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 reporting period ending 30 June 2003 and the financial position as at 30 June 2003.

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 The Minister for Health in his capacity as the Deemed Board of Metropolitan Public Hospitals

Date: 28/08/03

Philip Aylward
Principal Accounting Officer
The Minister for Health in his capacity as the Deemed Board of Metropolitan Public Hospitals

Date: 28/08/03

AUDITOR GENERAL

INDEPENDENT AUDIT OPINION

To the Parliament of Western Australia

THE MINISTER FOR HEALTH IN HIS CAPACITY AS THE DEEMED BOARD OF METROPOLITAN PUBLIC HOSPITALS FINANCIAL STATEMENTS FOR THE YEAR ENDED JUNE 30, 2003

Qualifications

Postal Remittances - Special Purpose Accounts

The controls exercised by the Health Service over postal remittances relating to Special Purpose Accounts were not adequate as not all remittances were being opened and recorded before being forwarded to individuals. As a result, assurance cannot be provided that all postal remittances have been receipted and properly brought to account.

Incurring and Certifying of Expenditure

The controls exercised by the Health Service over payments of moneys were not adequate and did not comply with legislative requirements. These included incurring and certifying officers not performing all the duties required by the Treasurer's Instructions, and instances of officers incurring payments outside their authority.

Qualified Audit Opinion

In my opinion,

(i) except for the qualifications, the controls exercised by The Minister for Health in his capacity as the Deemed Board of Metropolitan Public Hospitals 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 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, 2003 and its financial performance and its cash flows for the year ended on that date.

Scope

The Director General, Department of Health's Role

The Director General, Department of Health is responsible for keeping proper accounts and maintaining adequate systems of internal control, preparing the financial statements, and complying with the Financial Administration and Audit Act 1985 (the Act) and other relevant written law.

The financial statements consist of the Statement of Financial Performance, Statement of Financial Position, Statement of Cash Flows and the Notes to the Financial Statements.

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

The Minister for Health in his capacity as the Deemed Board of Metropolitan Public Hospitals
Financial statements for the year ended June 30, 2003

Summary of my Role

As required by the Act, I have independently audited the accounts and financial statements to express an opinion on the controls and financial statements. This was done by looking at a sample of the evidence.

An audit does not guarantee that every amount and disclosure in the financial statements is error free. The term "reasonable assurance" recognises that an audit does not examine all evidence and every transaction. However, my audit procedures should identify errors or omissions significant enough to adversely affect the decisions of users of the financial statements.

D D R PEARSON
AUDITOR GENERAL
November 19, 2003

Statement of Financial Performance

For the year ended 30 June 2003

	Note	2003 $000	2002 $000
COST OF SERVICES			
Expenses from Ordinary Activities			
Employee expenses	2	1,111,635	1,011,811
Fees for visiting medical practitioners		31,601	28,177
Patient support costs	3	290,432	261,075
Borrowing costs expense		12,158	13,014
Depreciation expense	4	45,299	62,460
Capital user charge	6	44,751	42,456
Other expenses from ordinary activities	7	170,467	179,461
Total cost of services		**1,706,343**	**1,598,454**
Revenues from Ordinary Activities			
Revenue from operating activities			
Patient charges	8	41,786	40,324
Commonwealth grants and contributions	9	3,283	2,508
Grants and subsidies from non-government sources		6,465	6,196
Other revenues from ordinary activities	10	32,973	30,384
Revenue from non-operating activities			
Interest revenue		7,105	4,100
Proceeds from disposal of non-current assets	5	581	711
Other revenues from ordinary activities	10	16,078	13,201
Total revenues from ordinary activities		**108,271**	**97,424**
NET COST OF SERVICES		**1,598,072**	**1,501,030**
REVENUES FROM STATE GOVERNMENT			
Output appropriations	11	1,597,729	1,478,684
Liabilities assumed by the Treasurer	12	2,387	1,167
Resources received free of charge	13	428	880
Total revenues from State Government		**1,600,544**	**1,480,731**
CHANGE IN NET ASSETS		**2,472**	**(20,299)**
Net increase / (decrease) in asset revaluation reserve	25	5,767	-
Net initial adjustments on adoption of AASB 1028 "Employee Benefits"	25	(1,552)	-
Total revenues, expenses and valuation adjustments recognised directly in equity		**4,215**	**-**
Total changes in equity other than those resulting from transactions with WA State Government as owners		**6,687**	**(20,299)**

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

Statement of Financial Position

As at year 30 June 2003

	Note	2003 $000	2002 $000
Current Assets			
Cash assets	14	53,750	47,485
Restricted cash assets	15	40,630	37,695
Restricted other financial assets	15a	3,600	4,419
Receivables	16	30,105	33,382
Amounts receivable for outputs	17	51,970	46,620
Inventories	18	12,589	11,911
Other current assets	19	3,377	2,456
Total Current Assets		**196,021**	**183,968**
Non-Current Assets			
Amounts receivable for outputs	17	7,993	-
Property, plant and equipment	20	986,531	970,838
Total Non-Current Assets		**994,524**	**970,838**
Total Assets		**1,190,545**	**1,154,806**
Current Liabilities			
Payables	21	57,292	38,154
Interest-bearing liabilities	22	6,913	6,688
Provisions	23	181,167	167,608
Other liabilities	24	29,753	39,107
Total Current Liabilities		**275,125**	**251,557**
Non-Current Liabilities			
Interest-bearing liabilities	22	173,693	180,604
Provisions	23	189,288	186,184
Total Non-Current Liabilities		**362,981**	**366,788**
Total Liabilities		**638,106**	**618,345**
NET ASSETS		**552,439**	**536,461**
Equity	25		
Contributed equity		647,085	637,794
Reserves		5,767	-
Accumulated surplus / (deficiency)		(100,413)	(101,333)
TOTAL EQUITY		**552,439**	**536,461**

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

	Note	2003 $000 Inflows (Outflows)	2002 $000 Inflows (Outflows)
Cash flows from State Government	26		
Output appropriations		1,484,282	1,378,648
Capital contributions		7,854	46,863
Holding account drawdowns		41,027	-
Net cash provided by State Government		**1,533,163**	**1,425,511**
Utilised as follows:			
Cash flows from operating activities			
Payments			
Employee costs		(1,001,752)	(894,768)
Supplies and services		(580,330)	(546,636)
Borrowing costs		(3,919)	(4,131)
Receipts			
Patient charges and fees		42,209	38,211
Commonwealth grants and contributions		3,284	2,509
Grants and subsidies from non-government sources		6,468	6,195
Interest received		7,044	4,295
Other receipts		46,600	41,111
Net cash provided by / (used in) operating activities	27(b)	**(1,480,396)**	**(1,353,214)**
Cash flows from investing activities			
Purchase of non-current physical assets		(42,863)	(40,333)
Proceeds from sale of non-current physical assets		581	711
Receipts from term deposits		4,419	11,465
Purchase of term deposits		(3,600)	(4,419)
Net cash provided by / (used in) investing activities		**(41,463)**	**(32,576)**
Cash flows from financing activities			
Repayments of borrowings		(2,104)	(2,061)
Net cash provided by / (used in) financing activities		**(2,104)**	**(2,061)**
Net increase / (decrease) in cash held		9,200	37,660
Cash assets at the beginning of the reporting period		85,180	47,520
Cash assets at the end of the reporting period	27(a)	**94,380**	**85,180**

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.

General Statement

The financial statements constitute a general purpose financial report which has been prepared in accordance with Accounting Standards, Statements of Accounting Concepts and other authoritative pronouncements of the 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 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.

Basis of Accounting

The 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 fair value.

(a) 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.

(b) 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.

(c) Grants and Other Contributions Revenue

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

(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) 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 periodically. Useful lives for each class of depreciable assets are:

Buildings	50 years
Leasehold improvements	Term of the lease
Computer equipment	5 to 15 years
Furniture and fittings	5 to 50 years
Motor vehicles	4 to 10 years
Other plant and equipment	4 to 50 years

Works of art are classified as heritage assets. They are anticipated to have very long and indeterminate useful lives. Their service potential has not, in any material sense, been consumed during the reporting period. As such, no amount for depreciation has been recognised in respect of them.

(f) Valuation of land and buildings

Except for the Selby Lodge building, valuation of land and buildings are carried at cost. It is anticipated that revaluations will be completed within the next two years.

The Selby Lodge, being a specialised non-market asset, was revalued in June 2003 by the Department of Health using a depreciated Replacement Cost Valuation method. In accordance with AASB 1041 (5.8), the gross amount and accumulated depreciation for Selby Lodge was restated, with the net increment taken to the Asset Revaluation Reserve.

(g) Leases

The Health Service's rights and obligations under finance leases, which are leases that effectively transfer to the Health Service substantially all of the risks and benefits incident to ownership of the leased item, are initially recognised as assets and liabilities equal in amount to the present value of the minimum lease payments. The assets are disclosed as building, plant and equipment under lease and are depreciated to the Statement of Financial Performance over the period during which the Health Service is expected to benefit from use of the leased assets. Minimum lease payments are allocated between interest expense and reduction of the lease liability, according to the interest rate implicit in the lease.

Finance lease liabilities are allocated between current and non-current components. The principal component of these lease payments due on or before the end of the succeeding year is disclosed as a current liability, and the remainder of the lease liability is disclosed as a non-current liability.

The Health Service has entered into a number of operating lease arrangements for the rent of buildings and office equipment where the lessors effectively retain all of the risks and benefits incident to ownership of the items held under the operating lease. Equal instalments of the lease payments are charged to the Statement of Financial performance over the lease term as this is representative of the pattern of benefits to be derived for the leased property.

(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) Inventories

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

(j) 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.

(k) Revenue recognition

Revenue from the sale of goods and 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 delivery of the service to the customer

(l) Investments

Investments are brought to account at the lower of cost and recoverable amount.

Interest revenues are recognised as they are accrued.

(m) 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.

(n) Interest -bearing liabilities

Bank loans and other loans are recorded at an amount equal to the net proceeds received. Borrowing costs expense is recognised on an accrual basis.

(o) Employee benefits

Annual leave

This benefit is recognised at the reporting date in respect to employees' services up to that date and is measured at the nominal amounts expected to be paid when the liabilities are settled.

Long service leave

The liability for long service leave expected to be settled within 12 months of the reporting date is recognised in the provisions for employee benefits, and is measured at the nominal amounts expected to be paid when the liability is settled. The liability for long service leave expected to be settled more than 12 months from the reporting date is recognised in the provisions for employee benefits and is measured at 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 relevant on costs, experience of employee departures and periods of service. Expected future payments are discounted using market yields at the reporting date on national government bonds with terms to maturity and currency that match, as closely as possible, the estimated future cash outflows.

The methods of measurement of the liabilities are consistent with the requirements of Accounting Standard AASB 1028 "Employee Benefits".

Superannuation

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

The Pension Scheme and the pre-transfer benefit for employees who transferred to the Gold State Superannuation Scheme are unfunded and the liability for future payments under the Pension Scheme is provided for at reporting date.

The liabilities for superannuation charges under the Gold State Superannuation Scheme and West State Superannuation Scheme are extinguished by payment of employer contributions to the GESB.

The note disclosure required by paragraph 6.10 of AASB 1028 (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.

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.

Employee benefit on-costs

Employee benefit on-costs are recognised and included in employee benefit liabilities and costs when the employee benefits to which they relate are recognised as liabilities and expenses.

(p) 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.

(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) Foreign Currency Translation

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

(s) Comparative Figures

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

(t) Rounding

Amounts in the financial statements have been rounded to the nearest thousand dollars, or in certain cases, to the nearest dollar.

(u) Special Purpose accounts and Trust accounts

Special Purpose Accounts are used by the Health Service to account for contributions to which a condition of use has been attached, such as donations, gifts or grants for particular purposes. The Health Service has control of the use of these funds, and can deploy them to meet its objectives, although it has an obligation to only use these funds for the particular purpose for which they were contributed. The use of Special Purpose Accounts enables the contributions to be segregated from the operating funds of the Health Service and to ensure they are used in a manner that is consistent with the imposed conditions.

Trust Accounts are used by the Health Service to account for funds that they may be holding on behalf of another party, such as patients' cash. The Health Service does not have control of the use of these funds, and cannot deploy them to meet its objectives. Trust Accounts do not form part of the resources available to the Health Service, and are not reported as assets in the financial statements. However, details of Trust Accounts are reported as a note to the the financial statements (Note 38).

Note 2 Employee expenses

	2003 $000	2002 $000
Wages and salaries	906,579	810,649
Long service leave	20,112	24,882
Annual leave	83,733	85,580
Other related expenses	101,211	90,700
Total	1,111,635	1,011,811

Employee expenses include superannuation and other employment oncosts associated with the recognition of annual and long-service leave liability. The related on-costs liability is included in employee benefit liabilities at Note 23.

Note 3 Patient support costs

	2003 $000	2002 $000
Medical supplies and services	206,127	179,183
Purchased external services		
Medical and Surgical	17,499	16,001
Catering	12,425	11,451
Cleaning	2,907	5,288
Laundry and Linen	12,013	11,600
Other	855	759
Domestic charges	12,340	11,050
Fuel, light and power	18,016	18,092
Food supplies	8,250	7,651
Total	**290,432**	**261,075**

Note 4 Depreciation expense

	2003 $000	2002 $000
Buildings	21,399	41,465
Plant and equipment	2,099	2,178
Medical equipment	12,588	11,463
Office equipment, furniture and fittings	1,788	1,429
Computing equipment / software	6,679	5,367
Motor vehicles	709	532
Leased buildings	15	-
Leased plant and equipment	22	26
Total	**45,299**	**62,460**

Note 5 Net gain / (loss) on disposal of non-current assets

(a) Loss on disposal of non-current assets:

	2003 $000	2002 $000
Land & Buildings	-	(66)
Plant and equipment	(140)	(370)
Medical equipment	(1,606)	(2,906)
Computing equipment / software	(334)	(261)
Office equipment, furniture and fittings	(229)	(294)
Motor vehicles	(253)	(146)
	(2,562)	**(4,043)**

	2003 $000	2002 $000
(b) Gain on disposal of non-current assets:		
Plant and equipment	1	5
Medical equipment	12	24
Computing equipment / software	2	8
Office equipment, furniture and fittings	10	5
Motor vehicles	80	139
	105	**181**
Net gain / (loss) on disposal of non-current assets	**(2,457)**	**(3,862)**

(c) Proceeds from disposal of non-current assets

Proceeds were received for the sale of non-current assets during the reporting period as follows:

	2003	2002
Received as cash by the Health Service	581	711
Gross proceeds from disposal of non-current assets	**581**	**711**

Note 6 Capital user charge

	2003	2002
	44,751	**42,456**

A capital user charge rate of 8% has been set by the Government for 2002/2003 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

	2003	2002
Administrative expenses	6,927	6,250
Repairs and maintenance	25,603	25,287
Workers compensation insurance	10,197	16,570
Consumable equipment expenditure	5,660	7,006
Carrying amount of non-current assets disposed of	2,869	4,573
Purchased external services	43,991	47,396
Insurance	13,937	10,228
Printing and stationery	8,023	7,540
Other support costs	30,316	29,157
Additions and alterations (non-capital)	4,405	5,152
Communications	8,720	8,530
Lease expense	8,646	8,293
Bank charges	150	147
Audit fees - external	391	314
Audit fees - internal	15	378
Bad and doubtful debts	565	1,538
Inventory write offs	52	1,102
Total	**170,467**	**179,461**

	2003 $000	2002 $000
Note 8 Patient charges		
Inpatients Charges	34,560	33,396
Outpatient Charges	7,226	6,928
Total	**41,786**	**40,324**

Note 9 Commonwealth grants and contributions

	2003 $000	2002 $000
Grant for assisting in training of medical students	109	106
Grant for radiation oncology	1,306	779
Grant for Magnetic Resonance Imaging	1,511	1,412
Other grants	357	211
Total	**3,283**	**2,508**

Note 10 Other revenues from ordinary activities

	2003 $000	2002 $000
Revenue from operating activities		
Recoveries	12,056	8,206
Use of medical facilities	8,043	8,158
Other	12,874	14,020
Total	**32,973**	**30,384**
Revenue from non-operating activities		
Rent from Properties	280	339
Public Contributions / Donations	6,661	4,070
Income from sundry activities	7,530	7,240
Parking	1,607	1,548
Other	-	4
Total	**16,078**	**13,201**

Note 11 Output appropriations

	2003 $000	2002 $000
Appropriation revenue received during the year:		
- Output appropriations	**1,597,729**	**1,478,684**

	2003 $000	2002 $000

Note 12 Liabilities assumed by the Treasurer

- Superannuation	**2,387**	**1,167**

The unfunded employer's liability in respect of the pre-transfer benefit for employees who transferred from the Pension Scheme to the Gold State Superannuation Scheme is assumed by the Treasurer. The Health Service recognises revenues equivalent to the amount of the liability assumed and an expense relating to the change in this unfunded liability.

Note 13 Resources received free of charge

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

	2003 $000	2002 $000
- Office of the Auditor General - audit services	391	314
- Other	37	566
Total	**428**	**880**

Note 14 Cash assets (unrestricted)

	2003 $000	2002 $000
Cash on hand	104	83
Cash at bank	28,078	27,482
Term deposits	20,376	18,029
Bank bills	5,192	1,891
Total	**53,750**	**47,485**
Comprising:		
Operating cash assets	45,223	30,559
Special purpose cash assets - Not restricted	8,527	16,926
Total	**53,750**	**47,485**

Note 15 Restricted cash assets

Restricted assets are assets, the uses of which are restricted, wholly or partially, by regulations or other externally imposed requirements.

Restricted cash assets are comprised of bills, term deposits and other investments with financial institutions

	2003 $000	2002 $000
Term deposits and bank bills	40,120	35,637
Cash at bank	510	2,058
Total	**40,630**	**37,695**

	2003 $000	2002 $000

Note 15a Restricted other financial assets

Other financial assets are comprised of term deposits greater than 90 days.

	2003 $000	2002 $000
Term deposits and bank bills	3,600	4,419
Total	**3,600**	**4,419**

Note 16 Receivables

	2003 $000	2002 $000
Debtors	14,053	14,170
GST receivable	4,345	4,574
Patient fee debtors	9,652	9,823
Accrued Income	5,190	7,828
	33,240	36,395
Less: Provision for doubtful debts	3,135	3,013
Total	**30,105**	**33,382**

Note 17 Amounts receivable for outputs

	2003 $000	2002 $000
Current	51,970	46,620
Non-current	7,993	-
	59,963	**46,620**

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

	2003 $000	2002 $000
Inventories valued at cost:		
Supply stores	4,116	3,325
Pharmaceutical stores	7,646	7,750
Engineering stores	827	778
Goods held for resale	-	58
Total	**12,589**	**11,911**

Note 19 Other current assets

	2003 $000	2002 $000
Prepayments	2,974	2,352
Other	403	104
Total	**3,377**	**2,456**

Note 20 Property, plant and equipment

	2003 $000	2002 $000
Land - at cost	130,110	134,260
Buildings - at cost	825,414	839,398
Less: accumulated depreciation	(135,779)	(142,109)
Net carrying amount	689,635	697,289
Buildings - at fair value	7,950	-
Less: accumulated depreciation	(3,493)	-
Net carrying amount	4,457	-
Plant and equipment - at cost	26,758	25,223
Less: accumulated depreciation	(11,464)	(9,505)
Net carrying amount	15,294	15,718
Medical equipment - at cost	145,339	128,030
Less: accumulated depreciation	(60,149)	(49,721)
Net carrying amount	85,190	78,309
Office equipment / furniture and fittings - at cost	23,773	20,361
Less: accumulated depreciation	(7,361)	(5,722)
Net carrying amount	16,412	14,639
Computing equipment / software - at cost	46,854	41,136
Less: accumulated depreciation	(26,562)	(21,519)
Net carrying amount	20,292	19,617
Motor vehicles - at cost	3,367	3,053
Less: accumulated depreciation	(1,496)	(1,002)
Net carrying amount	1,871	2,051
Leased buildings - at capitalised cost	209	-
Less: accumulated depreciation	(144)	-
Net carrying amount	65	-
Leased plant and equipment - at capitalised cost	234	234
Less: accumulated depreciation	(100)	(78)
Net carrying amount	134	156
Works in progress - buildings	12,059	6,956
Works in progress - medical equipment & other	9,159	-
Artworks - at cost	1,853	1,843
Total property, plant and equipment	1,233,079	1,200,494
Less: accumulated depreciation	(246,548)	(229,656)
Total property, plant and equipment	**986,531**	**970,838**

	2003 $000	2002 $000
Payments made for non-current assets		
Payments were made for purchases of non-current assets during the period as follows:		
- Paid as cash by the Health Service from output appropriations	12,962	18,261
- Paid as cash by the Health Service from capital appropriations	29,419	22,072
- Paid as cash by the Health Service from other funding sources	482	-
	42,863	40,333
- Paid by the Department of Health	4,035	2,127
Gross payments for non-current assets	**46,898**	**42,460**

Reconciliations

Reconciliations of the carrying amounts of property, plant and equipment at the beginning and end of the current reporting period are set out below.

	2003 $000	2002 $000
Land		
Beginning carrying amount	134,260	134,308
Additions	-	-
Disposals (i)	(7,300)	(48)
Revaluations increments / (decrements)	3,150	-
Ending carrying amount	**130,110**	**134,260**

(i) Represents non reciprocal transfers of: (a) Perth Dental Hospital land to the Department of Health ($5.5M) and (b) Hillview Hospital land to the Department of Housing and Works ($1.8M).

	2003 $000	2002 $000
Buildings		
Beginning carrying amount	697,289	690,595
Additions	16,817	48,227
Disposals (ii)	(1,234)	(69)
Revaluations increments / (decrements)	2,617	-
Depreciation	(21,397)	(41,464)
Ending carrying amount	**694,092**	**697,289**

(ii) Represents non reciprocal transfers of: (a) Dental Health Therapy Centres to the Department of Education and Training ($0.166M) and (b) Hillview Hospital buildings to the Department of Housing and Works ($1.068M).

	2003 $000	2002 $000
Plant and equipment		
Beginning carrying amount	15,718	14,945
Additions	2,097	3,407
Disposals	(386)	(455)
Depreciation	(2,135)	(2,178)
Ending carrying amount	**15,294**	**15,718**
Medical equipment		
Beginning carrying amount	78,309	75,651
Additions	21,128	17,752
Disposals	(1,661)	(3,614)
Write-off of assets	(3)	-
Depreciation	(12,583)	(11,480)
Ending carrying amount	**85,190**	**78,309**

	2003 $000	2002 $000
Office equipment / furniture and fittings		
Beginning carrying amount	14,639	13,313
Additions	3,818	3,270
Disposals	(179)	(517)
Write-off of assets	(70)	-
Depreciation	(1,796)	(1,427)
Ending carrying amount	**16,412**	**14,639**
Computing equipment / software		
Beginning carrying amount	19,617	15,523
Additions	7,713	10,068
Disposals	(386)	(623)
Write-off of assets	(12)	-
Depreciation	(6,640)	(5,351)
Ending carrying amount	**20,292**	**19,617**
Motor vehicles		
Beginning carrying amount	2,051	2,016
Additions	1,051	1,347
Disposals	(520)	(781)
Depreciation	(711)	(531)
Ending carrying amount	**1,871**	**2,051**
Leased buildings		
Beginning carrying amount	-	-
Additions	80	-
Disposals	-	-
Depreciation	(15)	-
Ending carrying amount	**65**	**-**
Leased plant and equipment		
Beginning carrying amount	156	331
Additions	-	-
Disposals	-	(149)
Depreciation	(22)	(26)
Ending carrying amount	**134**	**156**
Works in progress - buildings		
Beginning carrying amount	6,956	44,839
Additions	9,720	7,373
Transfers to other asset classes	(4,617)	(45,256)
Ending carrying amount	**12,059**	**6,956**
Works in progress - medical equipment		
Beginning carrying amount	-	-
Additions	9,159	-
Transfers to other asset classes	-	-
Ending carrying amount	**9,159**	**-**
Artworks		
Beginning carrying amount	1,843	1,855
Additions	12	20
Disposals	(2)	(32)
Ending carrying amount	**1,853**	**1,843**

	2003 $000	2002 $000

Note 21 Payables

	2003 $000	2002 $000
Trade creditors	24,769	21,065
GST payable	11	2,834
Accrued expenses	32,512	14,255
Total	**57,292**	**38,154**

Note 22 Interest-bearing liabilities

	2003 $000	2002 $000
Current		
Finance lease liabilities	46	43
Borrowings	6,867	6,645
	6,913	**6,688**
Non-current		
Finance lease liabilities	30	76
Borrowings	173,663	180,528
	173,693	**180,604**
Total	**180,606**	**187,292**

(a) Finance lease liabilities

Lease liabilities are effectively secured as the rights to the leased assets revert to the lessor in the event of default.

The carrying amounts of non-current assets pledged as security are:

	2003 $000	2002 $000
Leased plant and equipment	134	147
Total	**134**	**147**

(b) Borrowings

(i) Western Australian Treasury Corporation (WATC).

	2003 $000	2002 $000
Beginning balance	121,561	125,788
Less loan repayments this year	4,321	4,227
Ending balance	**117,240**	**121,561**
Current	4,429	4,323
Non-current	112,811	117,238
Total	**117,240**	**121,561**

The debt is held in a portfolio of loans managed by the Department of Health. Repayments of the debt are made by the Department of Health on behalf of the Health Service.

	2003 $000	2002 $000
(ii) Department of Treasury and Finance Loans		
Beginning balance	65,612	67,832
Less loan repayments this year	2,324	2,220
Ending balance	**63,288**	**65,612**
Current	2,437	2,324
Non-current	60,851	63,288
Total	**63,288**	**65,612**

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

	2003 $000	2002 $000
(iii) Other Borrowings		
Beginning balance	-	517
Less loan repayments this year	-	517
Ending balance	**-**	**-**

Note 23 Provisions

	2003 $000	2002 $000
Current Liabilities		
Annual leave (i)	111,863	102,867
Long service leave (i)	56,296	51,135
Deferred salary scheme	123	1,897
Superannuation (ii)	12,885	11,709
	181,167	**167,608**
Non-Current Liabilities		
Long service leave (i)	39,143	37,755
Deferred salary scheme	-	1,427
Superannuation (ii)	150,145	147,002
	189,288	**186,184**
Total	**370,455**	**353,793**

(i) The settlement of annual and long service leave liabilities gives rise to the payment of employment on-costs including superannuation. The liability for such oncosts is included here. The associated expense is included under Employee expenses at Note 2.

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

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

	2003 $000	2002 $000

Note 24 Other liabilities

	2003 $000	2002 $000
Current		
Income received in advance	50	-
Accrued salaries	28,029	33,739
Fringe Benefits Tax	131	2,048
Refundable deposits	183	161
Other	1,360	3,159
Total	**29,753**	**39,107**

Note 25 Equity

	2003 $000	2002 $000
Contributed equity		
Opening balance	637,794	582,976
Capital contributions (i)	17,826	54,818
Distribution to owners (ii)	(8,535)	-
Closing balance	**647,085**	**637,794**

(i) Capital Contributions have been designated as contributions by owners and are credited directly to equity in the Statement of Financial Position.
(ii) Consists of non reciprocal transfers of: (a) Perth Dental Hospital property to the Department of Health ($5.5M), (b) Dental Health Therapy Centres to the Department of Education and Training ($0.166M) and (c) Hillview Hospital property to the Department of Housing and Works ($2.869M).

	2003 $000	2002 $000
Accumulated surplus / (deficiency)		
Opening balance	(101,333)	(81,034)
Change in net assets	2,472	(20,299)
Net initial adjustments on adoption of AASB 1028 "Employee Benefits"	(1,552)	-
Closing balance	**(100,413)**	**(101,333)**
Asset Revaluation Reserve		
Opening balance	-	-
Net revaluation increments / (decrements):		
Land	3,150	-
Buildings	2,617	-
Closing balance	**5,767**	**-**

Note 26 Notional cash flows

	2003 $000	2002 $000
Output appropriations as per Statement of Financial Performance	1,597,729	1,478,684
Capital appropriations credited directly to Contributed Equity (Refer Note 25).	17,826	54,818
Holding account drawdowns credited to Amounts Receivable for Outputs (Refer Note 17).	47,442	-
	1,662,997	**1,533,502**
Less notional cash flows:		
Items paid directly by the Department of Health for the Health Service and are therefore not included in the Statement of Cash Flows.		
- Interest paid to WA Treasury Corporation	(3,214)	(3,269)
- Repayment of interest-bearing liabilities to WA Treasury Corporation	(2,214)	(2,164)
- Interest paid to Department of Treasury and Finance	(4,921)	(5,743)
- Repayment of interest-bearing liabilities to Department of Treasury and Finance	(2,324)	(2,220)
- Capital user charge	(44,751)	(42,456)
- Accrual appropriations	(60,485)	(46,621)
- Non-cash capital items	(12,262)	(5,488)
- Other non cash adjustments to output appropriations	337	(30)
Total notional cash flow	**(129,834)**	**(107,991)**
Cash flows from State Government as per Statement of Cash Flows	**1,533,163**	**1,425,511**

Note 27 Notes to the statement of cash flows

(a) Reconciliation of cash

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

	2003 $000	2002 $000
Cash assets (unrestricted) (Refer note 14)	53,750	47,485
Restricted cash assets (Refer note 15)	40,630	37,695
	94,380	**85,180**

	2003 $000	2002 $000
(b) Reconciliation of net cost of services to net cash flows provided by / (used in) operating activities		
NET COST OF SERVICES	**(1,598,072)**	**(1,501,030)**
(Increase) / decrease in assets:		
Receivables	3,155	(1,247)
Inventories	(678)	(687)
Prepayments	(622)	536
Other current assets	(299)	42
Increase / (Decrease) in liabilities:		
Provision for doubtful debts	122	628
Payables	19,138	(8,412)
Provisions	16,662	25,015
Other liabilities	(9,355)	15,915
Non-cash items:		
Capital User Charge paid by Department of Health	44,751	42,456
Loss on disposal of fixed assets	2,562	4,043
Profit on disposal of fixed assets	(105)	(180)
Depreciation	45,299	62,458
Donations of non-current assets	(4,296)	(2,379)
Resources received free of charge	428	811
Interest on loans paid by Department of Health	8,135	8,869
Other expenses paid by the Department of Health	184	2,392
Liabilities assumed by Treasurer	2,387	1,166
Adjustments to non-current assets	(3,340)	969
Other	(6,452)	(4,579)
Net cash provided by / (used in) operating activities	**(1,480,396)**	**(1,353,214)**

Note 28 Revenue, public and other public property written off or presented as gifts

	2003 $000	2002 $000
i) Revenue written off	694	1,027
ii) Public and other property written off	610	447

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

	2003 $000	2002 $000
iii) Gifts of public property provided by the Health Service	-	-
Total	**1,304**	**1,474**

Note 29 Losses of public monies and other property

	2003 $000	2002 $000
Losses of public monies and other property through theft or default	143	133
Less recovery of losses	(95)	(93)
Net losses	**48**	**40**

	2003 $000	2002 $000

Note 30 Resources provided free of charge

During the year the following resources were provided free of charge to other agencies for functions outside the normal operations of the agency.

	2003 $000	2002 $000
Ministry of Justice - dental treatment to inmates	235	216
Disabilty Services Commission - dental treatment to DSC clients	220	172
Graylands Health Service - dental treatment to GHS clients	-	65
Dept of Education - transfer buildings closed DTC's	166	48
Dept of Health - transfer of Perth Dental Hospital land	2,350	-
Forensic Activity - Anataomical Pathology	290	-
Disabilty Services Commission - CAEP infrastructure costs	195	-
Total	**3,456**	**285**

Note 31 Commitments for expenditure

(a) Capital expenditure commitments

Capital expenditure commitments, being contracted capital expenditure additional to the amounts reported in the financial statements are payable as follows:

	2003 $000	2002 $000
Within one year	37,986	28,021
Later than one year, and not later than five years	3,193	8,823
Total	**41,179**	**36,844**

This is made up of commitments for construction work at:

	2003 $000
Osborne Park Hospital - Replacement Theatres, Day Procedure Units	7,709
King Edward Memorial Hospital major refurbishment	6,633
Princess Margaret Hospital Wards 8a/9a & ED/front entrance	7,471
Sir Charles Gairdner Hospital Emergency Dept	5,976
Sir Charles Gairdner Hospital PET project	2,202
East Metro - BHS Air Conditioning upgrade "A" block	1,500
East Metro - Ward refurbishments and upgrades - all sites	1,852
South Metropolitan Dental Clinic	1,458
Joondalup Dental Clinic	1,310
Other	5,068
Total	**41,179**

(b) Operating lease commitments

Commitments in relation to leases contracted for at the reporting date but not recognised as liabilities, are payable as follows:

	2003 $000	2002 $000
Within one year	7,238	6,271
Later than one year, and not later than five years	11,921	12,687
Later than five years	5,233	5,825
Total	**24,392**	**24,783**

	2003 $000	2002 $000
(c) Finance lease commitments		
Commitments in relation to finance leases are payable as follows:		
Within one year	49	49
Later than one year, and not later than five years	31	80
Minimum finance lease payments	80	129
Less future finance charges	(4)	(10)
Provided for as finance lease liabilities (Refer note 22)	**76**	**119**
Total		

Finance lease commitments relate to the hire purchase of equipment at Sir Charles Gairdner Hospital.

(d) Other expenditure commitments

Committed Medical Equipment and deferred maintenance at Swan and equipment and repairs for dental clinics on order at Perth Dental are payable as follows:

	2003 $000	2002 $000
Within one year	40	311
Total	**40**	**311**

(e) Guarantees and undertakings

There are no guarantees and undertakings that have been provided other than those recognised as liabilities in the Statement of Financial Position.

Note 32 Contingent liabilities

In addition to the liabilities incorporated in the financial statements, the Health service has the following contingent liabilities:

	2003 $000	2002 $000
(a) Litigation in progress (Recoverable from RiskCover)		
Pending potential litigation that may affect the financial position	**24,333**	**17,307**
Number of claims	**275**	**243**
(b) Litigation in progress (Not recoverable from RiskCover)		
Pending potential litigation that may affect the financial position	**29,590**	**20,381**
Number of claims	**58**	**58**

Note 33 Events occurring after reporting date

There were no events that occurred after reporting date that have a material effect on these financial statements.

Note 34 Remuneration of Members of the Accountable Authority and Senior Officers

Remuneration of Members of the Accountable Authority

The Metropolitan Health Services Board was dissolved in 2000-2001. The Director General for Health replaced the Board from 1 July 2001. The remuneration for the Director General for Health is paid by the Department of Health.

Remuneration of Senior Officers
Senior Officers defined as those employees who are chief executives.

The number of Senior Officers (other than Senior Officers reported as members of the Metropolitan Health Service Board, now dissolved), whose total of fees, salaries, superannuation and other benefits received or due and receivable for the reporting period, falls within the following bands:

	2003	2002
$20,001 - $30,000	1	-
$30,001 - $40,000	1	-
$60,001 - $70,000	2	-
$70,001 - $80,000	1	-
$80,001 - $90,000	2	-
$100,001 - $110,000	1	1
$110,001 - $120,000	3	1
$120,001 - $130,000	1	-
$130,001 - $140,000	-	1
$140,001 - $150,000	-	4
$150,001 - $160,000	1	1
$160,001 - $170,000	2	-
$230,001 - $240,000	1	2
$260,001 - $270,000	1	-
$280,001 - $290,000	1	1
	18	11
	$000	**$000**
The total remuneration of senior officers is ($000):	**2,276**	**1,826**

The superannuation included here represents the superannuation expense incurred by the Health Service in respect of Senior Officers other than senior officers reported as members of the Accountable Authority.

	2003	2002
Numbers of Senior Officers presently employed who are members of the Pension Scheme:	**1**	**1**

Note 35 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.

The Health Service does not provide financial assistance to any related body or class of related bodies for which it does not receive remuneration at the cost of providing those services.

Note 36 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 does not provide financial assistance to any affiliated body or class of affiliated bodies for which it does not receive remuneration at the cost of providing those services.

Note 37 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	Fixed Interest Rate Maturities			Non-interest bearing	
			Less than 1 year	1 to 5 years	Over 5 years		Total
As at 30 June 2003	%	$000	$000	$000	$000	$000	$000
Financial assets							
Cash assets	4.73%	11,583	38,503	-	-	3,664	53,750
Restricted cash assets	4.75%	290	39,865	-	-	475	40,630
Restricted other financial assets	4.83%	-	3,600	-	-	-	3,600
Receivables		-	-	-	-	30,105	30,105
		11,873	81,968	-	-	34,244	128,085
Financial liabilities							
Payables		-	-	-	-	57,292	57,292
Accrued salaries		-	-	-	-	28,029	28,029
Borrowings from WATC	5.69%	-	4,429	20,434	92,377	-	117,240
Borrowings from Treasury	7.77%	-	2,437	11,638	49,213	-	63,288
Finance lease liabilities	6.70%	-	46	30	-	-	76
		-	6,912	32,102	141,590	85,321	265,925
Net Financial Assets / (Liabilities)		11,873	75,056	(32,102)	(141,590)	(51,077)	(137,840)
As at 30 June 2002							
Financial assets		20,887	71,022	-	-	31,070	122,979
Financial liabilities		-	18,115	20,404	160,196	60,470	259,185
Net Financial Assets / (Liabilities)		20,887	52,907	(20,404)	(160,196)	(29,400)	(136,206)

(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 these amounts. The carrying amounts of financial assets recorded in the financial statements, net of any provisions or losses, represent the Health Service's maximum exposure to credit risk.

In respect of financial assets carrying amounts represent the Board'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.

	2003 $000	2002 $000

Note 38 Assets held in a trustee capacity or administered by the Health Service

Assets Held in a Trustee Capacity

These assets are not controlled by the Health service and are therefore not recognised in the financial statements.

The Health service administers trust accounts for the purposes of holding patients' private monies and other external parties. A summary of the account transactions are as follows:-

	2003 $000	2002 $000
Beginning balance	**406**	**414**
Add receipts		
- Deposits	3,671	4,023
- Interest	10	-
	4,087	**4,437**
Less payments		
- Withdrawals	3,171	4,031
Ending balance	**916**	**406**

The Health service administers trust accounts, such as for salaried medical practitioners under the rights to private practice scheme. A summary of the transactions in these accounts is as follows:

	2003 $000	2002 $000
Beginning balance	**388**	**547**
Further allocation to trust accounts for salaried medical practitioners under the rights to private practice scheme.		
Add receipts		
- Collections	5,761	4,995
- Fees	62	30
- Interest	13	14
	6,224	**5,586**
Less payments		
- Payments to medical practitioners	982	903
- Payments to hospital - fees/charges/trust funds	4,751	4,226
- Interest / charges	148	69
Ending balance	**343**	**388**

Note 39 Explanatory Statement

(A) Significant variations between actual revenues and expenditures for the financial year and revenues and expenditures for the immediately preceding financial year.

Reasons for significant variations between actual results with the corresponding items of the preceding reporting period are detailed below. Significant variations are those greater than 7% or that are 4% or more of the current year's Total Cost of Services.

	Note	2003 $000	2002 $000	Variance $000
Statement of Financial Performance - Expenses				
Employee expenses	(a)	1,111,635	1,011,811	99,824
Fees for visiting medical practitioners	(b)	31,601	28,177	3,424
Patient support costs	(c)	290,432	261,075	29,357
Depreciation expense	(d)	45,299	62,460	(17,161)
Capital user charge	(e)	44,751	42,456	2,295
Other expenses from ordinary activities	(f)	170,467	179,461	(8,994)
Statement of Financial Performance - Revenues				
Patient charges	(g)	41,786	40,324	1,462
Commonwealth grants and contributions	(h)	3,283	2,508	775
Other revenues from ordinary activities (operating)	(i)	32,973	30,384	2,589
Interest revenue	(j)	7,105	4,100	3,005
Other revenues from ordinary activities (non-operating)	(k)	16,078	13,201	2,877
Output appropriations	(l)	1,597,729	1,478,684	119,045

(a) Employee expenses

The increase primarily due to increased costs of awards. The costs of awards increased by an average of 4% across all categories causing wages to increase. The award increase had a flow on effect resulting in increased costs for employee entitlements There was also a general increase in the number of staff as a result of the implementation of new standards for nurse to patient ratio.

(b) Fees for visiting medical practitioners

There was a re-negotiation of the fee arrangement with visiting medical practitioners during the year resulting in an increase in fee charged.

(c) Patient support costs

The increase is primarily due to increase costs of drugs and increase costs of medical, surgical and prosthetic supplies and diagnostic costs. There were also additional costs as a consequence of caring for the victims of the “Bali Bombing”.

(d) Depreciation expense

Depreciation high for 2002 year as a result of accelerated depreciation of buildings for Perth Dental Hospital ($14m) and Anstey House at Sir Charles Gairdiner Hospital ($5.2m) that were due to be demolished.

(e) Capital user charge

This is due to an increase in the net assets of the Health Service.

Note 39 Explanatory Statement (continued)

(f) Other expenses from ordinary activities

There was a reduction in workers compensation ($6.4M) and purchased external services ($3.4m) during year. Better management of material resources resulted in a reduction in inventory write-offs ($1.5m) and consumable equipment expenditure ($1.3m).

(g) Patient charges

There was a one-off compensation claim for the Graylands Hospital for Hospital Ward Patients for whom Insurance Commission had been invoiced at a lower rate than they were entitled to be charged ($.5m).

(h) Commonwealth grants and contributions

There was an increase in the grant Sir Charles Gairdiner received for radiation oncology during the year ($.5m)

(i) Other revenues from ordinary activities (operating)

Increase in revenue from external projects and work completed by InfoHealth and rebates from insurance premiums.

(j) Interest revenue

Increase in interest receipt due to subsidy advance being received monthly instead of weekly. Interest being received from funds now being invested on behalf of non-teaching hospitals and also revenue is being received by investment of capital funds.

(k) Other revenues from ordinary activities (non-operating)

There was an increase in revenue from donations and sundry activities. Fremantle Hospital received a large donation from The University of Western Australia during the year ($1.8m)

(l) Output appropriations

Appropriation increased for the year due to 1) Increased funding for salaries and wages costs of award increases; 2) Annual CPI increase for consumable items; 3) Increase in funding from Commonwealth Government under National Health Development Fund.

Note 39 Explanatory Statement (continued)

(B) Significant variations between estimates and actual results 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 and will always include any reported extraordinary items in the statement of financial performance.

	Note	2003 Actual $000	2003 Estimates $000	Variance $000
Cost of Services				
Employee expenses	(a)	1,111,635	966,716	144,919
Other goods and services	(b)	594,708	611,516	(16,808)
Total expenses from ordinary activities		**1,706,343**	**1,578,232**	**128,111**
Revenues from ordinary activities	(c)	108,271	75,200	33,071
Cost of services		1,598,072	1,503,032	95,040

(a) Employee expenses
Employee expenses were greater than those estimated mainly due to greater than expected increase in wages and salaries rates.

(b) Other goods and services
Variance not material.

(c) Revenues from ordinary activities
Revenue from ordinary activities increased mainly due to those explained in Note 42 (A) (i).

Note 40 Output Information

	Prevention and Promotion		Diagnosis and Treatment		Continuing Care		Total	
	2003	2002	2003	2002	2003	2002	2003	2002
COST OF SERVICES	$000	$000	$000	$000	$000	$000	$000	$000
Expenses from Ordinary Activities								
Employee expenses	33,734	32,684	1,050,836	954,198	27,065	24,929	1,111,635	1,011,811
Fees for visiting medical practitioners	789	703	30,400	27,109	412	365	31,601	28,177
Patient support costs	7,316	6,738	277,369	249,135	5,747	5,202	290,432	261,075
Borrowing costs expense	216	271	11,802	12,596	140	147	12,158	13,014
Depreciation expense	1,195	4,046	43,174	57,491	930	923	45,299	62,460
Capital user charge	1,041	1,223	42,933	40,524	777	709	44,751	42,456
Other expenses from ordinary activities	6,048	6,356	160,645	169,563	3,774	3,542	170,467	179,461
Total cost of services	**50,339**	**52,021**	**1,617,159**	**1,510,616**	**38,845**	**35,817**	**1,706,343**	**1,598,454**
Revenues from Ordinary Activities								
Revenue from operating activities								
Patient charges	1,333	1,355	39,999	38,532	454	437	41,786	40,324
Commonwealth grants and contributions	15	14	3,223	2,461	45	33	3,283	2,508
Grants and subsidies from non-government sources	71	68	6,326	6,055	68	73	6,465	6,196
Other revenues from ordinary activities	837	630	31,364	29,375	772	379	32,973	30,384
Revenue from non-operating activities								
Interest revenue	141	69	6,876	3,984	88	47	7,105	4,100
Proceeds from disposal of non-current assets	9	7	565	695	7	9	581	711
Other revenues from ordinary activities	325	225	15,588	12,859	165	117	16,078	13,201
Total revenues from ordinary activities	**2,731**	**2,368**	**103,941**	**93,961**	**1,599**	**1,095**	**108,271**	**97,424**
NET COST OF SERVICES	**47,608**	**49,653**	**1,513,218**	**1,416,655**	**37,246**	**34,722**	**1,598,072**	**1,501,030**
REVENUES FROM STATE GOVERNMENT								
Output appropriations	48,233	46,882	1,511,493	1,396,597	38,003	35,205	1,597,729	1,478,684
Liabilities assumed by the Treasurer	105	53	2,206	1,102	76	12	2,387	1,167
Resources received free of charge	14	19	404	850	10	11	428	880
Total revenues from State Government	**48,352**	**46,954**	**1,514,103**	**1,398,549**	**38,089**	**35,228**	**1,600,544**	**1,480,731**
Change in net assets before extraordinary items	**744**	**(2,699)**	**885**	**(18,106)**	**843**	**506**	**2,472**	**(20,299)**
Extraordinary revenue / (expense)	-	-	-	-	-	-	-	-
CHANGE IN NET ASSETS	**744**	**(2,699)**	**885**	**(18,106)**	**843**	**506**	**2,472**	**(20,299)**

Note 41 Statement of Financial Performance by Region

	East Metropolitan Area		North Metropolitan Area		South Metropolitan Area		Women's and Children's Health Service		Dental Health Service		Central Support Services		TOTAL	
	2003 $000	2002 $000	2003 $000	2002 $000	2003 $000	2002 $000	2003 $000	2002 $000	2003 $000	2002 $000	2003 $000	2002 $000	2003 $000	2002 $000
COST OF SERVICES														
Expenses from Ordinary Activities														
Employee expenses	375,016	340,321	307,647	276,316	219,436	196,766	176,939	157,921	28,780	33,281	3,817	7,206	1,111,635	1,011,811
Fees for visiting medical practitioners	14,002	12,638	5,707	5,203	11,250	9,899	642	437	-	-	-	-	31,601	28,177
Patient support costs	124,391	110,169	82,563	73,816	50,893	45,913	30,217	28,325	2,266	2,770	102	82	290,432	261,075
Borrowing costs expense	2,309	2,364	4,528	4,567	2,938	3,316	2,224	2,402	159	365	-	-	12,158	13,014
Depreciation expense	12,421	12,331	13,104	17,710	9,880	9,301	6,706	6,503	922	15,312	2,266	1,303	45,299	62,460
Capital user charge	14,142	13,625	11,184	10,851	12,181	10,419	6,893	5,995	75	1,385	276	181	44,751	42,456
Other expenses from ordinary activities	42,796	45,024	33,911	38,688	26,062	26,627	22,634	20,605	10,977	11,492	34,087	37,025	170,467	179,461
Total cost of services	**585,077**	**536,472**	**458,644**	**427,151**	**332,640**	**302,241**	**246,255**	**222,188**	**43,179**	**64,605**	**40,548**	**45,797**	**1,706,343**	**1,598,454**
Revenues from Ordinary Activities														
Revenue from operating activities														
Patient charges	16,114	15,498	12,628	11,662	4,129	4,090	5,594	5,512	3,321	3,562	-	-	41,786	40,324
Commonwealth grants and contributions	6	6	3,115	2,320	50	76	109	106	3	-	-	-	3,283	2,508
Grants and subsidies from non-government sources	1,240	1,216	2,778	3,267	681	536	1,766	1,177	-	-	-	-	6,465	6,196
Other revenues from ordinary activities	9,925	10,300	10,449	10,953	6,057	4,406	2,334	1,709	290	309	3,918	2,707	32,973	30,384
Revenue from non-operating activities														
Interest revenue	2,530	1,265	2,222	1,319	939	447	1,092	646	117	30	205	393	7,105	4,100
Proceeds from disposal of non-current assets	141	177	312	452	101	-	27	82	-	-	-	-	581	711
Other revenues from ordinary activities	5465	4,936	1,095	882	4,330	1,795	5,109	5,498	84	90	(5)	-	16,078	13,201
Total revenues from ordinary activities	**35,421**	**33,398**	**32,599**	**30,855**	**16,287**	**11,350**	**16,031**	**14,730**	**3,815**	**3,991**	**4,118**	**3,100**	**108,271**	**97,424**
NET COST OF SERVICES	**549,656**	**503,074**	**426,045**	**396,296**	**316,353**	**290,891**	**230,224**	**207,458**	**39,364**	**60,614**	**36,430**	**42,697**	**1,598,072**	**1,501,030**
REVENUES FROM STATE GOVERNMENT														
Output appropriations	543,036	499,837	423,952	394,063	321,356	284,726	233,347	211,019	39,195	46,434	36,843	42,605	1,597,729	1,478,684
Liabilities assumed by the Treasurer	787	410	772	276	332	154	312	162	184	165	-	-	2,387	1,167
Resources received free of charge	168	180	105	89	74	58	54	43	16	11	11	499	428	880
Total revenues from State Government	**543,991**	**500,427**	**424,829**	**394,428**	**321,762**	**284,938**	**233,713**	**211,224**	**39,395**	**46,610**	**36,854**	**43,104**	**1,600,544**	**1,480,731**
CHANGE IN NET ASSETS	**(5,665)**	**(2,647)**	**(1,216)**	**(1,868)**	**5,409**	**(5,953)**	**3,489**	**3,766**	**31**	**(14,004)**	**424**	**407**	**2,472**	**(20,299)**
Net increase / (decrease) in asset revaluation reserve	-	-	2,617	-	-	-	-	-	3,150	-	-	-	5,767	-
Net initial adjustments on adoption of AASB 1028 "Employee	(602)	-	(412)	-	(186)	-	(287)	-	(65)	-	-	-	(1,552)	-
Total revenues, expenses and valuation adjustments recognised directly in equity	**(602)**	**-**	**2,205**	**-**	**(186)**	**-**	**(287)**	**-**	**3,085**	**-**	**-**	**-**	**4,215**	**-**
Total changes in equity other than those resulting from transactions with WA State Government as owners	**(6,267)**	**(2,647)**	**989**	**(1,868)**	**5,223**	**(5,953)**	**3,202**	**3,766**	**3,116**	**(14,004)**	**424**	**407**	**6,687**	**(20,299)**

Note 41 Statement of Financial Position by Region

	East Metropolitan Area		North Metropolitan Area		South Metropolitan Area		Women's and Children's Health Service		Dental Health Service		Central Support Services		TOTAL	
	2003 $000	2002 $000	2003 $000	2002 $000	2003 $000	2002 $000	2003 $000	2002 $000	2003 $000	2002 $000	2003 $000	2002 $000	2003 $000	2002 $000
Current Assets														
Cash assets	6,505	17,433	17,863	12,676	4,574	5,202	19,035	9,503	300	335	5,473	2,336	53,750	47,485
Restricted cash assets	16,738	14,743	14,783	15,565	5,163	4,298	3,946	3,089	-	-	-	-	40,630	37,695
Restricted other financial assets	3,600	4,419	-	-	-	-	-	-	-	-	-	-	3,600	4,419
Receivables	9,144	9,099	8,576	9,897	3,494	4,432	3,471	3,962	539	687	4,881	5,305	30,105	33,382
Amounts receivable for outputs	10,921	13,172	13,757	12,815	9,308	10,747	14,602	6,515	1,150	3,371	2,232	-	51,970	46,620
Inventories	5,469	5,554	3,152	2,884	1,988	1,745	1,427	1,202	553	526	-	-	12,589	11,911
Other current assets	894	894	665	421	829	162	384	867	22	111	583	1	3,377	2,456
Total Current Assets	**53,271**	**65,314**	**58,796**	**54,258**	**25,356**	**26,586**	**42,865**	**25,138**	**2,564**	**5,030**	**13,169**	**7,642**	**196,021**	**183,968**
Non-Current Assets														
Amounts receivable for outputs	10,519	-	(1,754)	-	8,435	-	(12,372)	-	3,165	-	-	-	7,993	-
Property, plant and equipment	291,768	290,936	276,643	266,411	231,537	229,945	160,940	155,645	20,086	22,210	5,557	5,691	986,531	970,838
Total Non-Current Assets	**302,287**	**290,936**	**274,889**	**266,411**	**239,972**	**229,945**	**148,568**	**155,645**	**23,251**	**22,210**	**5,557**	**5,691**	**994,524**	**970,838**
Total Assets	**355,558**	**356,250**	**333,685**	**320,669**	**265,328**	**256,531**	**191,433**	**180,783**	**25,815**	**27,240**	**18,726**	**13,333**	**1,190,545**	**1,154,806**
Current Liabilities														
Payables	18,954	12,760	14,756	9,196	10,078	7,845	6,953	4,055	602	334	5,949	3,964	57,292	38,154
Interest-bearing liabilities	1,437	1,391	2,587	2,528	1,469	1,406	1,234	1,183	186	180	-	-	6,913	6,688
Provisions	61,065	57,030	53,281	48,110	32,462	30,633	29,293	26,884	4,117	4,026	949	926	181,167	167,608
Other liabilities	13,353	16,129	5,222	9,809	3,543	5,819	6,683	6,285	851	1,063	101	3	29,753	39,107
Total Current Liabilities	**94,809**	**87,310**	**75,846**	**69,643**	**47,552**	**45,703**	**44,163**	**38,407**	**5,756**	**5,603**	**6,999**	**4,893**	**275,125**	**251,557**
Non-Current Liabilities														
Interest-bearing liabilities	34,339	35,775	68,336	70,923	36,438	37,907	30,050	31,284	4,530	4,714	-	-	173,693	180,604
Provisions	66,479	65,906	50,033	47,823	29,597	28,854	29,618	29,567	13,392	13,868	169	165	189,288	186,184
Total Non-Current Liabilities	**100,818**	**101,681**	**118,369**	**118,746**	**66,035**	**66,761**	**59,668**	**60,851**	**17,922**	**18,582**	**169**	**165**	**362,981**	**366,788**
Total Liabilities	**195,627**	**188,991**	**194,215**	**188,389**	**113,587**	**112,464**	**103,831**	**99,258**	**23,678**	**24,185**	**7,168**	**5,058**	**638,106**	**618,345**
NET ASSETS	**159,931**	**167,259**	**139,470**	**132,280**	**151,741**	**144,067**	**87,602**	**81,525**	**2,137**	**3,055**	**11,558**	**8,275**	**552,439**	**536,461**
Equity														
Contributed equity	200,562	201,623	197,289	191,088	137,623	135,172	100,948	98,073	4,547	8,581	6,116	3,257	647,085	637,794
Reserves	-	-	2,617	-	-	-	-	-	3,150	-	-	-	5,767	-
Accumulated surplus / (deficiency)	(40,631)	(34,364)	(60,436)	(58,808)	14,118	8,895	(13,346)	(16,548)	(5,560)	(5,526)	5,442	5,018	(100,413)	(101,333)
TOTAL EQUITY	**159,931**	**167,259**	**139,470**	**132,280**	**151,741**	**144,067**	**87,602**	**81,525**	**2,137**	**3,055**	**11,558**	**8,275**	**552,439**	**536,461**

Note 41 Statement of Cash Flows by Region

	East Metropolitan Area		North Metropolitan Area		South Metropolitan Area		Women's and Children's Health Service		Dental Health Service		Central Support Services		TOTAL	
	2003 $000 Inflows (Outflows)	2002 $000 Inflows (Outflows)	2003 $000 Inflows (Outflows)	2002 $000 Inflows (Outflows)	2003 $000 Inflows (Outflows)	2002 $000 Inflows (Outflows)	2003 $000 Inflows (Outflows)	2002 $000 Inflows (Outflows)	2003 $000 Inflows (Outflows)	2002 $000 Inflows (Outflows)	2003 $000 Inflows (Outflows)	2002 $000 Inflows (Outflows)	2003 $000 Inflows (Outflows)	2002 $000 Inflows (Outflows)
Cash flows from State Government														
Output appropriations	505,008	470,658	398,227	367,935	294,072	260,217	214,804	196,108	37,836	41,306	34,335	42,424	1,484,282	1,378,648
Capital contributions	285	13,525	3,338	9,754	969	14,537	-	5,741	365	49	2,897	3,257	7,854	46,863
Holding account drawdowns	8,724	-	16,343	-	3,061	-	12,899	-	-	-	-	-	41,027	-
Net cash provided by State Government	**514,017**	**484,183**	**417,908**	**377,689**	**298,102**	**274,754**	**227,703**	**201,849**	**38,201**	**41,355**	**37,232**	**45,681**	**1,533,163**	**1,425,511**
Utilised as follows:														
Cash flows from operating activities														
Payments														
Employee costs	(338,416)	(294,212)	(277,632)	(247,165)	(199,021)	(175,493)	(158,149)	(140,612)	(25,808)	(29,529)	(2,726)	(7,757)	(1,001,752)	(894,768)
Supplies and services	(209,911)	(197,643)	(142,661)	(138,760)	(106,659)	(93,728)	(68,232)	(63,445)	(19,697)	(17,346)	(33,170)	(35,715)	(580,330)	(546,636)
Borrowing costs	-	-	(3,919)	(4,131)	-	-	-	-	-	-	-	-	(3,919)	(4,131)
Receipts														
Patient charges and fees	16,955	14,234	11,982	11,361	4,080	3,552	5,657	5,770	3,466	3,351	69	(58)	42,209	38,211
Commonwealth grants and contributions	6	7	3,115	2,320	50	76	110	106	3	-	-	-	3,284	2,509
Grants and subsidies from non-government sources	1,241	1,215	2,779	3,267	681	536	1,767	1,177	-	-	-	-	6,468	6,195
Interest received	2,467	1,245	2,220	1,281	1,208	444	1,097	626	(65)	306	117	393	7,044	4,295
Other receipts	15,256	15,192	11,472	11,146	9,546	7,422	6,040	4,246	373	399	3,913	2,706	46,600	41,111
Net cash provided by / (used in) operating activities	**(512,402)**	**(459,962)**	**(392,644)**	**(360,681)**	**(290,115)**	**(257,191)**	**(211,710)**	**(192,132)**	**(41,728)**	**(42,819)**	**(31,797)**	**(40,431)**	**(1,480,396)**	**(1,353,214)**
Cash flows from investing activities														
Purchase of non-current physical assets	(11,511)	(10,582)	(19,064)	(7,931)	(7,851)	(13,122)	(5,631)	(4,627)	3,492	(490)	(2,298)	(3,581)	(42,863)	(40,333)
Proceeds from sale of non-current physical assets	141	177	312	452	101	-	27	82	-	-	-	-	581	711
Receipts from term deposits	4,419	11,465	-	-	-	-	-	-	-	-	-	-	4,419	11,465
Purchase of term deposits	(3,600)	(4,419)	-	-	-	-	-	-	-	-	-	-	(3,600)	(4,419)
Net cash provided by / (used in) investing activities	**(10,551)**	**(3,359)**	**(18,752)**	**(7,479)**	**(7,750)**	**(13,122)**	**(5,604)**	**(4,545)**	**3,492**	**(490)**	**(2,298)**	**(3,581)**	**(41,463)**	**(32,576)**
Cash flows from financing activities														
Repayments of borrowings	3	-	(2,107)	(2,061)	-	-	-	-	-	-	-	-	(2,104)	(2,061)
Net cash provided by / (used in) financing activities	**3**	**-**	**(2,107)**	**(2,061)**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**(2,104)**	**(2,061)**
Net increase / (decrease) in cash held	**(8,933)**	**20,862**	**4,405**	**7,468**	**237**	**4,441**	**10,389**	**5,172**	**(35)**	**(1,954)**	**3,137**	**1,669**	**9,200**	**37,660**
Cash assets at the beginning of the reporting period	32,176	11,314	28,241	20,773	9,500	5,059	12,592	7,420	335	2,289	2,336	667	85,180	47,520
Cash assets at the end of the reporting period	**23,243**	**32,176**	**32,646**	**28,241**	**9,737**	**9,500**	**22,981**	**12,592**	**300**	**335**	**5,473**	**2,336**	**94,380**	**85,180**