Department of
Health

Metropolitan Health Service

Annual Report 2007-08

North Metropolitan Area Health Service
South Metropolitan Area Health Service
Child and Adolescent Health Service
Peel Health Service
Dental Health Services
PathWest Laboratory Medicine WA

Website: www.health.wa.gov.au

Statement of Compliance

HON DR KIM HAMES MLA
MINISTER FOR HEALTH

In accordance with Section 61 of the *Financial Management Act 2006*, I hereby submit for your information and presentation to Parliament, the Report of the Metropolitan Health Service for the year ended 30 June 2008.

This report has been prepared in accordance with the provisions of the *Financial Management Act 2006*.

Dr Peter Flett
ACTING DIRECTOR GENERAL OF HEALTH
Accountable Authority for The Minister For Health in his Capacity
As the Deemed Board of Metropolitan Public Hospitals

26th September 2008

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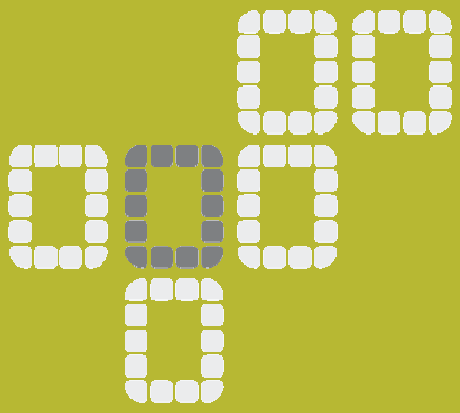
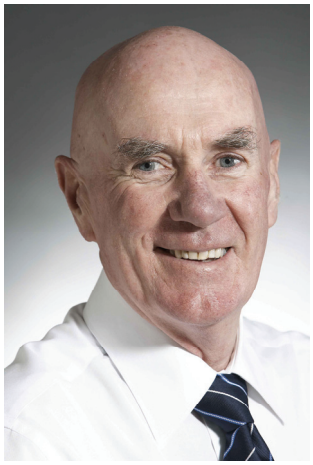
Illustrations

This Report is available in alternative formats
upon request from a person with a disability



Overview of Agency

Executive Summary



The Department of Health is committed to ensuring healthier, longer and better lives for all West Australians and protecting the health of our community. We aim to do this by providing a safe, high quality, accountable and sustainable health care system. In 2007-08 the Department has continued to implement a broad-based reform agenda, underpinned by our *Strategic Directions 2005 - 2010* framework.

The Metropolitan Health Service (MHS) provides the greater part of hospital services, including pathology and dental health to the people of WA, and continues to work to achieve the highest quality service to our community through its primary, secondary and tertiary care providers. Below is just a small sample of the progress that the Department and the MHS have made in our six priority areas: healthy workforce; healthy hospitals, health services and Infrastructure; healthy partnerships; healthy communities; healthy resources and healthy leadership.

Healthy workforce

A record 586 new registered nursing graduates commenced with WA Health in 2008 – an increase of 110 on the 2007 recruitment year. In 2007-08, new initiatives were introduced to boost the skills and sustainability of our workforce. These included programs to attract experienced nurses back into the profession, introduction of training for the Assistant in Nursing role and the successful piloting of a program of community residencies for junior doctors. Workforce improvements were also delivered through the completion of the Aged Care Assessment Team quality framework, and the delivery of an improved suite of disaster training courses. In these ways and more the Department delivered on its commitment to develop and maintain a skilled, healthy and sustainable workforce to protect and promote the health of the WA community.

Healthy hospitals, health services and infrastructure

In 2007-08 the Department continued to improve and enhance the quality of our hospitals, infrastructure and health services, with a focus on accessibility, efficiency and responsiveness to community needs. Significant improvements have been made in terms of waiting times for elective surgery at Perth public hospitals and for clinic appointments at metropolitan outpatient clinics. Substantial progress has been made on the improvement and expansion of our hospital infrastructure. The past year saw the completion of the new $8 million State Major Trauma Unit at Royal Perth Hospital, while the $115 million expansion of Rockingham-Kwinana Hospital is more than two thirds complete. The upgrade of the Emergency Department at Peel Health Campus has been completed, while ED upgrades are underway at Royal Perth and Armadale-Kelmscott Hospitals.

The past year saw the endorsement of a new model of care for palliative care, and ongoing work by the WA Health Aged Care Network on the formulation of service models that specifically include a model of care for dementia. Construction of supported, community-based mental health accommodation was completed at Kelmscott and other locations throughout the state. In 2007-08 more than 241,000 school children across WA continued to access free oral health treatment through the school dental program.

Healthy partnerships

The Department has continued to develop innovative partnerships with non-government organisations, private sector providers, community groups and other government agencies aimed at improving service delivery, boosting research and development and maximising capital investment. Our partnership with the Telethon Institute of Child Health Research has gained international recognition, linking WA's genomics sector with the global genomics industry. There have been significant

developments in the Department's collaborative Aboriginal health partnerships, while the 2007 Mental Health Good Outcomes Awards recognised innovation and excellence across the WA mental health sector.

Healthy communities

In 2007-08 the Department has continued to work towards improving lifestyles, preventing ill-health and implementing long term, integrated health promotion programs. There has been strong action to combat childhood obesity through the implementation of healthy eating, healthy weight and physical activity programs to be delivered in school and community settings. A number of new initiatives have been established to combat perinatal and postnatal depression, and the Australian Better Health Initiative has been progressively implemented at Kwinana and other locations throughout the state. Falls prevention activities have continued and we have commenced demonstration projects to simplify client access to Home and Community Care services. The Public Health Division has been drafting the new Public Health Bill and has undertaken a number of sexual health initiatives. Licensing infrastructure for tobacco retailers and wholesalers has been established and a statewide compliance program implemented. The Department has improved the health of our workplaces and facilities through implementation of non-smoking and positive food and nutrition policies at WA Health facilities.

Healthy resources

The Department has continued to deliver robust resource administration, planning and management practices to oversee our health service programs and support the area health services. Disaster preparedness and management arrangements have been enhanced, including through significant upgrades to emergency communication facilities at rural hospitals. Video-conferencing equipment to allow the expansion of tele-psychiatry services has been installed in an additional 58 centres across the state. Health information improvements have included significant progress towards the new WA Cancer Registry information system and preparation for the ongoing monitoring of road safety indicators.

Healthy leadership

The Department recognises that identifying, nurturing and promoting strong leadership at all levels is vital for the effectiveness of the health system now and into the future. The Institute for Healthy Leadership was established in July 2007. The Institute has already commissioned a number of programs to develop WA Health's future leaders. The Institute's Service Improvement Workshops provide training in the principles and methods of health service improvement. The Emerging Leaders Development Program and the Delivering the Future Leadership Development Program target senior managers and potential future directors and executive directors and provide high-level leadership training. As part of our commitment to fostering leadership at all levels, nine graduate officers were recruited and commenced with the Department in February 2008.

Conclusion

The report that follows provides more detail on how the Metropolitan Health Service and Department of Health have worked towards our goals of delivering a healthy WA. None of the achievements detailed below would have been possible without the hard-work and dedication of all our staff. I would like to thank each member of our MHS workforce for their contribution over the past year and reaffirm our commitment to providing a world-class health service to the people of Western Australia.

Dr Peter Flett
ACTING DIRECTOR GENERAL OF HEALTH

26th September 2008

Address and Location

North Metropolitan Area Health Service

Sir Charles Gairdner Hospital
Hospital Avenue, NEDLANDS WA 6009
Postal address
Locked Bag 2012, NEDLANDS WA 6009
Phone: (08) 9346 3333
Fax: (08) 9346 3759
Internet: www.nmahs.health.wa.gov.au

NMAHS Sir Charles Gairdner Group (including Osborne Park Hospital Program)
Sir Charles Gairdner Hospital (as above)
Internet: http://www.scgh.health.wa.gov.au
Email: scgh.webmaster@health.wa.gov.au

Osborne Park Hospital Program
Osborne Place, STIRLING WA 6021
Phone: (08) 9346 8000
Fax: (08) 9346 8431
Internet: www.oph.health.wa.gov.au
Email: oph.webmaster@health.wa.gov.au

NMAHS Ambulatory Care
Sir Charles Gairdner Hospital (as above)
Phone: (08) 9346 3333
Fax: (08) 9346 3853
Internet: http://www.scgh.health.wa.gov.au
Email: scgh.webmaster@health.wa.gov.au

NMAHS Area Mental Health Service
Moore House, Graylands Campus
Brockway Rd, MOUNT CLAREMONT WA 6010
Postal address
Private Bag 1, CLAREMONT WA 6910
Phone: (08) 9347 6933
Fax: (08) 9347 6949
Internet:
http://www.nmahsmh.health.wa.gov.au
Email: Sharon.Dutton@health.wa.gov.au

Swan Kalamunda Health Service
Eveline Road, MIDDLE SWAN WA 6056
Postal address
PO Box 195, MIDLAND WA 6936
Phone: (08) 9347 5400
Fax: (08) 9347 5410
Internet: http://www.nmahs.health.wa.gov.au/
Email: swanhealthservice@health.wa.gov.au

Women and Newborn Health Service
King Edward Memorial Hospital for Women
374 Bagot Road SUBIACO WA 6904
Postal address
PO Box 134, SUBIACO WA 6904
Phone: (08) 9340 2222
Fax: (08) 9388 1780
Internet: www.wnhs.health.wa.gov.au

WA Cervical Cancer Prevention Program
2nd Floor, Eastpoint Plaza
233 Adelaide Terrace, PERTH WA 6000
Phone: (08) 9323 6788 or 13 15 56
Fax: (08) 9323 6711

Mother and Baby Unit
11 Loretto St, SUBIACO WA 6008
Postal address
PO Box 134, SUBIACO WA 6904
Phone: (08) 9340 1799
1800 422 588 [outside metro area]
Fax: (08) 9340 1790
Internet: www.wnhs.health.wa.gov.au

Sexual Assault Resource Centre
PO Box 842, SUBIACO WA 6904
Phone: (08) 9340 1820
Fax: (08) 9381 5426
24 hour crisis line: (08) 9340 1828
SARC counselling line: (08) 9340 1899 or
Freecall: 1800 199 888
Internet: www.wnhs.health.wa.gov.au

BreastScreen WA
9th Floor, Eastpoint Plaza
233 Adelaide Terrace, PERTH WA 6000
Phone: (08) 9323 6700
Fax: (08) 9323 6799
Internet: www.breastscreen.health.wa.gov.au
Email: breastscreenwa@health.wa.gov.au

South Metropolitan Area Health Service

Executive Offices
Level 3 South Block, Royal Perth Hospital
Wellington Street, PERTH WA 6001
Postal address
GPO Box X2213, PERTH WA 6847
Phone: (08) 9224 3604
Fax: (08) 9224 3444
Internet: www.smahs.health.wa.gov.au

Armadale-Kelmscott Memorial Hospital
3056 Albany Highway, ARMADALE WA 6112
Postal Address
PO Box 460, ARMADALE WA 6992
Phone: (08) 9391 2000
Fax: (08) 9391 2129
Internet: www.ahs.health.wa.gov.au
Email : ahs@health.wa.gov.au

Bentley Hospital
33 Mills Street, BENTLEY WA 6102
Postal address
PO Box 158, BENTLEY WA 6982
Phone: (08) 9334 3666
Fax: (08) 9356 1632
Internet: www.health.wa.gov.au/bhs
Email: bl.enquires@health.wa.gov.au

Fremantle Hospital
Alma Street, FREMANTLE WA 6160
Postal address
PO Box 480, FREMANTLE WA 6959
Phone: (08) 9431 3333
Fax: (08) 9431 2918
Internet: www.fhhs.health.wa.gov.au
Email: fhweb@health.wa.gov.au

Kaleeya Hospital
Corner Staton Road and Wolsely Road
EAST FREMANTLE WA 6158
Postal address
PO Box 480, FREMANTLE WA 6959
Phone: (08) 9319 0300
Fax: (08) 9319 1958

Murray District Hospital
McKay Street, PINJARRA WA 6208
Postal address
PO Box 243, PINJARRA WA 6208
Phone: (08) 9531 7222
Fax: (08) 9531 7241

Rockingham-Kwinana District Hospital
Elanora Drive, COOLOONGUP WA 6168
Postal address
PO Box 2033, ROCKINGHAM WA 6967
Phone: (08) 9592 0600
Fax: (08) 9592 0619

Royal Perth Hospital
Wellington Street, PERTH WA 6001
Postal address
GPO Box X2213, PERTH WA 6847
Phone: (08) 9224 2244
Fax: (08) 9224 3511
Internet: www.rph.wa.gov.au
Email: rph.feedback@health.wa.gov.au

Royal Perth Hospital: Shenton Park Campus
6 Selby Street, SHENTON PARK WA 6008
Phone: (08) 9382 7171
Fax: (08) 9382 7351

Rottnest Island Nursing Post
1 Abbott Street, ROTTNEST ISLAND WA 6161
Postal address
PO Box 480, FREMANTLE WA 6959
Phone: (08) 9292 5030
Fax: (08) 9292 5121

South Metropolitan Mental Health Service
18 Dalgety Street, EAST FREMANTLE WA 6158
Postal address
PO Box 480, FREMANTLE WA 6959
Phone: (08) 9319 7200
Fax: (08) 9319 7222

South Metropolitan Population Health
Public Health Unit
Level 2, 7 Pakenham Street
FREMANTLE WA 6160
PO Box 546, FREMANTLE WA 6959
Phone: (08) 9431 0200
Fax: (08) 9431 0227

Address and Location (continued)

Child and Adolescent Health Service

Princess Margaret Hospital for Children
Roberts Road, SUBIACO WA 6008
Phone: (08) 9340 8222
Fax: (08) 9340 7000
Internet: www.cahs.health.wa.gov.au

Child and Community Health Division
WASON Building
151 Wellington St, PERTH WA 6000
Phone: (08) 9224 1625
Fax: (08) 9224 1612
Internet: www.cahs.health.wa.gov.au

Dental Health Services

43 Mt Henry Road, COMO WA 6152
Postal Address
Locked Bag 15, Bentley Delivery Centre
PERTH WA 6983
Phone: (08) 9313 0555
Fax: (08) 9313 1302
TTY: (08) 9313 2085
Internet: www.dental.wa.gov.au

PathWest Laboratory Medicine WA

J Block, QEII Medical Centre
Hospital Avenue, NEDLANDS WA 6009
Postal address
Locked Bag 2009, NEDLANDS WA 6909
Phone: (08) 9346 3000
Fax: (08) 9381 7594
Email: pathwest@health.wa.gov.au
Internet: www.pathwest.com.au

PathWest Laboratory Medicine WA RPH
North Block, Royal Perth Hospital
Wellington Street, PERTH WA 6001
Postal address
GPO Box X2213, PERTH WA 6847
Phone: (08) 9224 2422
Fax: (08) 9224 3466

PathWest Laboratory Medicine WA KEMH
King Edward Memorial Hospital for Women
Bagot Road, SUBIACO WA 6008
Postal address
PO Box 134, SUBIACO WA 6904
Phone: (08) 9340 2712
Fax: (08) 9340 2714

PathWest Laboratory Medicine WA PMH
Princess Margaret Hospital for Children
Roberts Road, SUBIACO WA 6008
Phone: (08) 9340 8271
Fax: (08) 9340 8117

PathWest Laboratory Medicine WA FHHS
Fremantle Hospital and Health Service
Alma Street, FREMANTLE WA 6160
Postal address
PO Box 480, FREMANTLE WA 6959
Phone: (08) 9431 2744
Fax: (08) 9431 2520

Twenty-five PathWest Laboratory Medicine WA branch laboratories and 45 collection points are located throughout the state. Of these, six branch laboratories and 28 collection points are located within the wider metropolitan area.

Our Purpose

Our purpose is to ensure healthier, longer and better lives for all West Australians.

Our Vision

Our vision is to improve and protect the health of West Australians by providing a safe, high quality, accountable and sustainable health care system. We recognise that this care is achieved through an integrated approach to all the components of our health system. These components include workforce, hospitals and infrastructure, partnerships, communities, resources and leadership. We also recognise that the Department of Health must work with a vast number of groups if it is to achieve the vision of a world-class health system.

Service Framework

Better Planning: Better Futures

In September 2006, the State Government of Western Australia released *Better Planning: Better Futures – A Framework for the Strategic Management of the Western Australian Public Sector.*

The framework states that the Western Australian public sector seeks to provide the best opportunities for current and future generations to live better, longer and healthier lives. Its vision is to promote a creative, sustainable and economically successful State that embraces the diversity of its people and values its rich natural resources.

The framework outlines five strategic goals. Broad, high-level government goals are supported at agency level by more specific desired outcomes. The whole of health delivers services to achieve these desired outcomes, which ultimately contribute to meeting the high-level government goals.

Goal 1: Better services

Enhancing the quality of life and wellbeing of all people throughout Western Australia by providing high quality, accessible services.

Goal 2: Jobs and economic development

Creating conditions that foster a strong economy, delivering more jobs, opportunities and greater wealth for all West Australians.

Goal 3: Lifestyle and environment

Protecting and enhancing the unique Western Australian lifestyle and ensuring sustainable management of the environment.

Goal 4: Regional development

Ensuring that regional Western Australia is strong and vibrant.

Goal 5: Governance and public sector improvement

Developing and maintaining a skilled, diverse and ethical public sector, serving the Government with consideration of the public interest.

WA Health outcomes and strategic directions

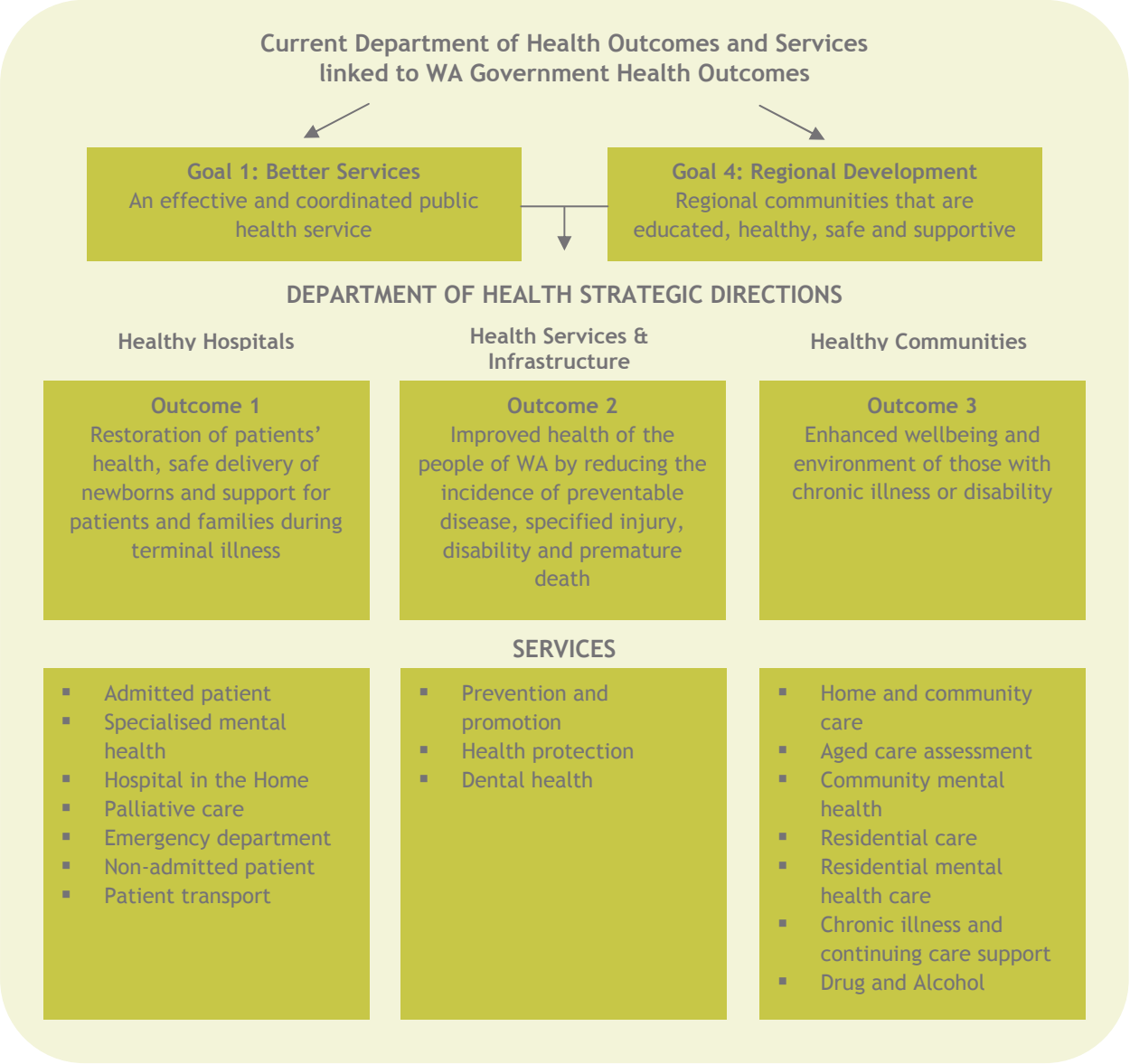
WA Health principally contributes to Better Planning: Better Futures - Goals 1 and 4.

Figure 1 shows the relationship between the Government's and WA Health's desired outcomes.

The strategic directions or priority areas of healthy "hospitals, health services and infrastructure", "communities" along with "workforce", "partnerships", "resources" and "leadership" were identified by the Department of Health's senior leadership team in December, 2004 and provide the WA Health framework for improving the efficiency and effectiveness of health care provided to West Australians for the period 2005-2010.

Service Framework (continued)

Figure 1: Department of Health strategic directions



Services Provided

Metropolitan Health Service

Direct patient services

- acute mental health
- adolescent clinic
- adolescent medicine
- adult mental health
- aged care assessment
- after hours general practice
- ambulatory surgery
- antenatal service
- amputee service
- anaesthesia
- antenatal clinic
- audiology
- bone marrow transplantation
- breast assessment service
- burns clinics
- cardiothoracic surgery
- cardiovascular medicine
- child and adolescent mental health
- child protection unit
- chronic obstructive pulmonary disease service
- clinical haematology
- clinical immunology
- clinical investigation
- cleft-lip palate
- community and developmental paediatrics
- continence services
- cornea grafting
- coronary care
- cranio-maxillo facial and plastic surgery
- day surgery
- dermatology
- diabetes education
- dietetics and nutrition
- domiciliary pathology collection service
- ear, nose and throat
- eating disorders service
- emergency centre
- emergency medicine
- endocrinology
- enuresis and stomal therapy
- epilepsy service
- family early intervention program
- gastroenterology
- general medicine
- general surgery
- geriatric medicine and extended care
- geriatric mental health
- gynaecology
- haematology
- haemophilia
- hand surgery
- hepatology
- HIV/AIDS education
- home care midwifery
- home visiting nurse
- hyperbaric medicine
- infection control
- infectious diseases
- intensive care
- intra-ocular surgery
- maxillo-facial surgery
- medical clinic
- menopause services
- mental health
- neck of femur unit
- neonatal follow up
- neonatology
- nephrology
- neurology
- neurosurgery
- newborn hearing screening
- nuclear medicine
- obstetrics and midwifery
- occupational therapy
- oncology
- ophthalmology
- oral surgery
- orthopaedics
- orthotics and prosthetics
- paediatric gynaecology
- paediatric medicine
- paediatric surgery
- paediatric urology
- pain management
- palliative care
- parent education
- pathology
- pharmacy
- physiotherapy
- plastic surgery
- podiatry
- postnatal infants
- primary health care
- psychology
- radiation oncology
- radiology
- rehabilitation
- renal services/dialysis
- respiratory medicine
- respite care
- rheumatology
- rural paediatric service
- same day unit

Services Provided (continued)

- sexual health service
- social work
- speech pathology
- State Adult Burns Centre
- State Spinal Unit
- State Trauma Unit
- stomal therapy
- team midwifery service
- transcultural psychiatry
- tropical medicine
- ultrasound
- urology
- vascular surgery
- visiting nursing

Medical support services

- audiology
- biochemistry
- bio-engineering
- chaplaincy
- clinical psychology
- clinical research and education
- community aids & equipment
- continence service
- cytopathology
- dietetics and nutrition
- health record management
- histopathology
- imaging
- immunology
- infection control
- medical illustration
- medical technology
- micobiology
- occupational therapy
- orthotics and prosthetics
- patient information management systems
- pathology
- pharmacy
- physiotherapy
- podiatry
- post mortem services
- radiology & ultrasound
- social work
- speech pathology toxicology
- transfusion medicine

Community services

- Aboriginal health
- asthma education
- bed-wetting program
- child and family health
- child development
- chronic disease and ambulatory care
- community physiotherapy
- chronic disease management teams
- diabetes education
- family and child health
- food and water testing
- forensic biology testing
- health promotion
- home care
- Hospital in the Home
- mental health outpatient services, community services and day hospital
- migrant health
- Positive Parenting Program
- psychiatric emergency services
- rehabilitation and living skills services
- Rehabilitation in the Home
- school health
- youth and sexual health

PathWest Laboratory Medicine WA

Direct patient services

- clinical consultation in all disciplines of pathology
- domiciliary collection service

Medical support services

- histopathology
- cytopathology
- biochemistry
- haematology
- transfusion medicine
- toxicology
- immunology
- microbiology
- post-mortem services

Community services

- food and water testing
- forensic biology testing

Dental Health Services

Direct patient services

- emergency and general dental care
- Medical support services
- dental prosthetic services

Community services

- domiciliary dental care for the homebound
- aged care oral health program

Other support services

- corporate services
- engineering and maintenance
- hotel services
- financial services
- supply
- oral health promotion

Compliance Reports

The Department of Health is established by the Governor under section 35 of the Public Sector Management Act 1994 and includes the Metropolitan and Country Health Services. The Director General of Health is responsible to the Minister for Health for the efficient and effective management of the organisation.

The Department of Health supports the Minister in the administration of 40 Acts and 101 sets of subsidiary legislation.

Acts administered

- *Alcohol and Drug Authority Act 1974*
- *Anatomy Act 1930*
- *Animal Resources Authority Act 1981*
- *Blood Donation (Limitation of Liability) Act 1985*
- *Cannabis Control Act 2003*
- *Chiropractors Act 2005*
- *Co-opted Medical and Dental Services for the Northern Portion of the State Act 1951*
- *Cremation Act 1929*
- *Dental Act 1939*
- *Dental Prosthetists Act 1985*
- *Fluoridation of Public Water Supplies Act 1966*
- *Food Act 2008*
- *Health Act 1911*
- *Health Legislation Administration Act 1984*
- *Health Professionals (Special Events Exemption) Act 2000*
- *Health Services (Conciliation and Review) Act 1995*
- *Health Services (Quality Improvement) Act 1994*
- *Hospital Fund Act 1930*
- *Hospitals and Health Services Act 1927*
- *Human Reproductive Technology Act 1991*
- *Human Tissue and Transplant Act 1982*
- *Medical Act 1894*
- *Medical Practitioners Act 2008*
- *Medical Radiation Technologists Act 2006*
- *Mental Health Act 1996*
- *Nuclear Waste Storage and Transportation (Prohibition) Act 1999*
- *Nurses and Midwives Act 2006*
- *Occupational Therapists Act 2005*
- *Optometrists Act 2005*
- *Osteopaths Act 2005*
- *Pharmacy Act 1964*
- *Physiotherapists Act 2005*
- *Podiatrists Act 2005*
- *Poisons Act 1964*
- *Psychologists Act 2005*
- *Queen Elizabeth II Medical Centre Act 1966*
- *Radiation Safety Act 1975*
- *Tobacco Products Control Act 2006*
- *University Medical School Teaching Hospitals Act 1955*
- *White Phosphorous Matches Prohibition Act 1912*

Acts passed during 2007-08

- *Food Act 2008*
- *Medical Practitioners Act 2008*

Bills in Parliament as at 30 June 2008

- *Alcohol and Drug Authority Repeal Bill 2005*
- *Dental Bill 2005*
- *Pharmacists Bill 2005*
- *Surrogacy Bill 2006*

Amalgamation and establishment of Boards

There were no Boards amalgamated or established during 2007-08.

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 Resource Management, the Western Australian Public Sector Code of Ethics and the WA Health Code of Conduct.

I am satisfied that procedures and internal processes I have implemented and overseen for the Metropolitan Health Service support this statement.

To ensure compliance with the requirements of the Public Sector Standards and to encourage best practice, the Department conducts regular reviews of the relevant policies and procedures. The Metropolitan Health Service continually monitors compliance and occasionally external consultants are requested to undertake breach reviews to gain an independent view of the Metropolitan Health Service's processes.

During 2007-08 the Metropolitan Health Service received 29 breach claims: 22 for recruitment and selection and six for grievance resolution. Six were either resolved or dismissed following investigation, two were resolved following investigation by the Office of the Public Sector Standards Commissioner (OPSSC), 16 were witdrawn and four were held pending completion of an appropriate investigation. One breach claim was upheld.

This information includes compliance returns from Dental Health Services and PathWest Laboratory Medicine WA.

Code of Ethics and Code of Conduct

The Public Sector Code of Ethics and the WA Health Service Code of Conduct are available to all employees via the intranet site and documentation distributions via global e-mailing and during induction and training workshops. New employees are required to read and acknowledge the Codes as part of the induction and orientation procedures.

Compliance with the codes is monitored through analysis of employee grievances and complaints and the identification of relevant subject matter.

In 2007-08 the Metropolitan Health Service received 227 complaints alleging non-compliance with either the Code of Ethics or the Code of Conduct.

Dr Peter Flett
ACTING DIRECTOR GENERAL OF HEALTH

26th September 2008

Pecuniary Interests

Senior officers of the Metropolitan Health Service have declared no pecuniary interests in 2007-08.

Accountable Authority

The Acting Director General of Health, Dr Peter Flett, in his capacity as Chief Executive Officer, is the accountable authority for the Metropolitan Health Service.

Senior Officers

Senior officers for the Metropolitan Health Service and their areas of responsibility as at 30 June 2008 are listed below:

Table 1: Senior officers - North Metropolitan Area Health Service as at 30 June 2008

North Metropolitan Area Health Service		
Area of responsibility	**Title**	**Name**
Corporate Management	**Chief Executive**	**David Russell-Weisz**
Mental Health	Executive Director	Ann Hodge
Finance	A/Executive Director	Alain St Flour
Nursing Services	Executive Director	Di Twigg
Medical Services	A/Executive Director	Mark Salmon
Workforce	Executive Director	Jon Frame
Facilities Management	Executive Director	Alan Buckley
Safety, Quality & Performance	A/Director	Sandra Miller
Sir Charles Gairdner Group	Executive Director	Amanda Ling
Swan Kalamunda Health Service	Executive Director	Peter Wynn Owen
Capital Management	Director	Ian Anderson
Clinical Planning	Director	Liz Macleod
Public Health and Ambulatory Care	A/Executive Director	Ros Elmes
Women and Newborn Health Service	A/Executive Director	Philip Aylward

Senior Officers (continued)

Table 2: Senior officers - South Metropolitan Area Health Service as at 30 June 2008

South Metropolitan Area Health Service		
Area of responsibility	**Title**	**Name**
Corporate Management	**A/Chief Executive**	**Mark Platell**
Royal Perth Hospital Group	A/Executive Director	Paul Mark
Armadale and Bentley Group	Executive Director	Russell McKenney
Fremantle Hospital Group	A/Executive Director	Alex Smith
Rockingham Peel Group	Executive Director	Geraldine Carlton
Fiona Stanley Hospital	Executive Director	Brad Sebbes
Public Health Unit	A/Executive Director	Clory Carrello
Mental Health Services	Executive Director	Elizabeth Moore
Medical Services	Area Director (part-time)	Paul Mark
Nursing Services	Area Director (part-time)	Ruth Letts
Workforce Development	Area Executive Director	Suzanne McCavanagh
Safety Quality & Performance	Executive Director	Patricia O'Farrell
Major Capital Works	A/Director	Sam Carrello
Finance	A/Area Executive Director	Ian Male
Strategic Issues	Director	Patsy Turner

Table 3: Senior officers - Child and Adolescent Health Service as at 30 June 2008

Child and Adolescent Health Service		
Area of responsibility	**Title**	**Name**
Corporate Management	**A/Executive Director**	**Anne Bourke**
Nursing Services	A/Executive Director	Marie Baxter
Medical Services	A/Executive Director	Mark Salmon
Child and Adolescent Community Health	Executive Director	Mark Morrissey
Surgical Services	Chairman	Colin Kikiros
Paediatric Medicine	Chairman	David Forbes
Surgical Services	A/Nursing Director	Nicole Flendt
Paediatric Medicine	Nursing Director	Ann Stynes

Table 4: Senior officers - PathWest Laboratory Medicine WA as at 30 June 2008

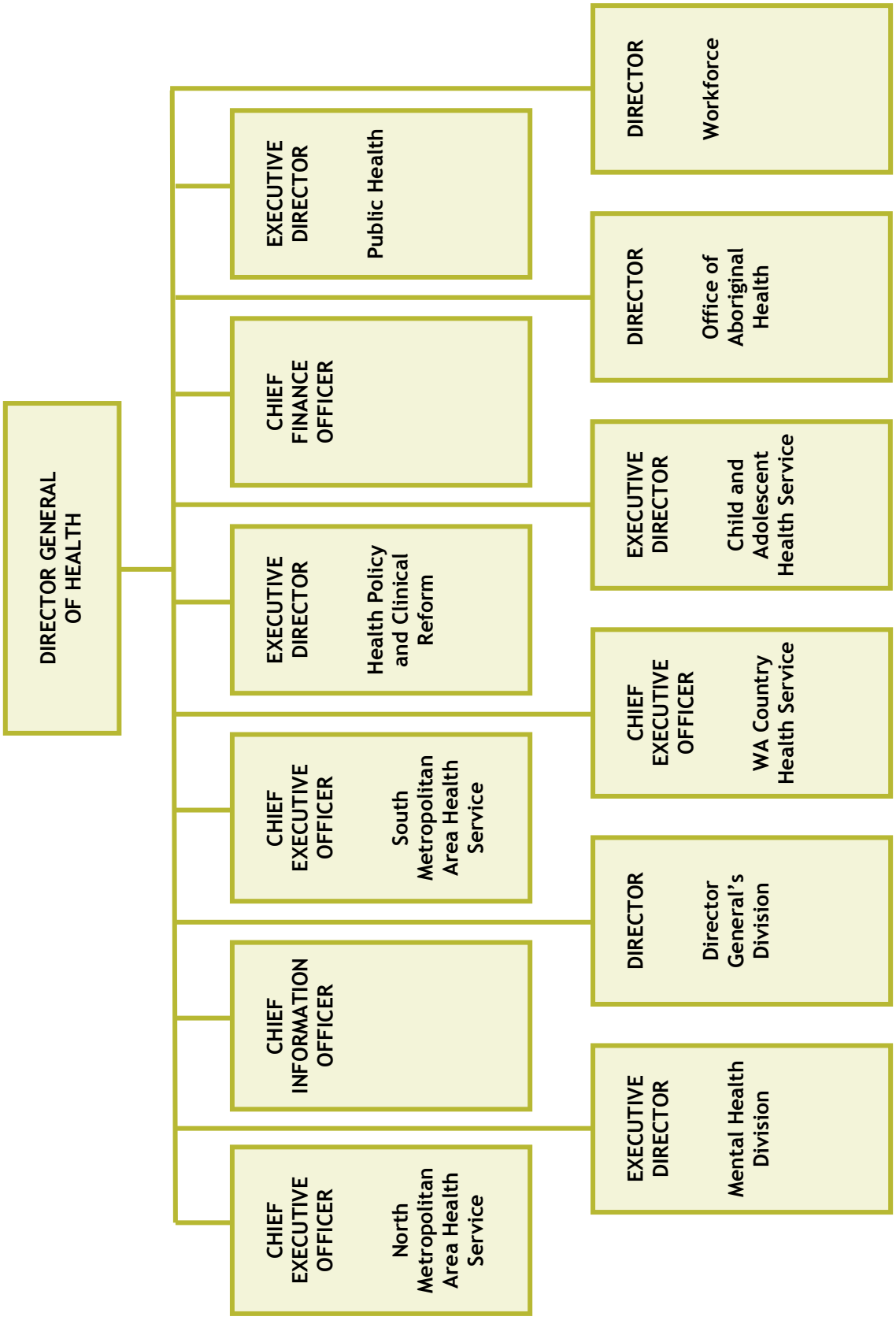
PathWest Laboratory Medicine WA		
Area of responsibility	**Title**	**Name**
Corporate Management	**Chief Executive**	**Peter Flett**
Corporate Management	Executive Director	Darryl Nicol
Corporate Management	General Manager	David Taylor
Corporate Management	Director	Frances Brogden
Corporate Management	General Manager	David Miotti
Site Management, QEII	Site Director	David Smith
Site Management, Royal Perth Hospital	Site Director	Frank Christiansen
Site Management, Child and Adolescent Health Service; Women and Newborn Health Service	Site Director	Ashleigh Murch
Site Management, Fremantle Hospital	Site Director	David McGechie

Table 5: Senior officers - Dental Health Services as at 30 June 2008

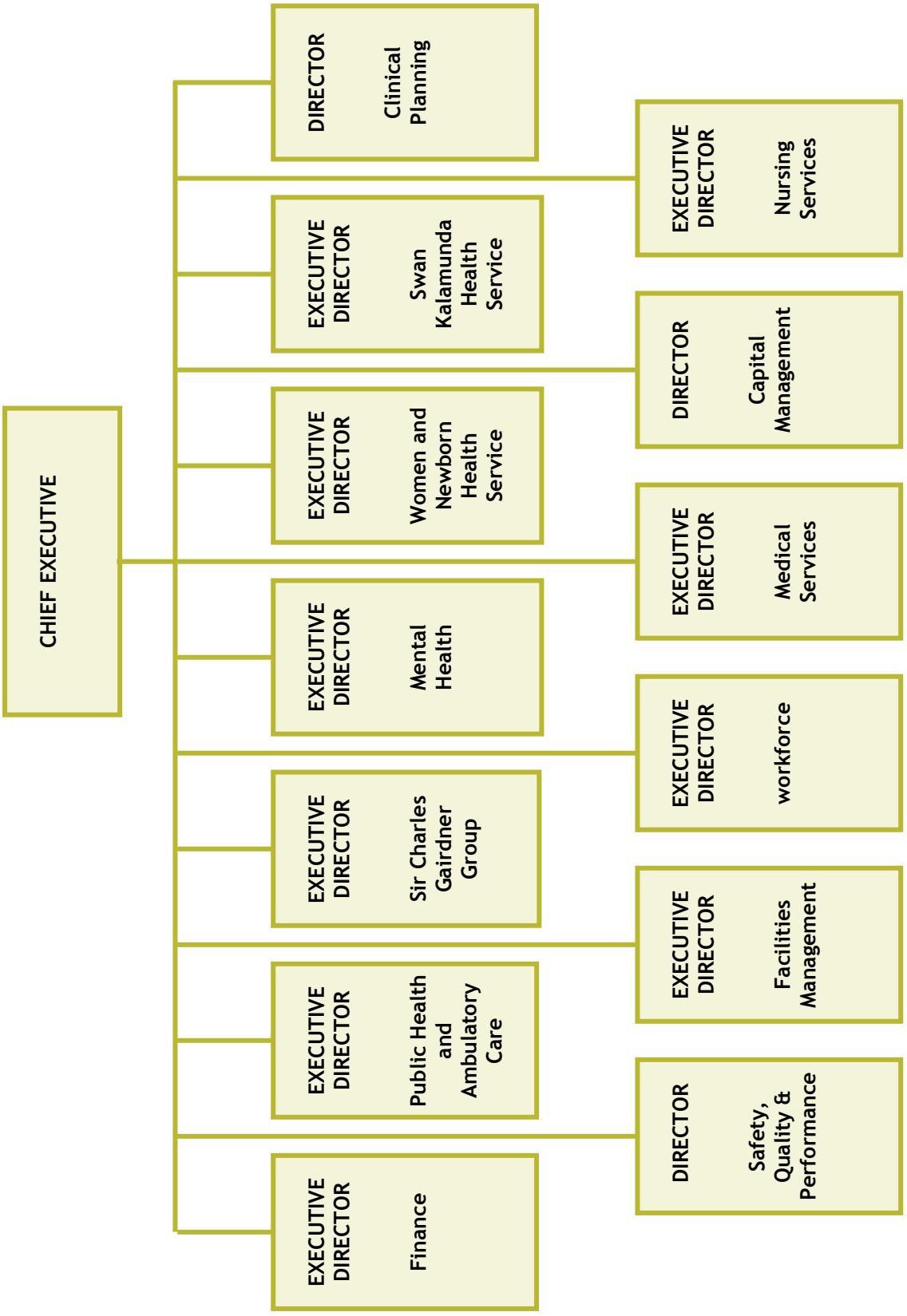
Dental Health Services		
Area of responsibility	**Title**	**Name**
Corporate Management	**Director**	**Peter Jarman**
Central Clinical & Support Services	Manager	Martin Glick
Community Dental Services	Manager	Soniya Nanda-Paul
Corporate Services	Manager	Claude Minuta
Information Systems	Manager	Glen Walker
Financial Services	Manager	Dayle Bryant

Management Structure

Department of Health State Health Executive Forum (June 2008)

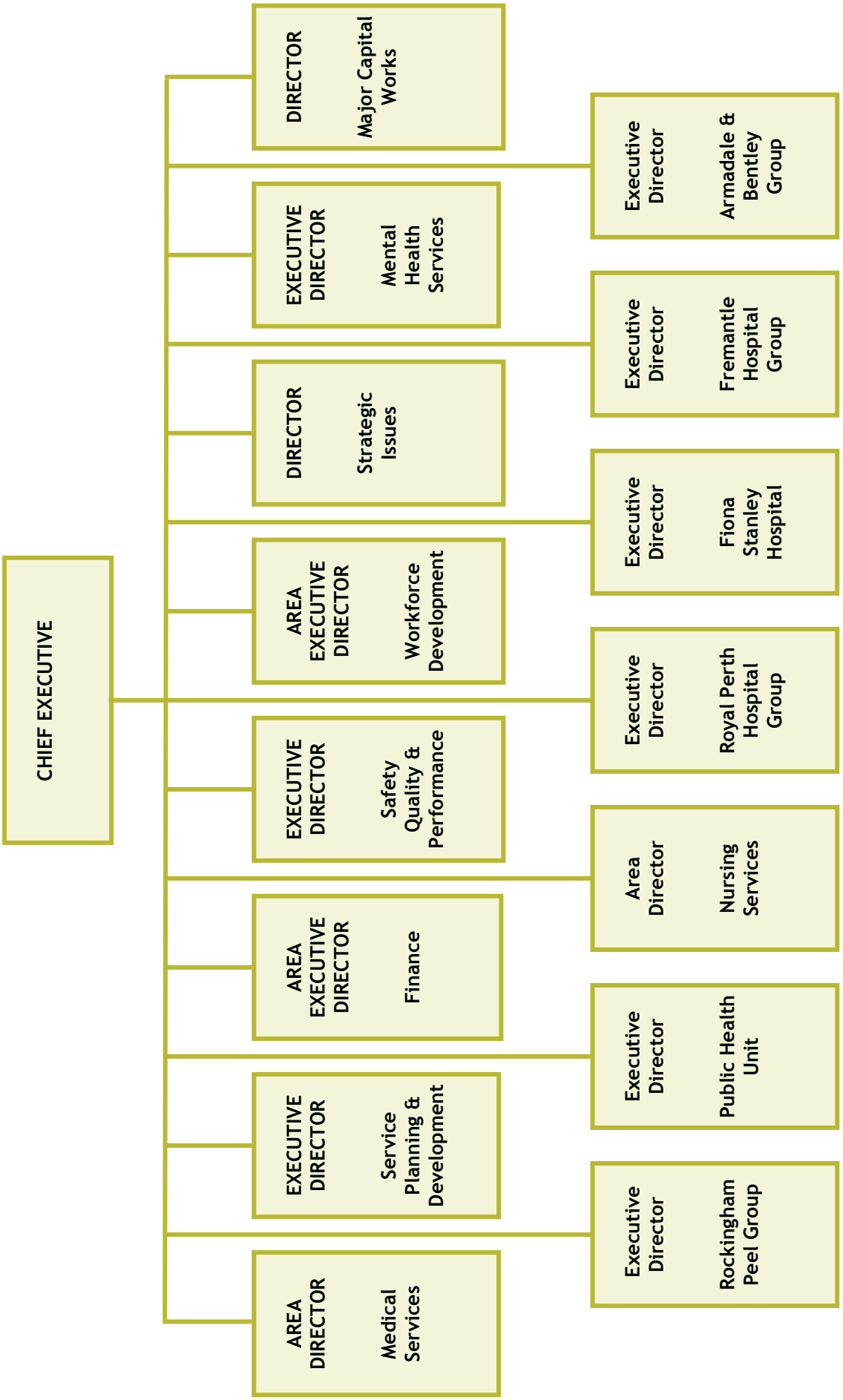


North Metropolitan Area Health Service (June 2008)

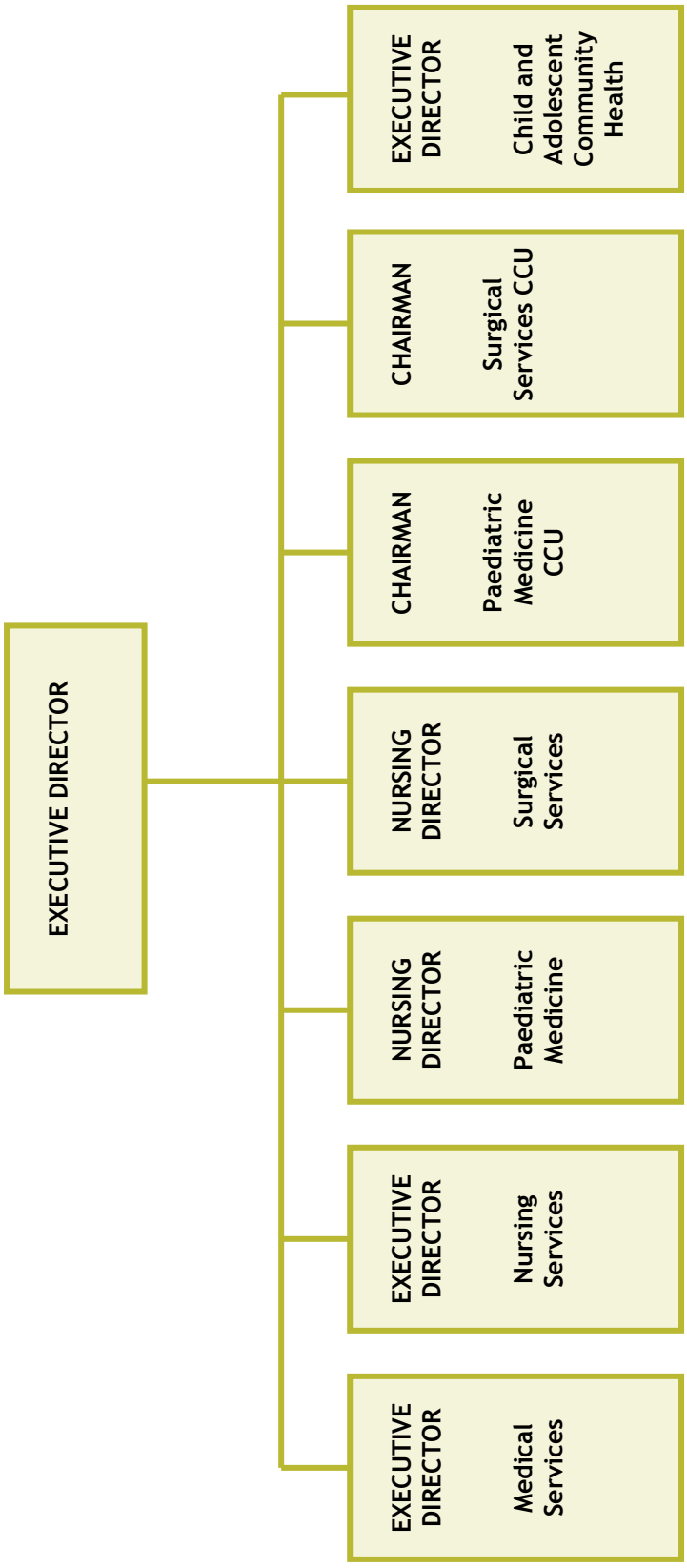


Management Structure (continued)

South Metropolitan Area Health Service (June 2008)

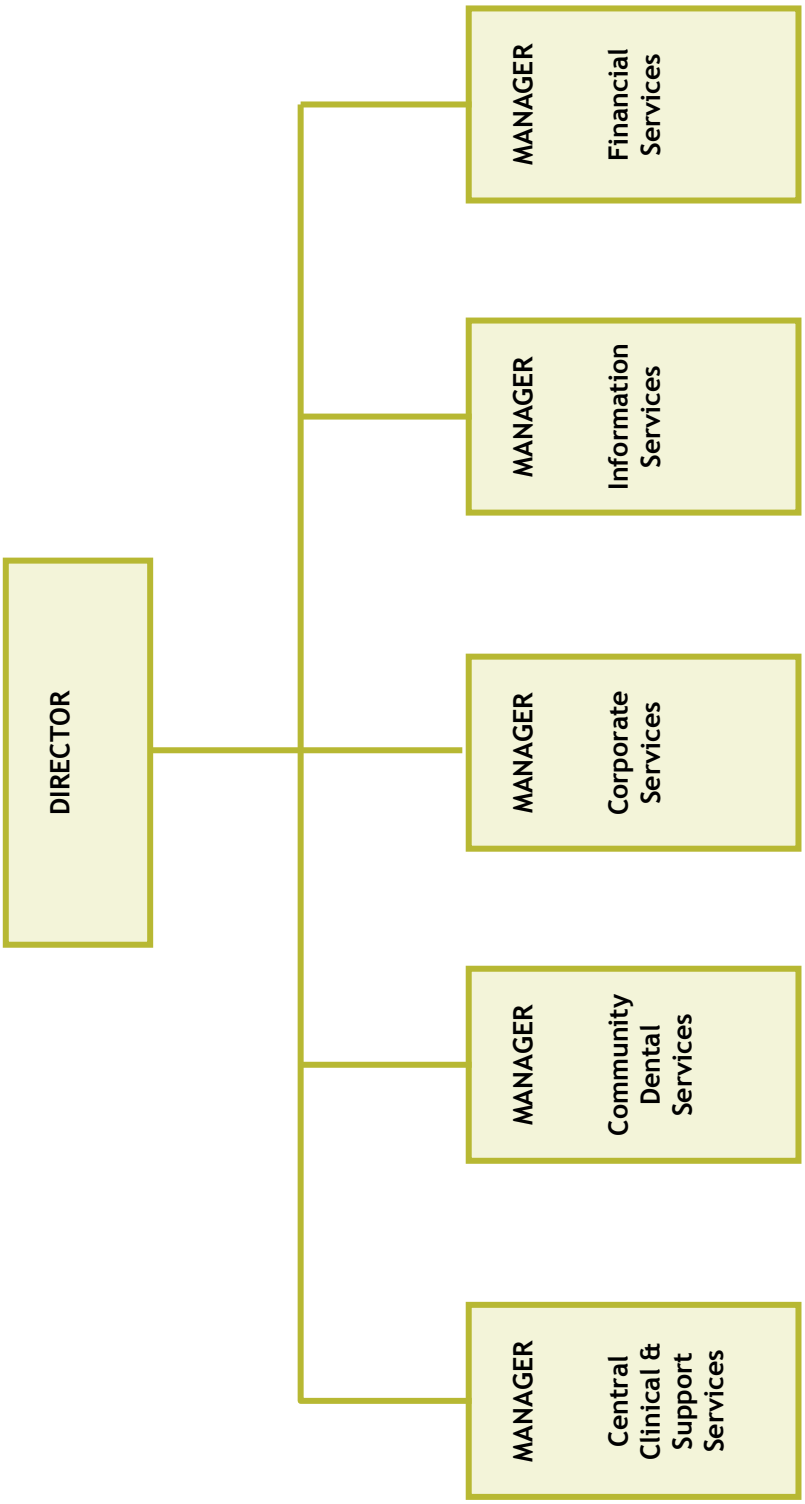


Child and Adolescent Health Service (June 2008)

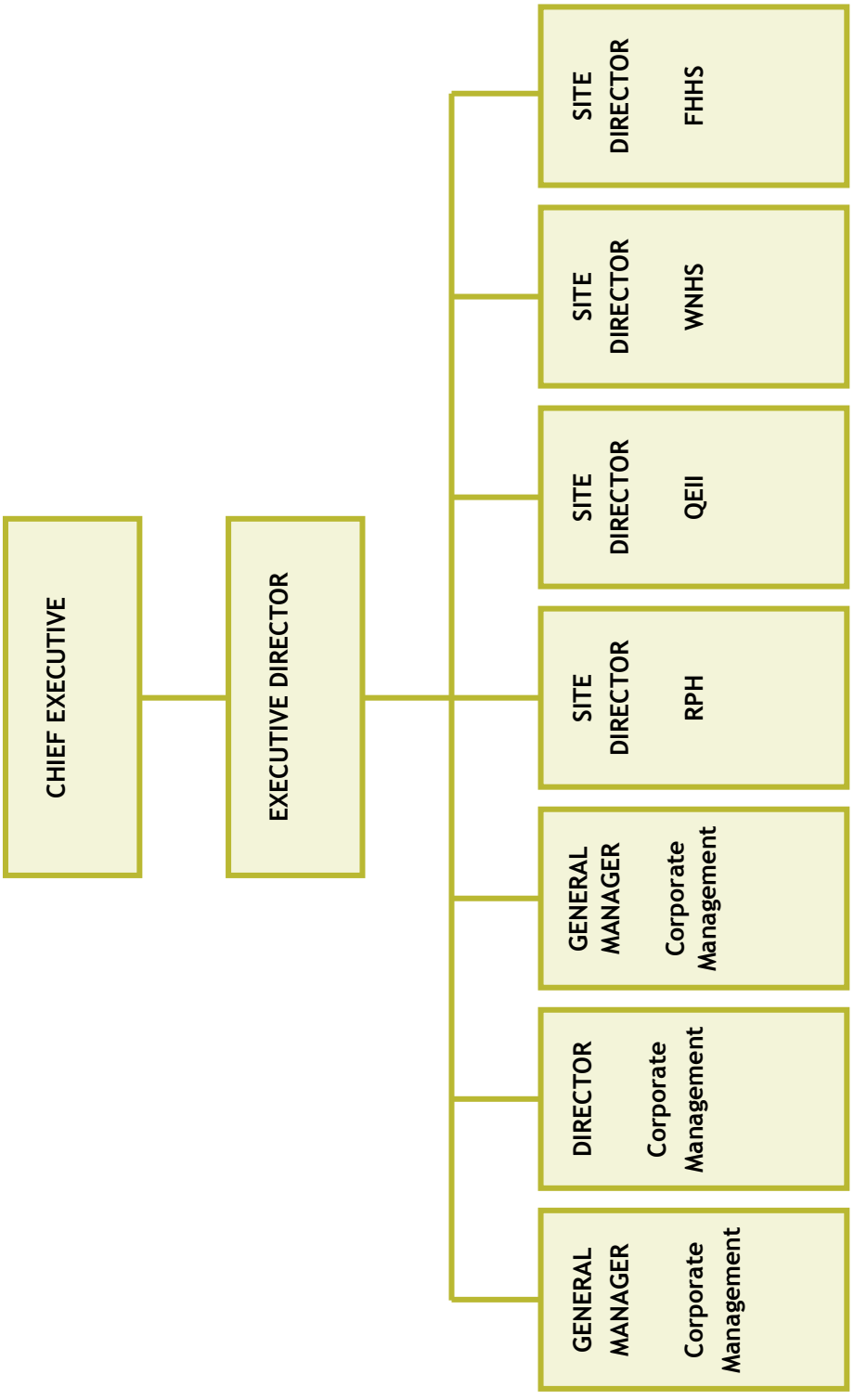


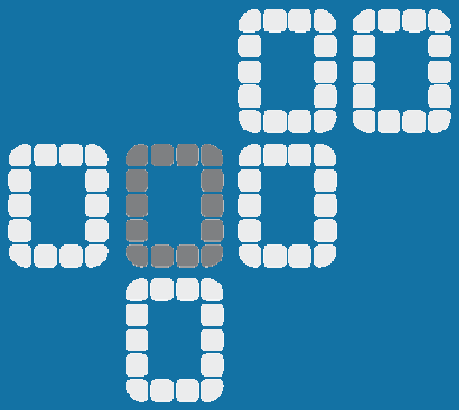
Management Structure (continued)

Dental Health Service (June 2008)



PathWest Laboratory Medicine WA (June 2008)





Key Performance Indicators

Certification Statement

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 2008

I hereby certify 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 the Deemed Board of Metropolitan Public Hospitals and fairly represent the performance of the board for the financial year ended 30 June 2008.

Dr Peter Flett
Acting Director General of Health
Accountable Authority for The Minister For Health in his Capacity as the
Deemed Board of Metropolitan Public Hospitals

17 September 2008

Audit Opinion

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 AND KEY PERFORMANCE INDICATORS
FOR THE YEAR ENDED 30 JUNE 2008

I have audited the accounts, financial statements, controls and key performance indicators of The Minister for Health in his Capacity as the Deemed Board of Metropolitan Public Hospitals .

The financial statements comprise the Balance Sheet as at 30 June 2008, and the Income Statement, Statement of Changes in Equity and Cash Flow Statement of the Metropolitan Public Hospitals for the year then ended, a summary of significant accounting policies and other explanatory Notes.

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

Director General's Responsibility for the Financial Statements and Key Performance Indicators
The Director General is responsible for keeping proper accounts, and the preparation and fair presentation of the financial statements in accordance with Australian Accounting Standards (including the Australian Accounting Interpretations) and the Treasurer's Instructions, and the key performance indicators. This responsibility includes establishing and maintaining internal controls relevant to the preparation and fair presentation of the financial statements and key performance indicators that are free from material misstatement, whether due to fraud or error; selecting and applying appropriate accounting policies; making accounting estimates that are reasonable in the circumstances; and complying with the Financial Management Act 2006 and other relevant written law.

Summary of my Role
As required by the Auditor General Act 2006, my responsibility is to express an opinion on the financial statements, controls and key performance indicators based on my audit. This was done by testing selected samples of the audit evidence. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my audit opinion. Further information on my audit approach is provided in my audit practice statement. Refer "http://www.audit.wa.gov.au/pubs/Audit-Practice-Statement.pdf".

An audit does not guarantee that every amount and disclosure in the financial statements and key performance indicators 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 and key performance indicators.

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

Audit Opinion (continued)

The Minister for Health in his Capacity as the Deemed Board of Metropolitan Public Hospitals
Financial Statements and Key Performance Indicators for the year ended 30 June 2008

Audit Opinion

In my opinion,

(i) the financial statements are based on proper accounts and present fairly the financial position of The Minister for Health in his Capacity as the Deemed Board of Metropolitan Public Hospitals at 30 June 2008 and its financial performance and cash flows for the year ended on that date. They are in accordance with Australian Accounting Standards (including the Australian Accounting Interpretations) and the Treasurer's Instructions,

(ii) the controls exercised by the Metropolitan Public Hospitals provide reasonable assurance that the receipt, expenditure and investment of money, the acquisition and disposal of property, and the incurring of liabilities have been in accordance with legislative provisions; and

(iii) the key performance indicators of the Metropolitan Public Hospitals are relevant and appropriate to help users assess the Metropolitan Public Hospitals' performance and fairly represent the indicated performance for the year ended 30 June 2008

GLEN CLARKE
ACTING AUDITOR GENERAL
22 September 2008

Page 2 of 2

Introduction

The health of the West Australian community has many determinants, including the provision of health services, access to and use of other government services and numerous environmental and social factors.

The Key Performance Indicators outlined in the following pages address the extent to which the strategies and activities of the health services contribute to the improvement of the health of the Western Australian community. This overarching goal is divided into three health outcomes:

- **Outcome 1:** Restoration of patient's health, safe delivery of newborns and support for patients and families during terminal illness
- **Outcome 2:** Improved health of people of Western Australian by reducing the incidence of preventable disease, specified injury, disability and premature death
- **Outcome 3:** Enhanced wellbeing and environment of those with chronic disease or disability.

All health entities contribute to the achievement of these outcomes, with different health service divisions taking responsibility for specific areas. While the largest proportion of health service activity is directed to Outcome 1 (particularly within the Metropolitan Health Service (MHS)), some health services within WA Country Health Service (WACHS) have proportionally more activity directed to delivering Outcome 3. Therefore, to ascertain the overall performance of the health system all of the following annual reports must be read in conjunction:

- Department of Health
- Metropolitan Health Service
- WA Country Health Service
- Drug & Alcohol Office

Peel Health Service

Commencing for 2007-08 reporting period the Key Performance Indicators (KPIs) for the Peel Health Service will be included with the Metropolitan Health Service KPIs.

Table 6: Service activities in relation to the components of the outcome

Outcome 1		Outcome 2		Outcome 3	
Service 1	Admitted patients	**Service 8**	Prevention and promotion	**Service 11**	Home and Community Care
Service 2	Specialised mental health	**Service 9**	Health protection	**Service 12**	Aged care Assessment
Service 3	Hospital in the Home	**Service 10**	Dental health	**Service 13**	Community mental health
Service 4	Palliative care			**Service 14**	Residential care
Service 5	Emergency department			**Service 15**	Residential mental health
Service 6	Non-admitted patients			**Service 16**	Chronic illness and continuing care support
Service 7	Patient transport			**Service 17**	Drug and Alcohol

Comparative Results

Where possible comparative results to prior years are provided.

Performance Targets

Performance targets have been developed for the Effectiveness and Efficiency Key Performance Indicators wherever possible. Effectiveness indicator targets have been based on published national averages for the indicators where available, or from the analysis of previous performance results. Efficiency indicator targets are those contributing to the State-wide targets published in the 2007-08 Government Budget Statements (GBS) for estimated expenditure for 2007-08.

Consumer Price Index (CPI) Deflator Series

The index figures are derived from the CPI all groups, weighted average of the eight capital cities index numbers. For the financial year series the index is the average of the December and March quarters and is rebased to reflect a five year series that appears in the annual reports. The average of the December and March quarters is used, because the full year index series is not available in time for the annual reporting cycle.

The financial year costs for the annual report can be adjusted by applying the following formula. The result will be that financial data is converted to 2003-04 dollars:

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

Table 7: Consumer Price Index figures for the financial year

Financial year	2003-04	2004-05	2005-06	2006-07	2007-08
Index (Base 2003-04)	100.00	102.48	105.44	108.44	112.34

Efficiency Indicators

The efficient use of resources can help minimise the overall costs of providing health care. The efficiency indicators included in the Annual Report describe the health service's expenditure against a selected number of activity outputs representative of the health service's provision of health care.

Outcome 1: Restoration of patients' health, safe delivery of newborns and support for patients and families during terminal illness

The achievement of this component of the health objective involves activities which:

- Ensure that people have appropriate and timely access to acute care services when they are in need of them so that intervention occurs as early as possible. Timely and appropriate access ensures that the acute illness does not progress or the effects of injury do not progress, increasing the chance of complete recovery from the illness or injury (for example access to elective surgery).
- Provide quality diagnostic and treatment services that ensure the maximum restoration to health after an acute illness or injury.
- Provide appropriate after-care and rehabilitation to ensure that people's physical and social functioning is restored as far as possible.
- Provide appropriate obstetric care during pregnancy and the birth episode to both mother and child.
- Provide appropriate care and support for patients and their families during terminal illness.

Table 8: Key Performance Indicators for Outcome 1 by reporting entity

Outcome 1	Metropolitan Health Service	Department of Health	WA Country Health Service
Restoration of patients' health	1-00 1-02 1-03	R1-50 R1-51	1-00 1-02 1-03 1-20
Timely access to admitted hospital care	1-01		1-01
Provide safe services	1-05	R1-52 R1-53	1-05
Safe delivery of newborns	1-06		1-06
Timely emergency care	1-07 1-08		1-07
Provide palliative care services		R1-54	

1-00: Proportion of public patients discharged to home after admitted hospital treatment

This indicator reports the proportion of public patients discharged to home after admitted hospital treatment.

Rationale

A direct measure of the extent to which people have been restored to health after an acute illness is that they are well enough to be discharged home after the required hospitalisation. The percentage of people discharged home over time provides an indication of how effective the public system is in restoring people to health.

The performance indicator shows the percentage of all separations for patients admitted to Metropolitan and Peel Health Service hospitals (excluding inter-hospital transfers) that are discharged home after hospital treatment.

An important indicator of how well patients have been restored to health (as well as survival rate) is that they are not readmitted to hospital for treatment of the same condition within a short time of discharge. Therefore this indicator should be examined in conjunction with KPI 1-02 and KPI 1-03.

As the normal ageing process tends to decrease a patient's chances of returning home, the figures are presented in ten-year age groups for the 2007 year. Data includes those patients separated after episodes of acute illness, rehabilitation, psycho-geriatric care and geriatric evaluation and management but excludes other care types.

Results

Metropolitan Health Service (MHS)

The overall proportion of all public patients discharged home from MHS hospitals was 98.0% and is within target. In 2007, the proportion under 40 years of age discharged to home was 98.8%, while for those over the age of 80 years the rate was 94.5%

Peel Health Service (PHS)

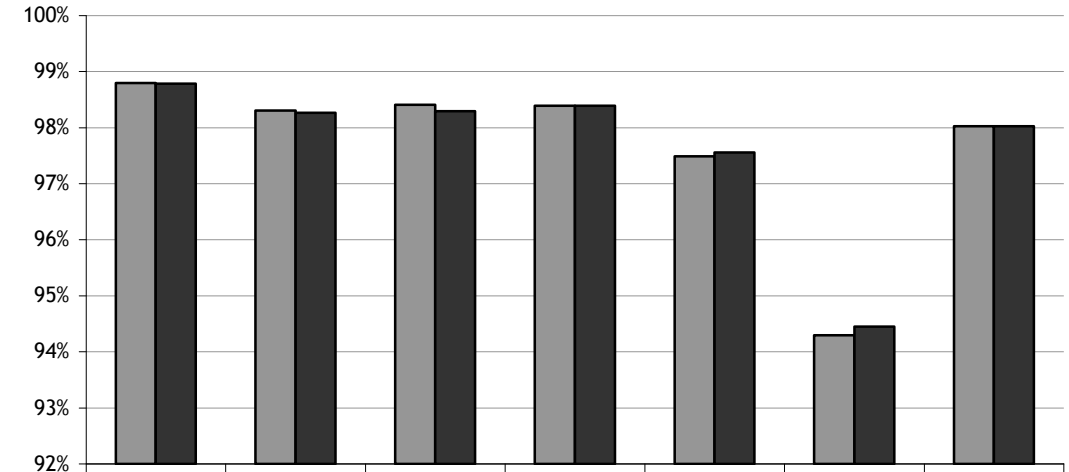
The overall proportion of all public patients discharged home from PHS hospitals was 95.2%, which did not meet the target. PHS facilities generally experience acute admissions in the higher age cohorts and this may affect the overall result.

The results for both Health Services for the age cohorts demonstrate that the probability of being restored to health (discharged home after hospitalisation) generally reduces with age. This was especially evident for the PHS where 9 of the 11 patients not discharged occurred in the two highest age cohorts.

Refer to next page for Figures 2 & 3

Figure 2: Proportion of public patients discharged to home after admitted hospital treatment in Metropolitan Health Service public hospitals

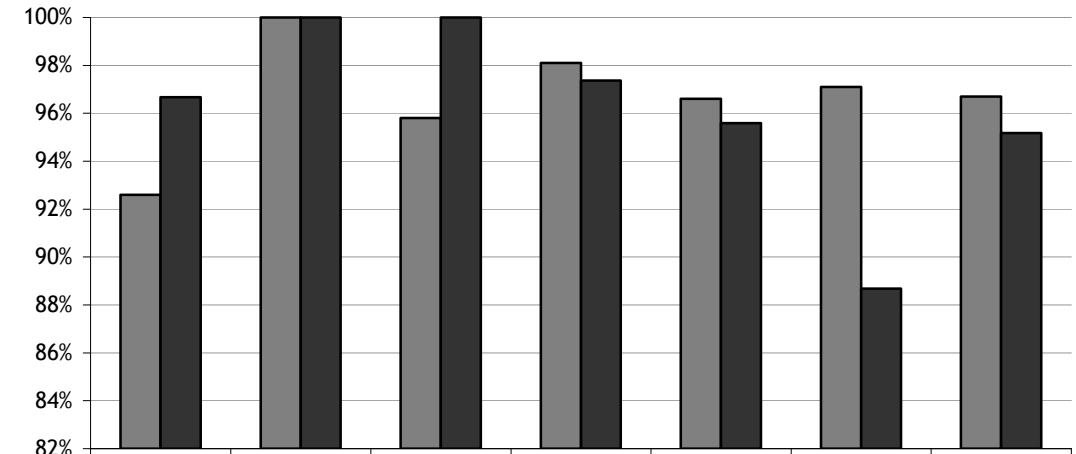
Overall (total) target ≥98%



	<40	40-49	50-59	60-69	70-79	80+	Total
2006	98.8%	98.3%	98.4%	98.4%	97.5%	94.3%	98.0%
2007	98.8%	98.3%	98.3%	98.4%	97.6%	94.5%	98.0%

Figure 3: Proportion of public patients discharged to home after admitted hospital treatment in Peel Health Service

Overall (total) target ≥98%



	<40	40-49	50-59	60-69	70-79	80+	Total
2006	92.6%	100.0%	95.8%	98.1%	96.6%	97.1%	96.7%
2007	96.7%	100.0%	100.0%	97.4%	95.6%	88.7%	95.2%

Data Source
Hospital Morbidity Data System.

1-01: Elective surgery waiting times

This indicator reports the waiting times for those elective surgery patients remaining as at 30 June 2008.

Rationale

For health services to be effective, access to there needs to be provided on the basis of clinical need. If patients requiring admission to hospital wait for long periods of time, there is the potential for them to experience an increased degree of pain, dysfunction and disability relating to their condition. After surgery, some types of patients will be restored to health, while for others, surgery will improve the quality of life.

Patients who are referred for elective surgery are classified by senior medical staff into one of the following urgency categories based on the likelihood of the condition becoming an emergency if not seen within the recommended time frame, known as the boundary.

Target

Category 1: Admission desirable within 30 days
Category 2: Admission desirable within 90 days
Category 3: Admission desirable within 365 days

Results

As at 30 June 2008 there were 84 over boundary Category 1 patients. While over boundary cases occurred in all categories as at June 30 for the Metropolitan elective surgery program, the number of over boundary cases remaining has been reduced for categories 1 and 2, and remaining relatively stable for category 3 cases compared to 30 June 2007. The median wait times for those cases remaining as at June 30 were maintained or improved in comparison to 30 June 2007 wait times.

Elective surgery capacity remains affected by the availability of surgeons and the acute demand pressure in Metropolitan hospitals. An additional factor affecting activity continues to be where patients are unwilling to accept surgery dates. Patients continue to be offered surgery at any site with capacity able to provide the level of care required to facilitate timely access to surgery.

Refer to next page for Tables 9, 10 & 11

Table 9: People remaining on the elective surgery wait list as at 30 June 2008

	Category 1			Category 2			Category 3		
	Cases	%	Median waiting time in days	Cases	%	Median waiting time in days	Cases	%	Median waiting time in days
People remaining within boundary	519	86	11	2,004	60	63	5,603	96	90
People remaining over boundary	84	14		1,344	40		240	4	

Table 10: People remaining on the elective surgery wait list as at 30 June 2007

	Category 1			Category 2			Category 3		
	Cases	%	Median waiting time in days	Cases	%	Median waiting time in days	Cases	%	Median waiting time in days
People remaining within boundary	629	80	11	2,034	55	73	5,854	96	101
People remaining over boundary	153	20		1,639	45		229	4	

Table 11: People remaining on the elective surgery wait list as at 30 June 2006

	Category 1			Category 2			Category 3		
	Cases	%	Median waiting time in days	Cases	%	Median waiting time in days	Cases	%	Median waiting time in days
People remaining within boundary	604	80	11	2,274	49	93	6,331	82	133
People remaining over boundary	147	20		2,388	51		1,382	18	

Data Source
Patient Electronic Analysis Referral Liaison System.

1-02: Rate of unplanned hospital readmissions within 28 days to the same hospital for a related condition

This indicator reports the rate of unplanned hospital readmissions within 28 days to the same hospital for a related condition.

Rationale

Good medical and/or surgical intervention together with good discharge planning will decrease the likelihood of unplanned hospital readmissions. An unplanned readmission 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 within 28 days. Unplanned readmissions 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 readmission to hospital would be planned. A low unplanned readmission rate suggests that good clinical practice is in operation. This indicator should be considered in conjunction with the indicator discharged to home KPI 1-00.

Results

The 2007-08 readmission percentages for both Metropolitan Health Service and Peel Health Service hospitals were within the target. These results suggest that good clinical practice and discharge planning are in place.

Table 12: Rate of unplanned hospital readmissions within 28 days to the same Metropolitan Health Service hospital for a related condition

	2003-04	2004-05	2005-06	2006-07	2007-08	Target
Unplanned readmission rate	1.62%	1.68%	1.77%	1.58%	1.52%	**<2.8%**

Table 13: Rate of unplanned hospital readmissions within 28 days to the same Peel Health Service hospital for a related condition

	2003-04	2004-05	2005-06	2006-07	2007-08	Target
Unplanned readmission rate	7.6%	6.2%	4.03%	5.21%	2.50%	**<2.8%**

Data Source
Hospital Morbidity Data System.

1-03: Rate of unplanned hospital readmissions within 28 days to the same hospital for a mental health condition

This indicator reports the rate of unplanned hospital readmissions within 28 days to the same hospital for a mental health condition.

Rationale

An unplanned readmission for a patient with a mental health condition is an unplanned return to hospital, as an admitted patient, for the same or related mental health 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 readmissions may indicate that improvements could be made to discharge planning or to aspects of inpatient therapy protocols. Appropriate therapy, together with good discharge planning will decrease the likelihood of unplanned hospital readmissions. Unplanned readmissions necessitate patients spending additional periods of time in hospital as well as utilising additional hospital resources.

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, readmission to hospital would be planned. A low unplanned readmission percentage suggests good clinical practice is in operation.

Results

The 2007-08 readmission percentage for all Metropolitan Health Service hospitals was low with an overall readmission rate of 5.24%. This result suggests that good clinical practice and discharge planning are in place.

The Peel Health Service recorded a mental health condition readmission rate of 25% exceeding the target. However, low numbers have a significant impact on the results and for this health service there was one unplanned readmission for a mental health condition in 2007-08.

Table 14: Rate of unplanned hospital readmissions within 28 days to the same Metropolitan Health Service hospital for a mental health condition

	2003-04	2004-05	2005-06	2006-07	2007-08	Target
Unplanned readmissions rate	4.95%	5.74%	5.72%	5.31%	5.24%	**<10%**

Table 15: Rate of unplanned hospital readmissions within 28 days to the same Peel Health Service hospital for a mental health condition

	2003-04	2004-05	2005-06	2006-07	2007-08	Target
Unplanned readmissions rate	10.00%	0.00%	14.30%	0.00%	25.00%	**<10%**

Note
A return to hospital is a readmission only if the reason for this admission is the same or is related to the condition treated in a previous admission within 28 days.

Data Source
Hospital Morbidity Data System.

1-05: Survival rates for sentinel conditions

This indicator reports the survival rates for sentinel conditions.

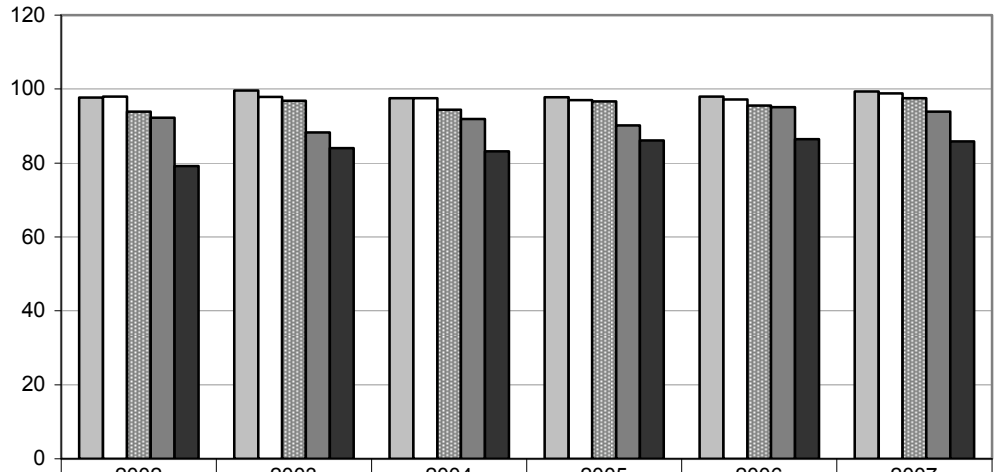
Rationale

The survival rate of patients in hospitals can be affected by many factors. This includes the diagnosis, the treatment given or procedure performed and the age, sex and condition of each individual patient. Other factors include whether the patient had other (co-morbid) conditions at the time of admission or developed complications while in hospital.

The comparison of 'whole of hospital' survival rates between hospitals may not be appropriate due to differences in mortality associated with different diagnoses and procedures. Therefore, three 'sentinel' procedures have been selected for which the survival rates are to be measured by specified age groups. These are stroke, heart attack (acute myocardial infarction - AMI) and fractured hip (fractured neck of femur - FNOF). For each of these conditions a good recovery is more likely when there is early intervention and appropriate care. Patients with these conditions are also more like to develop additional co-morbid conditions, and therefore better comparisons can be made, if comparing particular age groups, rather than the whole population.

This indicator measures the hospitals' performance in relation to restoring the health of people who have had a stroke, acute myocardial infarction or fractured neck of femur by measuring those who survive the illness and are discharged well. Following acute admission, some patients may be transferred to another hospital for specialist rehabilitation or to a hospital closer to home for additional rehabilitation.

Figure 4: Rate of acute myocardial infarction survival - Metropolitan Health Service



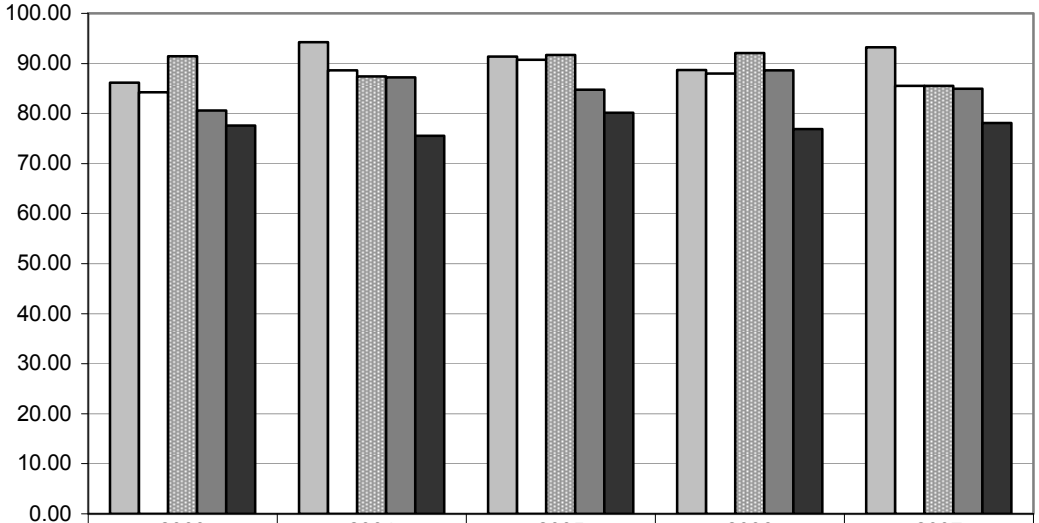
	2002	2003	2004	2005	2006	2007
0-49 years	97.67	99.56	97.56	97.79	97.92	99.33
50-59 years	97.93	97.85	97.53	96.96	97.21	98.82
60-69 years	93.93	96.86	94.42	96.63	95.57	97.52
70-79 years	92.23	88.25	91.91	90.18	95.07	93.89
80+ years	79.18	84.03	83.20	86.12	86.46	85.81

Targets
0-49 = >98%
50-59 = >97%
60-69 = >95%
70-79 = >92%
80+ = >85%

Results

For the Metropolitan Health Service the survival rates for AMI in 2007 are comparable to previous years and are all within target. The Peel Health Service reported no admissions for AMI in 2007.

Figure 5: Rate of stroke survival – Metropolitan Health Service

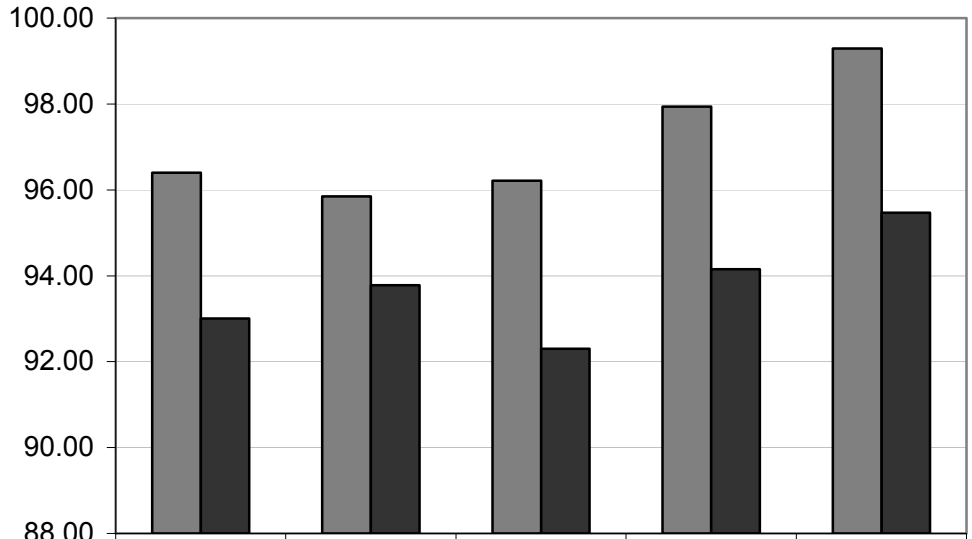


	2003	2004	2005	2006	2007
0-49 years	86.14	94.25	91.35	88.70	93.24
50-59 years	84.25	88.61	90.71	87.98	85.51
60-69 years	91.45	87.41	91.73	92.05	85.51
70-79 years	80.56	87.25	84.74	88.62	84.93
80+ years	77.58	75.57	80.13	76.90	78.07

Targets
0-49 = >92%
50-59 = >90%
60-69 = >90%
70-79 = >87%
80+ = >77%

Results
For the Metropolitan Health Service the survival rates for stroke in 2007 are generally comparable to prior years, however age groups 50-59 years, 60-69 years and 70-79 years were below the target in 2007. The Peel Health Service reported three admissions for stroke, two in the 70-79 years age cohort and one in the 80+ years age cohort and all survived.

Figure 6: Rate of fractured neck of femur survival Metropolitan Health Service



	2003	2004	2005	2006	2007
70-79 years	96.40	95.85	96.21	97.94	99.29
80+ years	93.01	93.78	92.30	94.15	95.47

Targets
70-79 = >97%
80+ = >93%

Results
For the Metropolitan Health Service the survival rate for FNOF for 2007 has improved on the previous year's results and is within target. The Peel Health Service reported no admissions for FNOF in 2007.

Data source
Hospital Morbidity Data System.

1-06: Proportion of live births with an APGAR score of 3 or less, five minutes after delivery

This indicator reports the proportion of live births with an APGAR score of 3 or less, five minutes after delivery.

Rationale

A well-managed labour will normally result in the birth of a minimally distressed infant. The level of foetal wellbeing (lack of stress or other complications or conditions) is measured five minutes post delivery by a numerical scoring system (APGAR) through an assessment of heart rate, respiratory effort, muscle tone, reflex irritability and colour.

A high average APGAR score in a hospital will generally indicate that appropriate labour management practices are employed and also is an indication of the wellbeing of the baby.

This indicator reports on the rate of babies with a low APGAR score at birth (an APGAR score of 3 or less at 5 minutes post delivery). A baby with a low APGAR is more likely to be premature with immature lungs. Alternatively the mother may have had a more difficult delivery than one with a higher score.

Results

The results for babies born in Metropolitan Health Service (MHS) hospitals are comparable to results reported in 2006. There were 12,603 babies born in metropolitan public hospitals in 2007.

Table 16: Proportion of live births with an APGAR score of 3 or lower, five minutes after delivery

Birthweight (grams)	Proportion of babies %		Target (National)
	2006	2007	
0 - 1499	6.57	7.97	**≤13.80%**
1500 - 1999	0.35	1.28	**≤1.10%**
2000 - 2499	0.32	0.44	**≤0.50%**
2500 and over	0.14	0.11	**≤0.10%**

Note
Factors other than hospital maternity services can influence Apgar scores within birth weight categories – for example antenatal care, multiple births and socioeconomic factors.

Data Sources
Midwives Notification System
Report on Government Services 2008

1-07: 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 nursing staff who judge how urgently treatment should be provided. The aim of this process (known as triage) is to ensure treatment is given in the appropriate time. This should prevent adverse conditions arising from deterioration in the patient's condition. Treatment within recommended times should assist in the restoration to health either during the emergency visit or the admission to hospital that may follow Emergency Department care.

A patient is allocated a triage code between 1 and 5 that indicates their urgency (see below). This code provides an indication of how quickly patients should be reviewed by medical staff.

The triage process and scores are recognised by the Australasian College for Emergency Medicine and recommended for prioritising those who present to an Emergency Department. In a busy Emergency Department when several people present at the same time, the service aims for the best outcome for all. Treatment should be within the recommended time of the triage category allocated.

This indicator measures the percentage of patients in each triage category who were seen within the time periods recommended by the Australasian College for Emergency Medicine (ACEM) and is reported for those sites that meet the criteria to be designated an emergency department.

Results

While only achieving the benchmark for triage category 5 the results for triage categories 1 and 2 improved compared to 2006-07.

The principal factors contributing to patients not being seen within recommended times for categories 1, 2, 3 and 4 continues to be the increase in emergency department attendances driven by a growing metropolitan population, the increasing attendance of patients assessed to have the most urgent triage category 1, 2 or 3 conditions and the lack of available general practitioners in the community. These factors have substantially increased demand on emergency departments.

The Metropolitan Health Service continues to review, develop and implement strategies to improve the results recorded for this indicator.

Table 17: Proportion of emergency department patients seen within recommended times

	2003-04	2004-05	2005-06	2006-07	2007-08	Target
Triage category 1 (within 2 mins)	99.87%	99.7%	97.9%	97.8%	98.8%	**100%**
Triage category 2 (within 10 mins)	68.23%	74.3%	74.3%	67.1%	67.8%	**80%**
Triage category 3 (within 30 mins)	59.08%	59.5%	60.6%	52.0%	48.6%	**75%**
Triage category 4 (within 60 mins)	51.53%	53.6%	54.2%	49.7%	47.5%	**70%**
Triage category 5 (within 2 hours)	67.15%	75.3%	77.3%	75.5%	77.5%	**70%**

Data Source
Emergency Department Data Collection.

1-08: Percentage of admitted patients transferred to an inpatient ward within 8 hours of emergency department arrival

This indicator reports the percentage of admitted patients transferred to an inpatient ward within 8 hours of emergency department arrival.

Rationale

Emergency departments are specialist multidisciplinary units with expertise in managing acutely unwell patients for the first few hours in hospital. Queuing for initial care in emergency departments is managed by triage, which stratifies patients by urgency and ensures the most time-critical cases are seen first. Once it has been determined that a patient needs admission to a hospital bed the time until admission to a ward usually depends on the availability of a bed in the appropriate ward, for example cardiology, orthopaedic surgery, plastic surgery.

Most patients who require a bed will benefit from early transfer to the unit which can best treat the condition which requires the patient to be treated as an admitted patient. Patients may be restored to health more quickly and there may be less adverse incidents when overcrowding in emergency departments is limited. Timely movement of admitted patients to inpatient wards from the emergency department is desirable.

This indicator measures the percentage of patients who were transferred to an inpatient ward in less than or equal to 8 hours.

Results

In Metropolitan hospitals 62.7% of people who needed admission were admitted within 8 hours to an inpatient ward and did not meet the prescribed target. Metropolitan hospitals' occupancy rates continue to affect their ability to transfer patients to inpatient wards.

Table 18: Percentage of admitted patients transferred to an inpatient ward within 8 hours of emergency department arrival

	Percentage 2007	Target
Patients transferred to inpatient ward within 8 hours from emergency department	62.7%	**65%**

Note

No prior year comparison is provided for this Key Performance Indicator as the methodology for the indicator has been modified to conform to Emergency Department activity definitions developed by the Western Australian Health Management Information Group and used for other reporting forums.

Data source

Emergency Department Data Collection.

S1-00: Average cost per casemix adjusted separation for teaching hospitals

This indicator reports the average cost per casemix adjusted separation for teaching hospitals.

Rationale

The use of casemix for reporting hospital activity is a recognised methodology for adjusting actual activity data to reflect the complexity of health care provided against the resources allocated. Hence, the number of separations in a hospital may be adjusted from the actual raw number by a casemix index to reflect the complex service provided.

WA hospitals utilise the Australian Refined National Diagnostic Related Groups (AR-DRGs) to which cost weights are allocated.

This indicator measures the average cost of a casemix-adjusted separation in teaching hospitals. Separate results are reported for teaching and non-teaching sites as it is expected that the level of case acuity will be higher at teaching sites than that at non-teaching sites.

Results

In 2007-08 the average cost per casemix adjusted separation for teaching hospitals was $5,123 exceeding the target. This result reflects the additional costs incurred especially in relation to clinically-based services.

Table 19: Average cost per casemix adjusted separation for teaching hospitals

	2003-04	2004-05	2005-06	2006-07	2007-08	Target
Actual cost	$4,034	$4,365	$4,612	$4,862	$5,123	**$4,794**
CPI adjusted	$4,034	$4,259	$4,374	$4,484	$4,560	

Data Sources
Hospital Morbidity Data System.
Health Service Financial System.

Note
Statewide corporate costs have been apportioned to this key performance indicator.
This indicator does not include specialised mental health unit activity. (See KPIs 2-00 and 2-01)

S1-01: Average cost per casemix adjusted separation for non-teaching hospitals

This indicator reports the average cost per casemix adjusted separation for non-teaching hospitals.

Rationale

The use of casemix for reporting hospital activity is a recognised methodology for adjusting actual activity data to reflect the complexity of health care provided against the resources allocated. Hence, the number of separations in a hospital may be adjusted from the actual raw number by a casemix index to reflect the complex service provided.

WA hospitals utilise the Australian Refined National Diagnostic Related Groups (AR-DRGs) to which cost weights are allocated.

This indicator measures the average cost of a casemix-adjusted separation in non-teaching hospitals. Separate results are reported for teaching and non-teaching sites as it is expected that the level of case acuity will be higher at teaching sites than that at non-teaching sites.

Results

In 2007-08 the average cost per casemix adjusted separation for non-teaching hospitals was $4,437 and was over target. Metropolitan non-teaching hospitals in 2007-08 experienced a small reduction in weighted separations compared to 2006-07 although the total number of separations for the Metropolitan non-teaching hospitals remains comparable to prior years. This result also reflects additional costs incurred especially in relation to clinically-based services.

Table 20: Average cost per casemix adjusted separation for non-teaching hospitals

	2003-04	2004-05	2005-06	2006-07	2007-08	Target
Actual cost	$2,800	$3,070	$3,445	$4,040	$4,437	**$3,652**
CPI adjusted	$2,800	$2,996	$3,267	$3,725	$3,950	

Data Sources
Hospital Morbidity Data System.
Health Service Financial System.

Note
Statewide overhead costs have been apportioned to this key performance indicator.
This indicator does not include specialised mental health unit activity. (see KPIs 2-00 and 2-01)

S1-02: Average cost per occasion of service for PathWest functions performed at, or managed by, the QEII site of PathWest

This indicator reports the average cost of service for PathWest functions performed at the PathWest QEII site.

Rational

PathWest currently provides pathology services to meet the requirements of the Department of Health, public hospitals, private patients, medical practitioners and any other person or body. It also provides clinical teaching and research facilities and acts as a reference centre and centre for excellence for pathology services. Advice is provided to the Department of Health and other State Departments, the Commonwealth or any local authority that seeks advice.

The efficiency of PathWest can be gauged by measuring the average cost of its various services.

Results

Average cost per occasion of service for all services provided at the QEII site of PathWest is $21.96 within the prescribed target.

Table 21: Average cost per occasion of service for PathWest functions performed at, or managed by, the QEII site of PathWest

Service		2005-06	2006-07	2007-08	Target
PathWest (QEII site) Clinical Pathology	Actual Cost	$11.13	$13.55	$12.79	n/a
	CPI adjusted	$10.56	$12.50	$11.39	
PathWest (QEII site) Microbiology	Actual Cost	$22.35	$25.21	$23.03	n/a
	CPI adjusted	$21.20	$23.25	$20.50	
PathWest (QEII site) Tissue Pathology	Actual Cost	$143.16	$160.70	$187.44	n/a
	CPI adjusted	$135.77	$148.19	$166.85	
PathWest Branch Laboratories	Actual Cost	$20.63	$19.63	$20.97	n/a
	CPI adjusted	$19.57	$18.10	$18.67	
Total	Actual Cost	$21.93	$23.64	$21.96	**$22**
	CPI adjusted	$20.80	$21.80	$19.55	

Notes

1. An occasion of service refers to a laboratory test (or group of tests commonly performed as a panel).
2. Branch laboratories are those laboratories administered by the QEII site and situated in metropolitan and rural non-teaching hospitals/health centres.
3. PathWest expenditure directly relating to Royal Perth Hospital, Fremantle Hospital, King Edward Memorial Hospital and Child and Adolescent Health Service has been apportioned across MHS key performance indicators.

S1-20: Average cost per bedday for admitted patients (small hospitals)

This indicator reports the average cost per bedday for admitted patients for the Peel Health Service.

Rationale

While the use of casemix is a recognised methodology for measuring the cost and complexity of admitted patients in hospitals where there is a wide range of different medical and surgical patients, it is not the accepted method of costing patients in small rural hospitals.

Most small hospitals do not have the advantage of economies of scale. Minimum nursing services may have to be rostered for very few patients.

Accordingly these hospitals report patient costs by bed-days. This indicator measures the cost per bed-day for admitted patients.

Results

In 2007-08 the average cost per bedday for admitted patients for the Peel Health Service was $821, under the target. This was primarily due to increased activity within the economies of scale, reducing the average cost.

Table 22: Average cost per bedday for admitted patients Peel Health Service

	2003-04	2004-05	2005-06	2006-07	2007-08	Target
Actual cost	$693	$892	$917	$1,141	$821	**$958**
CPI adjusted	$693	$870	$870	$1,052	$731	

Data Source
Hospital Morbidity Data System
Area Health Service Financial Systems

S2-00: Average cost per bedday in an specialised mental health units

This indicator reports the average cost per bedday in specialised mental health units.

Rationale

The variations in care and episode characteristics for patients receiving admitted mental health care compared to other types of admitted care can result in differences in the service costs. It has therefore been recognised that for quality and cost effectiveness for the services provided under admitted mental health activity is better reported separately to other admitted activity and for beddays provided rather by a weighted separation.

These are hospitals or hospital wards devoted to the treatment and care of patients with psychiatric, mental or behavioural disorders that are by law able to admit people as involuntary patients for psychiatric treatment.

This indicator measures the average cost per bed day in specialised mental health units in the metropolitan area and includes authorised and designated mental health units in.

- Graylands Hospital
- Bentley Health Service - Mills St Centre and CAMHS Unit
- Alma Street Centre, Fremantle
- Armadale Adult Mental Health Service
- Swan Adult Mental Health Centre
- Ward 2K RPH, Ward 4H PMH, Mother/ Baby Unit KEMH, Ward D20 – SCGH

Results

In 2007-08 the average cost per bedday in a specialised mental health unit was $920 and exceeded the prescribed target. This was due primarily to incurring full operating costs at several expanding designated units while they worked to achieve optimum occupancy.

Table 23: Average cost per bedday in an specialised mental health unit

	2003-04	2004-05	2005-06	2006-07	2007-08	Target
Actual cost	$737	$751	$815	$915	$920	**$866**
CPI adjusted	$737	$733	$773	$844	$819	

Data Sources
Mental Health Information System.
Health Services Financial System.

Note
Statewide overhead costs have been apportioned to this key performance indicator.

S2-01: Average cost per bedday in older persons mental health inpatient units

This indicator reports the average cost per bedday in older persons' mental health inpatient units.

Rationale

The variations in care and episode characteristics for patients receiving admitted mental health care compared to other types of admitted care can result in differences in the service costs. It has therefore been recognised that for quality and cost effectiveness for the services provided under admitted mental health are better reported separately to other admitted activity and for beddays provided rather by a weighted separation.

The older persons' mental health inpatient units are dedicated wards or units that provide care for older persons with age-related brain impairment due to injury or disease with significant behavioural or late onset psychiatric disturbance, or a physical condition accompanied by severe psychiatric or behavioural disturbance.

This indicator measures the average cost per bed day in older persons' mental health inpatient units and includes:

- Armadale Seniors Mental Health Service
- Bentley Elderly Mental Health Service
- Osborne Park Older Adult Mental Health Unit
- Boronia Inpatient Unit (Swan Mental Health Service)
- Fremantle Seniors Mental Health Services
- Selby Lemnos Adult Mental Health Unit

Results

In 2007-08 the average cost per bedday in older persons' mental health inpatient units was $694 and was within the prescribed target.

Table 24: Average cost per bedday in older persons' mental health inpatient units

	2003-04	2004-05	2005-06	2006-07	2007-08	Target
Actual cost	$641	$660	$741	$728	$694	**$786**
CPI adjusted	$641	$664	$703	$671	$618	

Data Sources
Mental Health Information System.
Health Services Financial System.

Note
Statewide overhead costs have been apportioned to this key performance indicator.

S3-00: Average cost per Hospital in the Home patient day

This indicator reports the average cost per Hospital in the Home (HITH) patient day.

Rationale

Hospital in the Home (HITH) and Rehabilitation in the Home (RITH) are recognised methods of providing acute medical care for some patients in their home environment. The medical governance for the patient care remains with the hospital physician and may be a full episode of care or part of an episode of care.

Results

The average cost per Hospital in the Home patient day was $283 and was over the prescribed target. This result reflects additional costs incurred especially in relation to clinically-based services.

Table 25: Average cost per Hospital in the Home patient day

	2006-07	2007-08	Target
Actual cost	$204	$283	**$225**
CPI adjusted	$188	$252	

Data Source
TOPAS
Health Services Financial System.

Note
Statewide overhead costs have been apportioned to this key performance indicator.

S5-00: Average cost per emergency department presentation for Metropolitan Health Service hospitals

This indicator reports the average cost per emergency department presentation for Metropolitan Health Service hospitals.

Rationale

The efficient use of hospital resources can help minimise the overall costs of providing health care, or provide for more patients to be treated for the same amount of resources.

Variations in patient-mix between sites and across time result in some differences in service delivery costs. It is important to monitor the unit cost of this part of the acute health service that is often the first point of contact with hospitals for residents of the community.

This indicator measures the average cost per presentation at the Emergency Department.

Results

In 2007-08 the average cost per emergency department presentation for Metropolitan Health Service hospitals was $427 and exceeded the prescribed target. This result reflects additional costs incurred especially in relation to clinically-based services.

Table 26: Average cost per emergency department presentation for Metropolitan Health Service hospitals

	2003-04	2004-05	2005-06	2006-07	2007-08	Target
Actual cost	$324	$348	$369	$390	$427	**$384**
CPI adjusted	$324	$340	$350	$360	$380	

Data Sources
Mental Health Information System.
Health Services Financial System.

Note
Statewide overhead costs have been apportioned to this key performance indicator.

S6-00: Average cost per doctor-attended episode in an outpatient clinic for Metropolitan Health Service hospitals

This indicator reports the average cost per doctor attended outpatient episode for Metropolitan Health Service hospitals.

Rationale

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

Variations in patient characteristics and clinic types between sites and across time may result in some differences in service delivery costs. It is important to monitor the unit cost of this non-admitted component of hospital care in order to ensure their overall quality and cost effectiveness.

This indicator measures the average cost per doctor attended outpatient clinic service.

Results

In 2007-08 the average cost per doctor-attended episode in an outpatient clinic for Metropolitan Health Service hospitals was $282 exceeding the target. This result reflects additional costs incurred especially in relation to clinically-based services.

Table 27: Average cost per doctor attended outpatient episode for Metropolitan Health Service hospitals

	2003-04	2004-05	2005-06	2006-07	2007-08	Target
Actual cost	$164	$184	$196	$222	$282	**$207**
CPI adjusted	$164	$180	$186	$205	$251	

Data Sources
The Open Patient Accounting System.
Health Service Financial System.

Note
Statewide overhead costs have been apportioned to this key performance indicator.

S6-01: Average cost per non-admitted occasion of service for Metropolitan Health Service hospitals (excludes emergency and doctor attended outpatients occasions)

This indicator reports the average cost per non-admitted occasion of service for Metropolitan Health Service hospitals (excludes emergency and doctor attended outpatients occasions).

Rationale

Variations in patient characteristics and clinic service types between sites and across time may result in some differences in service delivery costs. It is important to monitor the unit cost of this non-admitted component of hospital care in order to ensure their overall quality and cost effectiveness.

This indicator measures the average cost per non-inpatient occasion of service, incorporating hospital and non-hospital based services that are financially aligned to the Metropolitan Area Health Services.

Results

In 2007-08 the average cost per non-admitted occasion of service for Metropolitan Health Service hospitals (excluding emergency and doctor attended outpatients occasions) was $171 exceeding the target. Compared to 2006-07 this result reflects an increase in the number of occasions of service provided. Also please note that the target set in the Government Budget Statements in May 2007 was understated as the activity to be provided in 2007-08 was significantly over-estimated.

Table 28: Average cost per non-admitted occasion of service for Metropolitan Health Service hospitals (excludes emergency and doctor attended outpatients occasions)

	2006-07	2007-08	Target
Actual cost	$221	$171	**$117**
CPI adjusted	$204	$152	

Data Sources
Health Services Information System.
Health Services Financial Information.

Note
Statewide overhead costs have been apportioned to this key performance indicator.

S6-20: Average cost per non-admitted hospital based service for rural hospitals

This indicator reports the average cost per non-admitted hospital based service in the Peel health Service.

Rationale

Variations in patient characteristics and clinic service types between sites and across time can result in differences in service delivery costs. It is important to monitor the unit cost of this non-admitted component of hospital care in order to ensure overall quality and cost effectiveness.

This indicator measures the average cost per hospital based non-admitted occasion of service.

Results

In 2007-08 the average cost per non-admitted hospital based service was $56.15. This result reflects increased activity provided within the allocated resources.

Table 29: Average cost per bedday for non-admitted patients Peel health Service

	2003-04	2004-05	2005-06	2006-07	2007-08	Target
Actual cost	$62.84	$78.28	$80.93	$86.29	$56.15	**$85**
CPI adjusted	$62.84	$76.39	$76.75	$79.57	$49.98	

Data Source
Hospital Morbidity Data System, Information Management and Reporting.
Health Services Financial Information.

Note
Statewide overhead costs have been apportioned to this key performance indicator.

S7-20: Average cost of Patient Assisted Travel Scheme

This indicator reports the average cost of Patient Assisted Travel Scheme (PATS) provided at the Peel Health Service.

Rationale

The aim of PATS is to allow permanent country residents to access the nearest medical specialist and specialist medical services. A subsidy is provided towards the cost of travel and accommodation for patients and where necessary an escort for the patient. Assistance is provided to the residents of Peel living between 70kms and 100kms from Perth, subject to certain conditions. Without travel assistance many people would be unable to access the services needed to diagnose or treat some conditions.

Results

In 2007-08 the average cost of PATS was $31.17 exceeding the target.

Table 30: Average cost of Patient Assisted Travel Scheme

	2003-04	2004-05	2005-06	2006-07	2007-08	Target
Actual cost	$27.10	$25.55	$21.08	$26.38	$31.17	**$22**
CPI adjusted	$27.10	$24.93	$19.99	$24.33	$27.75	

Data Source
Health Service PATS activity data.
Health Services Financial Information.

Note
Statewide overhead costs have been apportioned to this key performance indicator.

Outcome 2: Improved health of the people of Western Australia by reducing the incidence of preventable disease, specified injury, disability and premature death

The achievement of this component of the health objective involves activities which:

1. Increase the likelihood of optimal health and wellbeing by:
   - Providing programs which support the optimal physical, social and emotional development of infants and children.
   - Encouraging healthy lifestyles (eg diet and exercise).
2. Reduce the likelihood of onset of disease or injury by:
   - Delivering immunisation programs.
   - Delivering safety programs.
   - Encouraging healthy lifestyles (eg diet and exercise).
3. Reduce the risk of long-term disability or premature death from injury or illness through prevention, early identification and intervention, such as:
   - Programs for early detection of developmental issues in children and appropriate referral for intervention.
   - Early identification of disease and disabling conditions (breast and cervical cancer screening, screening of newborns) with appropriate intervention referrals.
   - Programs which support self-management by people with diagnosed conditions and disease (diabetic education).
4. Monitor the incidence of disease in the population to determine the effectiveness of primary health measures.

Table 31: Key Performance Indicators for Outcome 2 by reporting entity

Outcome 2	Metropolitan Health Service	Department of Health	WA Country Health Service
Prevention and promotion activities	2-00 2-01 2-02	R2-50	2-01 2-02
Health protection		R2-51 R2-52	R2-51 R2-52
Dental health services	2-03 2-04 2-05 2-06	R2-53	

This section contains population-based indicators. The residential postcode of the individual receiving the service allows for epidemiological comparisons and is not the postcode of the location where the service was provided. Where appropriate, performance measurement for these indicators is provided for both Aboriginal and non-Aboriginal populations.

2-00: Loss of life from premature death due to identifiable causes of preventable disease (breast and cervical cancer)

This indicator reports the loss of life from premature death due to breast and cervical cancer.

Rationale

This indicator measures the impact of major illness prevention programs that reduce the incidence of breast and cervical cancer.

Cancer is one of the seven National Health Priority areas for preventable diseases and injury. As death from preventable diseases and injury contributes significantly to the total years of life lost from all preventable deaths that occurred prior to the age of 74, it is evident that these conditions should be targeted.

Person Years of Life Lost (PYLL) are used to reflect the impact of premature deaths. Deaths occurring in Western Australia and Australia over the period 1997 to 2006 from the two types of cancer illustrate the impact of the preventative programs. PYLL should be lower if the programs are successfully meeting needs.

Results

The result for cervical cancer for annual PYLL per 1,000 in the WA population has seen the decreasing trend shown over the past ten years continued.

The overall trend for breast cancer in annual PYLL per 1,000 in the WA population has been decreasing over the period 1997 to 2006, although there have been annual fluctuations.

Table 32: Person years of life lost from breast and cervical cancer

	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	Target
Breast Cancer	4.8	3.8	4.4	3.4	3.4	3.9	3.7	3.2	3.0	3.4	**3.8**
Cervical cancer	0.5	0.6	0.6	0.5	0.5	0.4	0.6	0.4	0.4	0.4	**0.4**

Notes

a. Age- standardised PYLLs up to 74 years of age per 1,000 population.

b. The following ICD-10 and 9-CM codes were used to select deaths for conditions known to be largely preventable.

Breast cancer	174.0 to 174.9	C50.0 to C50.9
Cervical cancer	180.0 to 180.9	C53.0 to C53.9

c. Although not all cases of these conditions will be avoidable, it is very difficult to assess what proportion was avoidable without extensive meta-analysis of the literature. The conditions identified above are those for which the Department of Health has screening or health promotion programs. Premature deaths from these causes should be largely preventable

d. Additional deaths registered in years following the year of occurrence may result in slight changes in some data shown in this report compared with previous years. Due to some cases still being before the Coroner's office, some deaths occurring in 2004 were not registered by the Australian Bureau of Statistics until 2005 and were not included in this analysis. The preliminary nature of the 2004 death data is likely to affect the calculation of PYLLs for conditions, which contribute to the greatest proportion of deaths. Consequently no trend analysis was applied to these data. Non-WA residents who died in WA were included. PYLL calculations were based on three year moving averages.

e. Person Years of Life Lost have been recalculated for all years as the method of calculation has been improved. The new method has resulted in higher PYLL values, but the relative trends over time have remained the same as found by the previous method.

Data Source

Mortality Database, Epidemiology Branch, Public Health Directorate, Department of Health, Western Australia.

2-01: Rate of hospitalisation for gastroenteritis in children (0-4 years)

This indicator reports the rate of hospitalisation for gastroenteritis in children 0-4 years.

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 rate of children who are admitted to hospital per 1,000 population for treatment of gastroenteritis may be an indication of improved primary care or community health strategies - for example, health education. Programs are delivered to ensure there is an understanding of hygiene within homes to assist and prevent gastroenteritis. 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.

The Department of Health is engaged in the surveillance of enteric diseases. Some forms of gastroenteritis for example salmonellosis and shigellosis are notifiable diseases and infection rates are monitored.

Results

During 2007, hospitalisation rates for non-Aboriginal children for the Metropolitan Health Service (MHS) has decreased compared to 2006 results and remains below the target rate. The rate for MHS Aboriginal children continues to exceed the total population target. However, the 2007 hospitalisation rate is comparable to all reported prior years except for 2005.

The hospitalisation rates for gastroenteritis for both population groups in the Peel Health Service remains below the target.

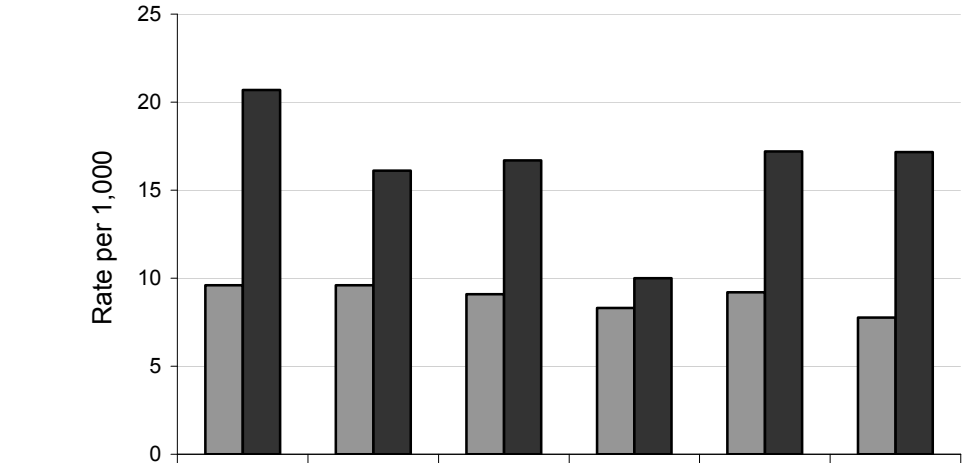
Note
This indicator measures hospital separations of children living in a given location who may attend a hospital close to home or in another Health Service area. This indicator is not a measure of the performance of the Health Service providing the hospitalisation.

Refer to next page for Fibures 7 & 8

2-01: Rate of hospitalisation for gastroenteritis in children (0-4 years) (continued)

Figure 7: Rate of hospitalisation per 1,000 for gastroenteritis in children 0-4 years (MHS)

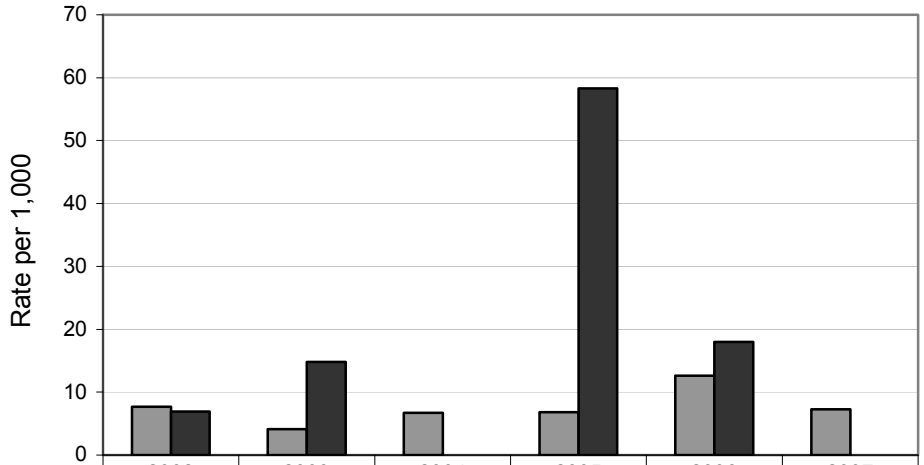
Target
<9.2 per 1,000



	2002	2003	2004	2005	2006	2007
Non aboriginal	9.6	9.6	9.1	8.3	9.2	7.8
Aboriginal	20.7	16.1	16.7	10	17.2	17.2

Figure 8: Rate of hospitalisation per 1,000 for gastroenteritis in children 0-4 years (PHS)

Target
<8.5 per 1,000



	2002	2003	2004	2005	2006	2007
Non aboriginal	7.7	4.1	6.7	6.8	12.6	7.3
Aboriginal	6.9	14.8	0.0	58.3	18.0	0.0

Data Sources
Hospital Morbidity Data System.
Australian Bureau of Statistics population figures

2-02: Rate of hospitalisation for respiratory conditions – Metropolitan Health Service

This indicator reports the rate of hospitalisation for respiratory conditions.

Rationale

The rate of admission to hospital per 1,000 population of children for treatment of respiratory conditions such as acute bronchitis, bronchiolitis and croup and the percentage of all persons admitted for the treatment of acute asthma may be an indication of improved primary care or community health strategies - for example, health education.

It is important to note, however, that other factors may influence the number of people hospitalised with these conditions. These conditions are ones that have a high number of patients treated either in hospital or in the community. It would be expected that hospital admissions for these conditions would decrease as performance and quality of service increases.

Target (total population)

Condition	Age	Population per 1,000
Asthma	0-4 years	<9.1
	5-12 years	<3.0
	13-18 years	<0.9
	19-34 years	<0.7
	35+ years	<0.7
Bronchiolitis	0-4 years	<10.1
Bronchitis	0-4 years	<0.1
Croup	0-4 years	<3.5

Results of Acute Asthma

In 2007, the hospitalisation rates in the Metropolitan Health Service for acute asthma for the non-Aboriginal population are comparable to prior years and are within the total population targets for all age cohorts.

In the Aboriginal population hospitalisation rates for acute asthma while comparable to prior years fall outside the target total population for all age cohorts.

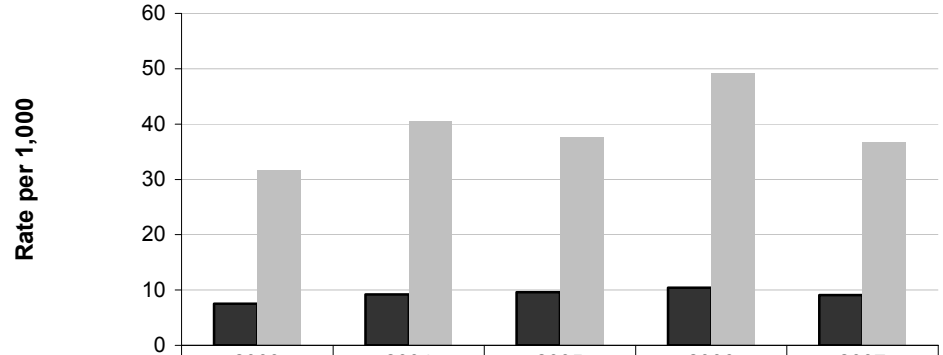
Table 33: Rate of hospitalisation per 1,000 for acute asthma (MHS)

	2003		2004		2005		2006		2007	
	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal
0-4 years	8.7	16.5	9.6	15.6	8.6	22.0	8.3	16.4	6.9	14.7
5-12 years	3.4	6.1	2.7	3.3	3.4	2.9	2.6	4.5	2.7	4.8
13-18 years	1.1	1.5	0.7	1.4	1.0	1.9	0.7	1.4	0.6	1.6
19-34 years	0.8	1.7	0.7	1.1	0.8	2.1	0.6	0.6	0.7	1.2
35+ years	0.7	5.9	0.7	7.3	0.7	4.9	0.6	3.6	0.7	2.5

Data Sources
Hospital Morbidity Data Systems.
Australian Bureau of Statistics population figures.

2-02: Rate of hospitalisation for respiratory conditions – Metropolitan Health Service (continued)

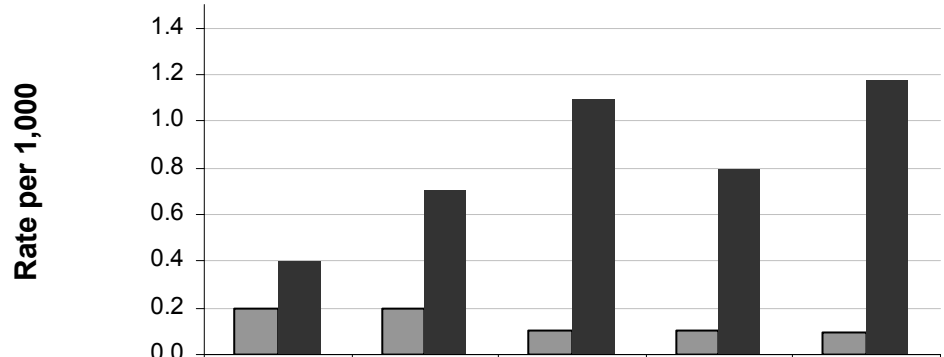
Figure 9: Rate of hospitalisation per 1,000 for bronchiolitis in 0-4 years (MHS)



	2003	2004	2005	2006	2007
Non Aboriginal	7.5	9.2	9.6	10.4	9.1
Aboriginal	31.6	40.5	37.6	49.2	36.8

Results
In 2007, the rates of hospitalisation for bronchiolitis decreased for both Aboriginal and non-Aboriginal children but exceeded the total population target for Aboriginal children.

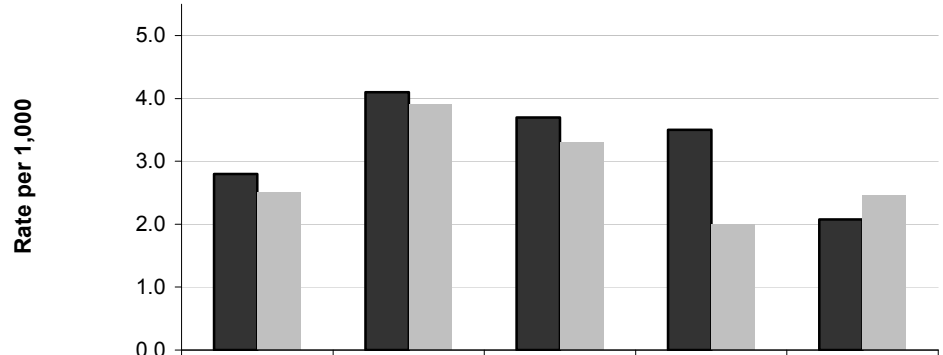
Figure 10: Rate of hospitalisation per 1,000 for acute bronchitis in 0-4 years (MHS)



	2003	2004	2005	2006	2007
Non Aboriginal	0.2	0.2	0.1	0.1	0.1
Aboriginal	0.4	0.7	1.1	0.8	1.2

Results
The rate of hospitalisation for acute bronchitis for Aboriginal children increased slightly in 2007 and remained above the total population target. The rate of hospitalisation for non-Aboriginal children remains comparable to prior years and within the total population target.

Figure 11: Rate of hospitalisation per 1,000 for croup in 0-4 years (MHS)



	2003	2004	2005	2006	2007
Non Aboriginal	2.8	4.1	3.7	3.5	2.1
Aboriginal	2.5	3.9	3.3	2.0	2.5

Results
The rate of hospitalisation for croup for both Aboriginal and non-Aboriginal children in 2007 are comparable to prior years and are within the total population target.

Data Sources
Hospital Morbidity Data System.
Australian Bureau of Statistics population figures

2-02: Rate of hospitalisation for respiratory conditions – Peel Health Service

This indicator reports the rate of hospitalisation for respiratory conditions.

Rationale

The rate of admission to hospital per 1,000 population of children for treatment of respiratory conditions such as acute bronchitis, bronchiolitis and croup and the percentage of all persons admitted for the treatment of acute asthma may be an indication of improved primary care or community health strategies - for example, health education.

It is important to note, however, that other factors may influence the number of people hospitalised with these conditions. These conditions are ones that have a high number of patients treated either in hospital or in the community. It would be expected that hospital admissions for these conditions would decrease as performance and quality of service increases.

Target (total population)

Condition	Age	Population per 1,000
Asthma	0-4 years	<6.5
	5-12 years	<1.8
	13-18 years	<0.8
	19-34 years	<1.0
	35+ years	<1.2
Bronchiolitis	0-4 years	<10.3
Bronchitis	0-4 years	<0.3
Croup	0-4 years	<2.4

Results of Acute Asthma

In 2007, the hospitalisation rates in the Peel Health Service for acute asthma for the non-Aboriginal population are comparable to prior years and are within target for all age cohorts except the 5-12 years group.

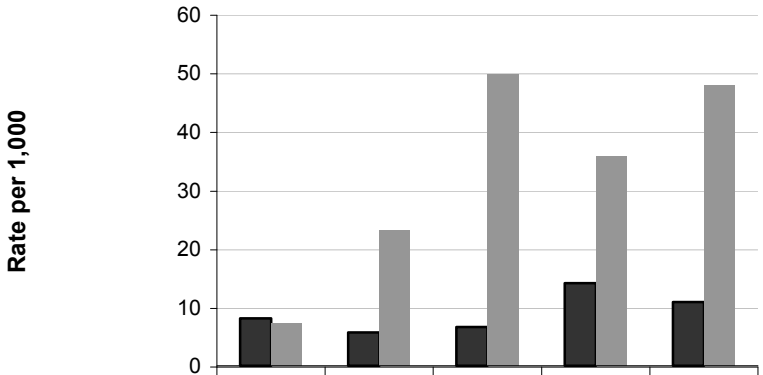
In the Aboriginal population hospitalisation rates for acute asthma where a hospitalisation event was recorded, were comparable to prior years but fall outside the target total population for those age cohorts.

Table 34: Rate of hospitalisation per 1,000 for acute asthma (PHS)

	2003		2004		2005		2006		2007	
	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal
0-4 years	6.6	14.8	4.8	15.5	8.0	0.0	5.9	18.0	4.6	0.0
5-12 years	0.8	3.5	0.9	0.0	3.3	3.5	1.5	3.7	2.2	4.0
13-18 years	0.5	0.0	0.7	0.0	1.0	0.0	0.8	0.0	0.5	0.0
19-34 years	0.8	0.0	0.8	3.6	1.0	0.0	0.9	0.0	0.7	0.0
35+ years	0.9	7.4	0.9	0.0	1.5	9.4	0.9	2.9	0.9	11.6

2-02: Rate of hospitalisation for respiratory conditions – Metropolitan Health Service (continued)

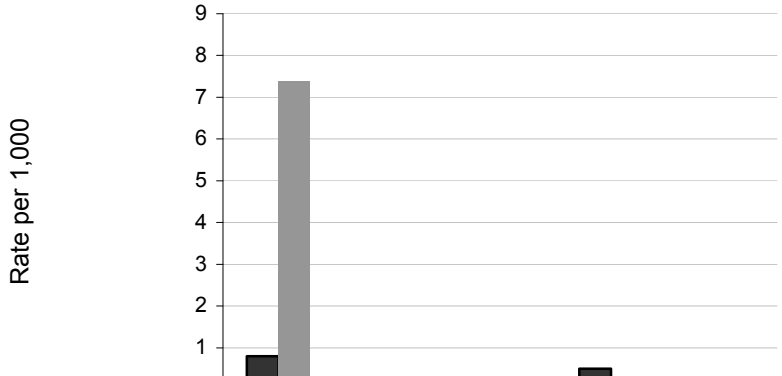
Figure 12: Rate of hospitalisation per 1,000 for bronchiolitis in 0-4 years (PHS)



	2003	2004	2005	2006	2007
Non Aboriginal	8.30	5.90	6.80	14.30	11.1
Aboriginal	7.40	23.30	50.00	36.00	48.1

Results
In 2007, the rates of hospitalisation for bronchiolitis decreased for non-Aboriginal children but increased in Aboriginal children. Both populations exceeded the total population target.

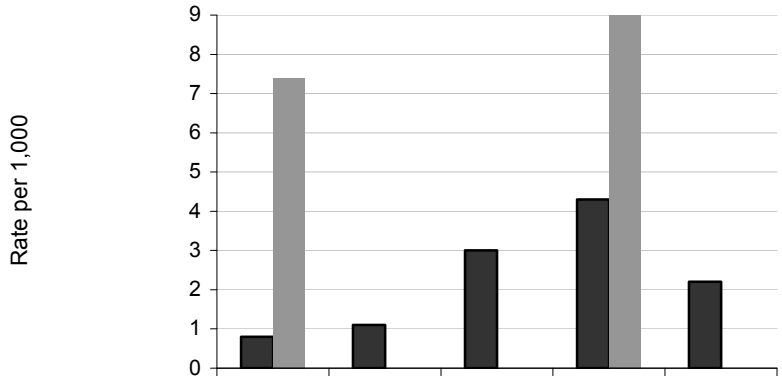
Figure 13: Rate of hospitalisation per 1,000 per 1,000 for acute bronchitis in 0-4 years (PHS)



	2003	2004	2005	2006	2007
Non Aboriginal	0.8	0.0	0.0	0.5	0.0
Aboriginal	7.4	0.0	0.0	0.0	0.0

Results
There were no recorded hospitalisations for acute bronchitis in 2007.

Figure 14: Rate of hospitalisation per 1,000 for croup in 0-4 years (PHS)



	2003	2004	2005	2006	2007
Non Aboriginal	0.8	1.1	3.0	4.3	2.2
Aboriginal	7.4	0.0	0.0	9.0	0.0

Results
The rate of hospitalisation for croup in non-Aboriginal children in 2007 decreased compared to 2006 and was within the target. There were recorded no hospitalisations for croup for Aboriginal children.

Data Sources
Hospital Morbidity Data System.
Australian Bureau of Statistics population figures

2-03: 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 health outcomes for children. This indicator examines the disease prevention and health promotion effectiveness of the school dental health service by measuring the enrolment and screening rates for school children who are eligible for the service. It also measures the 'free of active 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.

Results

Percentage of Children - School Dental Service

The percentage of school children enrolled in and receiving care from the service 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. The percentage of pre-primary and primary school children enrolled and under care has reduced and is therefore below target. This has been due to staff shortages resulting in closure of clinics. The secondary school targets have been met with the under care figures exceeding expectations. This is due to a number of strategies implemented to increase the participation rates.

Free of Active Caries

The 'Free of Active Caries on Recall' rate has remained relatively constant even though the average recall interval has increased from 17.5 months to 18.9 months over the past year. The caries free rate of 66.7% exceeds the target

Table 35: Rate of dental screening of pre-primary school children

	2003	2004	2005	2006	2007	Target
Enrolled in program	84.3%	83.7%	83.3%	82.6%	80.3%	**84.0%**
Under care	84.3%	83.7%	83.3%	82.6%	80.3%	**84.0%**

Table 36: Rate of dental screening of primary school children

	2003	2004	2005	2006	2007	Target
Enrolled in program	85.2%	84.7%	84.5%	84.0%	83.5%	**85.0%**
Under care	85.2%	84.7%	84.5%	84.0%	83.5%	**85.0%**

Table 37: Rate of dental screening of secondary school children

	2003	2004	2005	2006	2007	Target
Enrolled in program	82.2%	84.4%	80.7%	81.2%	82.9%	**84.0%**
Under care	58.9%	70.0%	58.3%	58.7%	60.4%	**58.0%**

Table 38: Rate of children free of dental caries when recalled

	2003	2004	2005	2006	2007	Target
Children free of active dental caries on recall	67.6%	67.6%	66.7%	66.0%	66.7%	**>65.0%**

Data Source
School Dental Health.

2-04: 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 reports the health status of school children and adults eligible to use the State government Dental Health Service. It determines the effectiveness of the school dental service and the adult dental program by measuring the 2007-08 rate of DMFT and comparing it with previous years.

Results

The 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.

The number of DMFT in children has remained effectively constant over the past five years and with the excellent dental health status, gains are relatively difficult to achieve. The Western Australian results for 12 year olds were 0.89 and compared favourably with international benchmarks:

International Benchmarks for 12 Year Olds	
Austria 1.0 (2002)	Denmark 0.80 (2005)
Finland 1.20 (2000)	Germany 0.70 (2005)
Italy 1.10 (2004)	Norway 1.7 (2000)

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

The number of DMFT in adults showed a small decrease in 2007-08. This data fluctuates with the dental health status of dental patients presenting in any given year.

Table 39: Average number of decayed, missing or filled teeth for school children

	2003-04	2004-05	2005-06	2006-07	2007-08
5 years old (deciduous DMFT)	1.45	1.52	1.45	1.57	1.35
8 years old	0.30	0.31	0.28	0.30	0.30
12 years old	0.85	0.85	0.85	0.84	0.89
15 years old	1.61	1.69	1.49	1.67	1.68

Table 40: Average number of decayed, missing or filled teeth for adults

	2003-04	2004-05	2005-06	2006-07	2007-08
Adults	12.1	11.5	13.1	12.9	12.5

Data Source
School Dental Health.

2-05: Access to dental treatment services for eligible people

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

Rationale

Dental Health Services provide financially disadvantaged people with access to non-specialist dental treatment services, both emergency and non-emergency.

There has been a shift in the emergency/non emergency ratio over the last five years. 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. The continuation of special funding to reduce and maintain waiting lists has resulted in an improvement in the ratio with a gradual increase in general rather than emergency dental care.

Results

Eligible persons who access services:

Historically only about 20% of eligible persons access care in government dental facilities. The Government initiative to provide additional funding to allow long term waiting patients to access dental care has maintained the percentage of patients accessing services in 2007-08.

Emergency/non-emergency mix of services:

There has been a stabilising in the Emergency/Non Emergency ratio over the last five years. Emergency care consumes greater resources than non-emergency care. The continuation of special funding to reduce and maintain waiting lists has allowed this stable situation to be maintained.

Table 41: Access to dental treatment services for eligible people

	2003-04	2004-05	2005-06	2006-07	2007-08	Target
Eligible people who access Dental Health Services	19%	21%	21%	20%	20%	**20%**

Table 42: Rate of completed dental care

	2003-04	2004-05	2005-06	2006-07	2007-08
Emergency completed courses of care	58%	58%	56%	56%	55%
Non-emergency completed courses of care	42%	42%	44%	44%	45%

Data Source
Dental Health Service Records.

2-06: Average waiting times for dental services

This indicator reports the waiting time in months for access to non-urgent dental care.

Rationale

Dental Health Services provides financially disadvantaged people with access to non specialist dental treatment services, both emergency and non-emergency. Emergency dental care is provided to patients presenting on the day. One of the key measures of the effectiveness of the service is the timeliness in accessing non-emergency services.

Results

The increase in waiting time in 2007-08 compared to 2006-07 is due to staff shortages at public clinics. Also impacting is that special funding to target long term waiting patients has seen an increase of 33% in the fee schedule to reimburse private dental practitioners providing dental care as part of the program. The 2007-08 result meets the target set by Dental Health Services

Table 43: Average waiting times (months) for dental treatment

	2003-04	2004-05	2005-06	2006-07	2007-08	Target
Waiting times (months) for non urgent dental care	14	14	12	13	14	**14**

Data Source
Dental Health Service Records.

S8-00: Cost per capita of population health units

This indicator reports the cost per capita of population health units.

Rationale

Population health considers the health of individuals, groups, families and communities by adopting an approach that addresses the determinants of health. With the aim of improving health, population health works to integrate all activities of the health sector and link them with broader social and economic services and resources. This is based on the growing understanding of the social, cultural and economic factors that contribute to a person's health status.

The population health unit supports individuals, families and communities to increase control over and improve their health. These services and programs include:

- Supporting growth and development, particularly in young children (community health activities).
- Promoting healthy environments.
- Prevention and control of communicable diseases.
- Injury prevention.
- Promotion of healthy lifestyle to prevent illness and disability.
- Support for self-management of chronic disease.
- Prevention and early detection of cancer.

Results

In 2007-08 the cost per capita of MHS population health units was $55.74 and exceeded the prescribed target. This indicator includes the Child and Adolescent Health Service (CAHS) population health unit which provides a Statewide service and received some additional funding in 2007-08.

In 2007-08 the cost per capita of PHS population health unit was $41.17 and is below the prescribed target.

Table 44: Cost per capita of Population Health Units – Metropolitan Health Service

	2003-04	2004-05	2005-06	2006-07	2007-08	Target
Actual cost	$29.02	$32.36	$34.72	$44.87	$55.74	**$43**
CPI adjusted	$29.02	$31.58	$32.93	$41.38	$49.62	

Table 45: Cost per capita of Population Health Units – Peel Health Service

	2003-04	2004-05	2005-06	2006-07	2007-08	Target
Actual cost	$47.39	$46.81	$45.27	$46.18	$41.17	**$45**
CPI adjusted	$47.39	$45.68	$42.93	$42.59	$36.65	

Data Source
Area Health Service Financial Systems.
Australian Bureau of Statistics (ABS)

Note
Statewide overhead costs have been apportioned to this key performance indicator.
Only the Metropolitan population figure is used to calculate the MHS population health unit cost. No provision has been made for the additional population serviced by the Statewide CAHS population health unit.

S8-01: Average cost per breast screening

This indicator reports the average cost per breast screening.

Rationale

Breast cancer remains the most common cause of cancer death in women under 65 years. Early detection is the key to reducing breast cancer morbidity and mortality. Women aged 50 to 65 are targeted as well as those with a family history of breast cancer and are offered screening.

This indicator reports the average cost per woman screened.

Results

In 2007-08 the average cost per breast screening was $112 and exceeds the prescribed target. This result reflects additional costs incurred especially in relation to clinically-based services.

Table 46: Average cost per breast screening

	2006-07	2007-08	Target
Actual cost	$103.65	$112	**$98**
CPI adjusted	$95.58	$99.70	

Data Sources
BreastScreen WA.
Area Health Service Financial Systems.

S10-00: Average cost of service for school dental care

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

Rationale

This indicator reports the cost per enrolled child in the care of the school dental service. 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 measures the average cost of providing a single dental service in the school program.

Results

In 2007-08 the average cost of service for school dental care was $97.36 and was over target, though less than the previous financial year.

Table 47: Average cost of service for school dental care

	2003-04	2004-05	2005-06	2006-07	2007-08	Target
Actual cost	$85.04	$88.18	$92.63	$99.77	$97.36	**$89**
CPI adjusted	$85.04	$86.05	$87.85	$92.00	$86.67	

Data Source
School Dental Health Service.

Note
Statewide overhead costs have been apportioned to this key performance indicator.

S10-01: 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 indicator measures the cost per adult dental treatment for non-specialist dental health services.

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

Results

In 2007-08, the average cost of completed courses of adult dental care was $297.

Increases in the Department of Veteran Affairs fee schedule, which is the basis for the fee paid to private practice participants in the dental subsidy schemes, has contributed to this cost result.

Table 48: Average cost of completed courses of adult dental care

	2003-04	2004-05	2005-06	2006-07	2007-08	Target
Actual cost	$228	$226	$257	$287	$297	**$279**
CPI adjusted	$228	$221	$243	$265	$264	

Data Source
Dental Health Services Data.

Note
Statewide overhead costs have been apportioned to this key performance indicator.

Outcome 3: Enhanced wellbeing and environment of those with chronic illness or disability

The achievement of this component of the health objective involves provision of services and programs that improve and enhance the wellbeing and the environment for people with chronic illness or disability. To enable people with chronic illness or disability to maintain as much independence in their everyday life as their illness permits, services are provided to enable normal patterns of living. Support is provided to people in their own homes for as long as possible but when extra care is required long term placement is found in residential institutions. This involves the provision of clinical and other services which:

- Ensure that people experience the minimum of pain and discomfort from their chronic illness or disability.
- Maintain the optimal level of physical and social functioning.
- Prevent or slow down the progression of the illness or disability.
- Make available aids and appliances that maintain, as far as possible, independent living (for example; wheelchairs).
- Enable people to live, as long as possible, in the place of their choice supported by, for example, home care services or home delivery of meals.
- Support families and carers in their roles.
- Provide access to recreation, education and employment opportunities.

Significant services are provided for people with a chronic illness or disability by the Area Health Services principally in the areas of Mental Health, Community Care and Aged Care. Services and programs provide people with chronic illness and disability choices regarding their lifestyle and accommodation.

A person with a disability, including a younger people, can also receive support through a number of other agencies including the Disability Services Commission and the Quadriplegic Centre. The DOH and Area Health Services also provide assistance to those with disabilities through the provision of Home and Community Care (HACC) services. This program is administered through the DOH and the effectiveness and efficiency indicators for HACC are reported by DOH.

Table 49: Key Performance Indicators for Outcome 3 by reporting entity

Outcome 3	Metropolitan Health Service	Department of Health	WA Country Health Service
Home and community care		R3-50 R3-51	
Community mental health	3-00	R3-52	3-00
Residential care			3-20

Note: Area Health Services will also provide acute services to those with disabilities under Outcome 1.

3-00: Percent of contacts with community-based public mental health non-admitted services within seven and fourteen days post discharge from public mental health inpatient units

This indicator reports on clients with a mental illness who had contact with community-based public mental health non-admitted services within seven and fourteen days following discharge from public mental health inpatient units.

Rationale

A large proportion of people with a mental illness generally have a chronic or recurrent type illness that results in only partial recovery between acute episodes and deterioration in functioning that can lead to problems in living an independent life. As a result, hospitalisation may be required on one or more occasions a year with the need for ongoing clinical care from community-based non-admitted services following discharge.

These community services provide ongoing mental health treatment and access to a range of rehabilitation and recovery programs that aim to reduce hospital readmission and maximise an individual's independent functioning and quality of life.

This type of care for persons who have experienced an acute psychiatric episode requiring hospitalisation is essential after discharge to maintain or improve clinical and functional stability, and to reduce the likelihood of an unplanned readmission.

The time period of seven days has been recommended nationally as an indicative measure of follow up with non-inpatient services for people with a persistent mental illness.

Results

Metropolitan Health Service (MHS)

In 2007 56.5% of the discharges from public mental health inpatient units received contact with a community-based public mental health non-admitted service within seven days of discharge. A further 12.1% of clients were seen within 8 to 14 days.

Peel Health Service (PHS)

In 2007 64.1% of the discharges from public mental health inpatient units received contact with a community-based public mental health non-admitted service within seven days of discharge. A further 8.3% of clients were seen within 8 to 14 days. The PHS has achieved the target for the expanded client group.

Approximately 9.6% of discharges from MHS hospitals and 8.3% from PHS hospitals had no contact within the year. However clients in this reporting category may be seen following discharge by private sector clinicians (eg General Practitioners, Private Psychiatrists, Private Psychologists) for which "contact made" data is not available. In addition to these clinical services clients have access to non-clinical support services reported under the Department of Health KPI R3-52.

The MHS continue to provide community based support services to clients with mental illness to ensure that contact occurs as soon as possible following discharge.

Note: Commencing in 2007 this indicator has been expanded to include all mental health conditions precluding prior year comparative analysis.

Refer to next page for Tables 50 & 51

Table 50: Percent of contacts with community-based public mental health non-admitted services within seven and fourteen days post discharge from Metropolitan Health Service public mental health inpatient units

Days to first contact	2007		Target
	%	Cumulative %	Cumulative %
0-7 days	56.5	56.5	60
8-14 days	12.1	68.6	70

Table 51: Percent of contacts with community-based public mental health non-admitted services within seven and fourteen days post discharge from Peel Health Service public mental health inpatient units

Days to first contact	2007		Target
	%	Cumulative %	Cumulative %
0-7 days	64.1	64.1	60
8-14 days	8.3	72.4	70

Data source
Mental Health Information System, Data Collection and Analysis-Inpatient and Mental Health, Information management and Reporting, Department of Health WA.

S12-00: Average cost per completed Aged Care Assessment Team (ACAT) assessment

This indicator reports the average cost per completed ACAT assessment.

Rationale

Aged people 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.

Some of these services specifically relate to funded programs that require an assessment by an Aged Care Assessment Teams (ACAT), without which access to the appropriate aged care service programs cannot be progressed.

This indicator measures the average cost per completed assessment provided by an ACAT.

Results

In 2007-08 the average cost per completed assessment provided by the Metropolitan Aged Care Assessment Teams was $471 exceeding the prescribed target.

In 2007-08 the average cost per completed assessment provided by the Peel Aged Care Assessment Team was $413 and was under target.

Table 52: Average cost per completed ACAT assessment - Metropolitan Health Service

	2003-04	2004-05	2005-06	2006-07	2007-08	Target
Actual cost	$368	$343	$385	$528	$471	**$422**
CPI adjusted	$368	$335	$365	$487	$419	

Table 53: Average cost per completed ACAT assessment - Peel Health Service

	2003-04	2004-05	2005-06	2006-07	2007-08	Target
Actual cost	$299	$504	$588	$666	$413	**$639**
CPI adjusted	$299	$492	$558	$614	$368	

Data Source
Aged Care Assessment Program WA Evaluation Unit Minimum Dataset Quarterly Reports, July 2007 to March 2008.
Area Health Service Financial Systems.

Note
Statewide overhead costs have been apportioned to this key performance indicator.

Peel Health Service includes the Rockingham region.

S12-01: Average cost per care awaiting placement (CAP) day

This indicator reports the average cost per CAP day.

Rationale

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

A number of transition care options for the elderly are available in WA. These include:

- Residential Care Awaiting Placement (CAP)
- Home Care Packages (HCP) (formerly Home Care Packages and Elderly Post Acute Services),
- Transitional Care Program (TPC)

The CAP program aims to facilitate the timely transfer of older patients who are approved for permanent residential care from the public acute care sector to an environment that is more appropriate for the provision of aged care services. HCP provides older patients therapy or non-therapy based services and post acute treatment services usually brokered through the health service to assist their transition from hospital to home. The TCP services provide time limited low-level post acute rehabilitation options to older people.

This indicator measures the cost per place-day of CAP and includes HCP and TCP places.

Results

In 2007-08 the average cost per CAP day was $286 exceeding the prescribed target. This result reflects additional costs incurred especially in relation to clinically-based services.

Table 54: Average cost per CAP day

	2003-04	2004-05	2005-06	2006-07	2007-08	Target
Actual cost	$311	$319	$354	$315	$286	**$269**
CPI adjusted	$311	$311	$335	$291	$255	

Data Source
Health Service Activity Systems.
Area Health Service Financial Systems.

Note
Statewide overhead costs have been apportioned to this key performance indicator.

S13-00: Average cost per person receiving care from public community-based mental health services

This indicator reports the average cost per person with mental illness under community care.

Rationale

The majority of services provided by public community-based 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 effectiveness of treatment for public psychiatric patients under community care (non-admitted/ambulatory patients).

Results

In 2007-08 the average cost per person receiving care from public community-based mental health services in the Metropolitan Health Service was $4,056 and exceeded the prescribed target. This result reflects additional funding provided during the year to community mental health care services under the Mental Health Strategy as well as additional costs incurred in relation to clinically-based services.

In 2007-08 the average cost per person receiving care from public community-based mental health services in the Peel Health Service was $2,836 and within the prescribed target.

Table 55: Average cost per person with a mental illness under community care - MHS

	2003-04	2004-05	2005-06	2006-07	2007-08	Target
Actual cost	$3,115	$3,659	$3,329	$4,273	$4,056	**$3,516**
CPI adjusted	$3,115	$3,570	$3,157	$3,940	$3,610	

Table 56: Average cost per person with a mental illness under community care - PHS

	2003-04	2004-05	2005-06	2006-07	2007-08	Target
Actual cost	$3,010	$3,305	$2,903	$3,139	$2,836	**$2,916**
CPI adjusted	$3,010	$2,937	$2,753	$2,894	$2,524	

Data Source
Mental Health Information Systems.
Area Health Service Financial Systems.

Note
Statewide overhead costs have been apportioned to this key performance indicator.

S16-00: Average cost per client in a chronic disease management program

This indicator reports the average cost per client in a chronic disease management program.

Rationale

As the population ages there are more people living in the community with chronic disease. Chronic diseases include conditions such as asthma, heart failure, respiratory disease and diabetes. Good chronic disease management can help prevent crises and deterioration of the condition and enable people living with chronic conditions to attain the best possible quality of life.

Self-care and self-management is important in the management of chronic disease and chronic disease management teams support clients to manage their own care. When successfully managed clients with chronic condition/s will have a better quality of life with less admissions to hospital for acute care.

Results

In 2007-08 the average cost per client in a chronic disease management program (CDMP) was $2,619 exceeding the prescribed target.

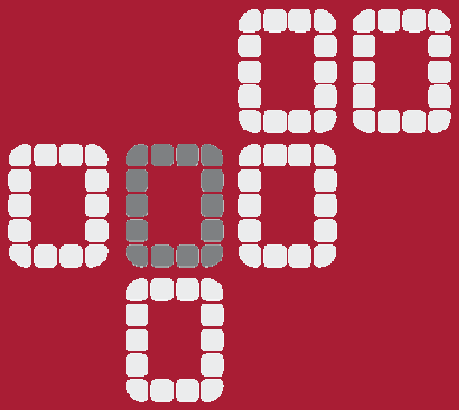
Note: The target set in the Government Budget Statements in May 2007 was understated as client activity was over-estimated for 2007-08.

Table 57: Average cost per client in a chronic disease management program

	2006-07	2007-08	Target
Actual cost	$2,078	$2,619	**$1,506**
CPI adjusted	$1,916	$2,331	

Data Sources
Chronic Disease - Patient Referral Registry.
Area Health Service Financial Systems.

Note
Statewide overhead costs have been apportioned to this key performance indicator.



Significant Issues and Trends

Overview

The Government's health reform plan and policies for the WA health system progressed during 2007-08, recognising the challenge of increasing demands for hospital and other health services.

Providing hospital and health services within the approved resource allocation and the capacity of the health system, especially in relation to the demand for emergency services and the provision of elective surgery were again prominent in 2007-08. The surgi-centres established at the Kaleeya and Osborne Park Hospitals during 2006-07, consolidated their service provision during the year and were especially important to WA's response to elective surgery under the 2008 Federal Government elective surgery initiative.

Commonwealth/State initiatives

The State and the new Federal Government also progressed a number of other health related initiatives in addition to elective surgery:

- the establishment of General Practitioner (GP) Super Clinics as a key element in building a stronger primary care system. A greater focus on health promotion and illness prevention and better service coordination with two GP Super Clinics announced for Midland and Wanneroo;
- introducing incentives to increase the nursing and midwifery workforce by encouraging nurses and midwives who have not been employed for at least 12 months to return to the workforce;
- participation in a national program to create additional transitional care places for older Australians waiting in hospital for a residential aged care bed; and
- the establishment of a Preventative Health Care Taskforce to develop a plan for the future of preventative health in Australia to increase the health of the population and improve workforce participation and productivity.

Service provision

Service activity provided by the Metropolitan Health Service (MHS) generally increased during 2007-08. For admitted patients, general weighted adjusted acute activity remained steady compared with activity provided in 2006-07, while admitted mental health patient activity increased. However, other areas of MHS activity especially for non-admitted services have seen significant growth in activity compared with 2006-07. Attendances at metropolitan emergency departments increased by 5.9%, doctor attended outpatients by 8%, other outpatients by 19.9% and dental health services by 0.2%. Care Awaiting Placement patient days, where significantly additional resources were made available, increased by 66.3%. Mental health persons under community care increased by 0.8%.

Capital

There were numerous MHS capital works initiatives in progress during 2007-08 including the Fiona Stanley Hospital project and projects at Armadale-Kelmscott Memorial Hospital, Joondalup Health Campus, King Edward Memorial Hospital, Osborne Park Hospital, Rockingham-Kwinana District Hospital, Princess Margaret Hospital, Mandurah Community Health Centre and the North Perth Dental Clinic. There were also a number of ongoing projects related to information, communication and data processing, equipment acquisition and replacement and a number of minor buildings works.

Projects completed during 2007-08 included the Peel Health Campus emergency department, Sir Charles Gairdner Hospital Neurological Centre and the Pathways Home program.

Note
The Metropolitan Health Service is a large and complex entity providing a variety of health care services. The achievements reported in the following sections contribute to the continued health benefit experienced by the community and may support more than one of the 'Healthy' outcomes

Major Achievements 2007-08

Healthy workforce

WA Health is committed to providing and promoting a healthy working environment, providing opportunities for personal and professional development, ensuring a high standard of knowledge and skill, and implementing planning tools to address workforce requirements to meet the needs of a diverse population.

Metropolitan Health Service (MHS) workforce initiatives in 2007-08 continue to focus on planning, attraction and retention, the development of innovative workforce models, cultivating partnerships with other employers and providers, and striving to be an employer of choice.

North Metropolitan Area Health Service

The development of the Governance and Performance Unit of the North Metropolitan Area Mental Health Service continued in 2007-08 with the appointment of officers for policy and procedures, and clinical governance.

The Women and Newborn Health Service has implemented a Safety and Quality screensaver, aimed at providing information for clinicians about safety and quality initiatives introduced at the King Edward Memorial Hospital.

The Women and Newborn Health Service received the 2008 WA Patient Safety Award for innovation in the approach to staff education on safety and quality.

South Metropolitan Area Health Service

Two Nurse Practitioners have been established at Fremantle Hospital's Emergency Department and a Renal Nurse Practitioner has been appointed at Armadale-Kelmscott Memorial Hospital.

The mental health liaison nursing service in the emergency department at Armadale-Kelmscott Memorial Hospital was increased to cover 24 hours and medical psychiatric cover was introduced.

Armadale Kelmscott Memorial Hospital has provided clinical placements for Marr Mooditj enrolled nurses and created an Aboriginal Health Care Worker position for the maternity service.

The Rockingham-Kwinana District Hospital Emergency Department appointed two nurse practitioners in February 2008. Additional medical staff for peak times commenced in January 2008 and an Aged Care Assessment Team social worker was appointed in the same month.

Child and Adolescent Health Service

With funding support from the Department of Health for the 'Gaps in Service' initiative, Princess Margaret Hospital for Children (PMH) has appointed additional staff to the areas of neurology, obesity and type 2 diabetes, retinopathy of prematurity, respiratory medicine and sleep, cerebral palsy mobility, refugee health clinics, psychological medicine, anaphylaxis, oncology, eating disorders and consultant liaison services. The additional staff have increased service capacity to address unmet needs and improved current clinical service delivery to meet the increasing demand.

Princess Margaret Hospital is participating in a 'whole of health' initiative to introduce a new health worker category "Assistants in Nursing". Further development of this role will be pursued in the coming year.

PMH has successfully recruited a surgeon to treat children with Scoliosis and together with the waitlist initiative funding, this has resulted in a decrease in the waiting list for this speciality.

To improve nurse morale, and staff retention and recruitment, reduce nurse on-call demand and increase the availability of specialised nursing staff, PMH has introduced a permanent night duty shift in the operating theatre.

PMH has created and appointed new clinical nurse positions in the Emergency Department and in Allergy Management and appointed a Palliative Care Clinical Nurse Consultant. The hospital has also supported the reclassification of Level 2 nursing positions in specialist roles to Senior Registered Nurse levels providing expanded scope in the role. Specialities benefiting from the reclassification include spinal rehabilitation, immunology, gastroenterology and oncology.

Healthy workforce (continued)

In 2007-08, Child and Adolescent Community Health undertook a number of workforce initiatives to promote breastfeeding including:

- offering staff training in the Breastfeeding Matters Program;
- establishing a lactation consultant network;
- promoting breastfeeding through community media; and
- promoting WA Health policy on breastfeeding with its staff.

PathWest Laboratory Medicine WA

The PathWest Workforce Planning Committee presented the PathWest Workforce Report to the Executive in June 2008. The report recommendations are currently being incorporated into PathWest's Strategic Plan.

Dental Health Services

During 2007-08 the Dental Health Workforce Plan to address a number of risks which might impact upon the future viability of dental programs was completed. This plan includes a project with the Department of Health Industrial Relations and Workforce Division to develop a remuneration package for clinical staff.

Healthy hospitals, health services and infrastructure

The Metropolitan Health Service provides the greater part of hospital services including pathology and dental health to the people of Western Australia and is committed to ensuring that these services are high quality, efficient, accessible, innovative and responsive to community needs.

Outpatient services

Administrative redesign and policy revision for the Metropolitan Outpatient Clinic appointment system has reduced average wait times for clinic appointments from 22 weeks to 12 weeks. Rates of non-attendance have been reduced by two per cent in 2007-08, making up to 10,000 appointments available.

High volume specialties at all tertiary facilities are now using WA Health's call centre, 'Outpatient Direct', for cancellation and rescheduling of appointments. Outpatient referral acknowledgement letters are being sent to clients and General Practitioners (GPs) by all adult tertiary sites.

A text messaging system for appointment reminders has been established at Princess Margaret Hospital for Children (PMH), resulting in a three per cent reduction in non-attendance.

An audit of orthopaedic outpatient waitlists was completed at all adult tertiary sites which found approximately 30 per cent of referrals were redundant and were removed from the system.

Telehealth

PMH has continued to expand its burns treatment role, coordinated centrally by the Burns Telehealth Coordinator. In 2007-08 rural/remote paediatric patients with burn wounds and/or scars were reviewed in more than 40 regularly scheduled multi-disciplinary burns 'Telehealth Clinics'. This resulted in more than 300 patient videoconference reviews and more than 300 digital image reviews in collaboration with family members and rural/remote clinicians.

Clinical priority access

Clinical Priority Access Nurses (CPAN) have been introduced at Fremantle, Royal Perth and Sir Charles Gairdner Hospitals. CPANs are responsible for the overall triage and management of patients referred from GPs and who require access to medical specialists in outpatient services. In addition a standard clinical priority access referral template has been developed for referring clinicians and clinical priority access nurse screening of referrals has reduced duplication from 25 per cent to less than five per cent.

Elective surgery

For 2008 the Metropolitan Health Service (MHS) received a funding allocation from stage one of the Commonwealth Government's Elective Surgery Wait List Reduction Plan, specifically for patients who have waited longer than is clinically appropriate. This work in the MHS will principally be carried out at Princess Margaret Hospital and metropolitan non-teaching hospitals.

An audit of neurology/neurosurgery and ear, nose and throat waitlists at all metropolitan sites has commenced. This will minimise duplication and expedite access to services.

Clinical service redesign projects for elective surgery were implemented during 2007-08 for the South Metropolitan Area Health Service (SMAHS) Princess Margaret Hospital for Children (PMH). Clinical redesign and improving care relevant to patient's needs, aims to minimise the time taken for patients to move across the different settings in hospitals and in the community, and for patients to receive care within agreed timeframes and minimise length of stay.

Aged care

The Care Awaiting Placement program provides time limited transition care options for aged care patients who are waiting in a metropolitan public hospital bed for alternative aged care services to become available. The program has expanded from 114 beds in February 2007 to 223 beds in February 2008.

Fiona Stanley Hospital

Planning for the Fiona Stanley Hospital has continued in 2007-08 with the completion of the project design brief and service plans for the major clinical groups detailed in the approved Clinical Service Plan. A master plan has been completed and initial consultation with the construction industry has commenced.

HITH/RITH

'Hospital in the Home' (HITH) and 'Rehabilitation in the Home' (RITH) patient day activity provided in the metropolitan North, South and Child and Adolescent Area Health Services increased by 17% in 2007-08 compared to 2006-07 providing 72,277 patient days.

Referrals to the SMAHS RITH Program continued to grow generally exceeding program monthly targets for the Royal Perth and Fremantle hospital programs.

The Rockingham Peel Group HITH program continued to mature in 2007-08 in partnership with the Fremantle Hospital program. Services increased by an estimated 20 per cent and the program's 1.8 per cent rate of readmissions compared favourably against the Australian Council on Healthcare Standards peer aggregate of 3.8 per cent.

Mental health bed management

The North Metropolitan Area Health Service (NMAHS) and the SMAHS are collaborating to implement a system-wide mental health bed management project to facilitate patient flow similar to that which is currently in operation for general health services. This process commenced with the appointment of a Mental Health Bed Management Nurse Director as the first step to establishing a patient flow system.

Emergency departments

A distribution system for direct and booked ambulances based on the numbers of beds at the tertiary sites was implemented in February 2008. The No Diversion Policy at the three tertiary hospital sites has been implemented.

Kidney transplants

With changes to the *Transplant Act,* paired kidney exchanges can now occur and Australia's first paired kidney exchange took place simultaneously over seven hours at Sir Charles Gairdner and Royal Perth Hospitals in October 2007. The WA paired kidney exchanges were the first in Australia. The State coordinating centre for the program is at the Department of Nephrology, Fremantle Hospital. Paired kidney exchange occurs where a donor, willing to donate to a spouse, friend or relative is found to be incompatible. The exchange program finds another incompatible pair and by exchanging the kidneys between the pairs, a compatible transplant might be possible.

North Metropolitan Area Health Service

The Short Stay Unit at Sir Charles Gairdner Hospital (SCGH) has been expanded following a $250,000 investment. The Unit is set to treat an additional 1,000 patients annually.

SCGH increased the Hospital in the Home (HITH) activity by 51.4% in 2007-08 compared to 2006-07 providing 13,288 patient days.

Healthy hospitals, health services and infrastructure (continued)

The pre-operative prophylaxis service at SCGH commenced in August 2007. Twenty-one patients have received services for cessation of pre-operative and post-operative anticoagulation management.

The opening of the NeuroInterventional Service has seen the consolidation of Neurosurgical Services at Sir Charles Gairdner Hospital (SCGH) resulting in economies in equipment purchasing and improved staff retention. Full Neurosurgical services are now available on the SCGH site.

The North Metropolitan Area Health Service (NMAHS) has developed Emergency Care Coordination Teams to undertake screening of emergency department patients and identify those that can be referred to allied health and ambulatory care programs. This will reduce avoidable presentations to emergency departments. Preliminary discussions have been held with orthopaedic surgeons to organise an after-hours orthopaedic service to support the emergency department at Swan District Hospital.

Increased use of ambulatory care strategies within the NMAHS includes:

- introduction of Homelink and Patient Exit Pathway services;
- use of Chronic Disease Management Teams;
- introduction of Older Patients Initiatives aimed at coordinating their care while in hospital and reducing avoidable admissions to hospital; and
- increased use of Allied Health Teams.

SCGH received an award for individual achievement in patient safety and quality at the 'Patient Safety Awards' in May 2008. The 2008 awards were announced as part of the 'Safety and Quality in Action Symposium'. SCGH Acute Assessment Unit was recognised for quality improvement initiatives to reduce patient falls.

The Women and Newborn Health Service has implemented a process to refer obstetric normal risk women to secondary hospitals diverting them from King Edward Memorial Hospital.

PMH increased the Hospital in the Home (HITH) activity by 22.8% in 2007-08 compared to 2006-07 providing 3,592 patient days.

NMAHS sites are participating in the identification and implementation of strategies in response to the 'Managing Adverse Events' project and the 'Safety and Quality Investment in Reform' program, administered by the Office of Safety and Quality in Healthcare.

Within the NMAHS, initiatives to expand hospital-wide patient flow, reduce length of stay and ensure the safe discharge of patients were implemented and included:

- extended coverage by the Emergency Care Coordination Teams;
- increased discharge coordination;
- increased Allied Health services;
- implementation of a float team and criteria-led discharge; and
- multi-disciplinary bed status meetings to ensure the optimum use of all available beds.

South Metropolitan Area Health Service

During 2007-08 the South Metropolitan Area Health Service (SMAHS) implemented a number of initiatives for its emergency departments. These included early identification of Care Awaiting Placement and 'at risk' elderly patients, integrated pathways for care resulting in reduced length of stay and gap analyses to aid preparation of actions to enhance integrated service provision for elderly patients.

Increased use of ambulatory care strategies within the SMAHS includes:

- establishment of Home Care Packages and HITH and RITH programs for patients and especially for older patients;
- introduction of the Emergency Department Care Coordination Team at Rockingham -Kwinana District Hospital to target early assessment of older patients; and
- forging of community links by Armadale-Kelmscott Memorial Hospital.

Planning for the construction of the acute mental health inpatient facility for adults and older people continued as part of the Rockingham-Kwinana District Hospital redevelopment under the WA Health Clinical Services Framework.

The Bentley Mental Health Service John Milne Centre opened in March 2008 providing new rehabilitation beds.

The 'Mental Health Beds in Emergency Department' project at Fremantle Hospital has commenced with an additional five beds in the

Emergency Short Stay Unit to be used for mental health patients.

Medical Imaging Services at Rockingham-Kwinana District, Kaleeya and Fremantle Hospitals were surveyed by the National Association of Testing Authorities during 2007 with each site achieving accreditation.

The SMAHS increased the 'Hospital in the Home' (HITH) activity by 10.6% in 2007-08 compared to 2006-07 providing 55,397 patient days.

The tender for construction of the Murray District Health Centre at Pinjarra was awarded in December 2007. Construction commenced in January 2008 and is scheduled for completion in October 2008.

A complexity-based streaming project has commenced at Fremantle Hospital's Emergency Department to reduce waiting times for low complexity patients (Triage 3-5).

A review and evaluation of Kaleeya Hospital's visiting midwifery service will be completed in 2008. Initial results indicate that the service is well regarded by women who utilise it. The review has assessed the service's efficiency and effectiveness against other best practice models to identify any gaps in the current service.

Royal Perth Hospital (RPH) has completed Stages 1-3 of renovations to the Emergency Department with Stages 4-9 to be completed in 2008-09. RPH constructed outpatient podiatry and diabetes clinics at the former Perth Dental Hospital site.

RPH also opened the State Major Trauma Unit in February 2008, followed by the State Adults Burns Unit in March 2008. These two new units provide WA with world-class facilities to treat trauma and burns-affected patients. The units comprise 40 beds in total with five beds that can be used for either speciality as needed.

The redevelopment of the Armadale-Kelmscott Memorial Hospital emergency department commenced in December 2007, with completion scheduled for late 2008. The renovation will add 12 beds to the emergency department.

Child and Adolescent Health Service

The Johanna Sewell Adolescent Oncology Ward was opened at Princess Margaret Hospital (PMH) in 2007-08. Additional nursing and medical staff have been appointed to the ward that will provide care for adolescents and young adults with cancer in an age-appropriate environment.

PMH has also commenced a Clinical Services redesign project to map and improve surgical patient outcomes.

The Child and Adolescent Health Service implemented an additional procedure list per week for botox injections as part of the Cerebral Palsy Mobility Service and additional clinics for orthopaedics and obstructive pulmonary disease.

The Child and Adolescent Health Service has launched the Ambulatory Care Co-ordination Program providing prospective, integrated health care planning and 24-hour, seven-day telephone support for families of children with medically complex care needs.

Reform initiatives introduced at PMH for inpatient services have effectively reduced the length of stay with a four per cent reduction in the admitted acute multi-day length of stay.

PathWest Laboratory Medicine WA

In partnership with the Area Health Services, PathWest is assisting in the planning and design of new laboratory facilities at the QEII Medical Centre and the Fiona Stanley Hospital campus.

Dental Health Services

In conjunction with WA Country Health Service the Dental Health Service has facilitated new dental clinics at Bunbury which opened on 14 January 2008, Fitzroy Crossing which has been completed and will open following the recruitment of a dentist, and at Broome. The Kununurra Dental Clinic commenced operation in January 2008 servicing the surrounding communities.

A new dental therapy centre has been constructed and opened at South Halls Head.

Planning to redevelop the North Perth Dental Clinic for special needs patients to replace the facility in the Disability Services Commission is progressing and is anticipated to be operational by November 2008.

The average wait time for patients to receive general dental care has been maintained at 14 months, a significant achievement when considered against the increased costs of provision of dental care and difficulties in recruiting and retaining clinicians.

Healthy communities

The Metropolitan Health Service provides numerous health promotion and prevention services that focus on individuals and on communities, providing information about prevention of illness and injury, about healthy lifestyles, and about the self management of chronic disease. Services include screening and immunisation programs, and the Statewide population health unit at the Child and Adolescent Health Service.

BreastScreen

BreastScreen Western Australia achieved a four year accreditation status to February 2012 and provided its millionth screen in December 2007. A new clinic at Padbury commenced screening in May 2008.

A digital mammographic workstation to integrate assessment centres at Royal Perth and Sir Charles Gairdner Hospitals is now operational, and online access to assessment records is proving beneficial in providing clinical feedback to reading radiologists.

Aged care

The Aged Care Assessment Team (ACAT) quality framework to identify and promote good practice across Western Australia has been completed and provided to the teams.

The ACAT Quality and Training Reference Group was formed to implement the Western Australian training and quality frameworks. The Group met on a quarterly basis to provide a forum for the development and implementation of quality and training initiatives.

Nine training sessions covering the key clinical operational and policy requirements of the aged care assessment program have been completed. This is part of the state-wide implementation of the ACAT Training Framework.

The ACAT Managers Group was developed and met twice in 2007-08 providing a forum for the development, promotion and implementation of operational management initiatives with particular reference to timeliness, quality and consistency of assessments.

The Residential Care Line continues to demonstrate rapid growth since implementation in 2004. Fifty six percent of referrals to the Residential Care Line in 2007 deferred attendance at emergency departments, 20 per cent above target. This service will be expanded to seven days per week.

A number of initiatives have been implemented to enhance residential aged care:

- stronger links have been made with the Royal Perth Hospital Emergency Department's Care Coordinating Team. This multi-disciplinary team identifies high risk residential aged care patients over the age of 65 (or 45 for Aboriginal and Torres Strait Islander patients) who might require follow up when discharged back to a residential aged care facility;
- stronger partnerships and links have been established with Divisions of General Practice and Silver Chain; and
- Residential Care Line data collection has been streamlined to ensure all services are reporting information.

Community mental health

During 2007-08 the Metropolitan Health Service (MHS) implemented an initiative to address postnatal depression with a six month pilot project to deliver perinatal 'hospital at home' services. The aim was to decrease the pressure on the utilisation of beds in the new Mother Baby Unit at King Edward Memorial Hospital. The pilot provided perinatal training to staff, increased staff awareness of the specific needs of perinatal patients admitted to the 'hospital at home' program and fostered a closer working relationship between HITH and the new Mother Baby Unit.

North Metropolitan Area Health Service

The North Metropolitan Area Health Service has instigated a number of projects to promote a healthy community including the:

- Mid-west Metropolitan Family Aboriginal Corporation Engagement Centre (MWMFAC) Capacity building project - to support Corporation members in service planning, informing culturally appropriate and effective services, promoting working relationships between service providers and clients, ensuring community members are aware of service provision policies and processes and facilitating community input.

- MWMFAC Deadly Tucker Cookbook and Cook-ups – in collaboration with NMAHS, this initiative was implemented to promote nutrition, physical activity, budgeting and healthy lifestyles through cooking demonstrations and yarning sessions.
- Women on Wellness (WOW) – is a key partnership for the NMAHS promoting the social model of health to increase engagement with disadvantaged groups, in this case disadvantaged women and those with special needs. This initiative includes a WOW Week in May each year.
- Healthy, vibrant Mirrabooka – this community participation and social inclusion project is an interagency group facilitating community consultation, and identify and implement priority actions. Community consultations include using the book of proceedings by identified action groups and implementing identified community education programs. Local businesses and agencies are supported in promoting healthy environments and participants are encouraged to enter a Memorandum of Understanding to participate in the design and implementation of Healthy cities.
- The NMAHS has promoted the 'You are not alone' series for Post Natal depression prevention in CALD refugee families. This followed qualitative research within six new emerging refugee ethnicity groups: Sudanese Dinka, Sudanese Arabic, Iraqi, Kurdish, Ethiopian Amharic and Tigrinya from Eritrea. The DVD series is in six languages and is available in the YourZone website.
- The NMAHS has promoted the use of Boodjarri resources for Aboriginal maternal health and child attachment which includes a DVD for consumers and another for clinicians and a Handbook for Aboriginal Health Workers.
- The NMAHS actively participates in 'Alana's Project'. This is a Family and Domestic Violence project involving ongoing tree planting as an environmental memorial to represent lives lost to victims of domestic violence. Alana project was launched during 'Women On Wellness' (WOW) Week on Sunday 4 May 2008 at Kings Park by the Executive Directors King Edward Memorial Hospital Dr Amanda Frazer and NMAHS Public Health Ros Elmes. This launch during WOW Week was thought an appropriate occasion to promote healthy family and community environments by promoting positive strategies and increased family and community support for the safety of all its members.

South Metropolitan Area Health Service

The South Metropolitan Public Health Unit has developed a strategic plan for 2008-2011 that aligns with the Health Promotion Strategic Framework. Some of the health promotion projects include:

- two major tobacco cessation programs for inpatients at Fremantle and Royal Perth hospitals in collaboration with the Respiratory Network;
- the Boronia Quit program, which involves a multi-strategy approach at the Boronia Pre-Release Centre for Women;
- the Fremantle Physical Activity Project, the Cockburn Physical Activity Project and the Coodanup Food Coalition Program;
- partnerships between the Public Health Unit and the local governments in Cockburn, Gosnells, Fremantle and Kwinana in the areas of chronic disease prevention and health promotion, and with 'Be Active Belmont' and the 'Bentley Food Coalition'; and
- a partnership between the Public Health Unit and the Hilton Police and Citizens Youth Club to deliver physical activity and nutrition promotion to Indigenous girls.

The final report on the outcomes of the pilot program, 'the Journey of Living with Diabetes', was submitted to Healthway in November 2007. Eight Aboriginal health professionals received intensive training for the pilot program with a further eight completing the training in 2008 to enable them to deliver the program. Sixteen community programs have been completed during 2007-08 with a further five commencing.

The Public Health Unit supported pandemic planning with the Fremantle Health Service, and coordinated and provided education and training to health professionals within the SMAHS in the area of communicable diseases.

A diabetes service has been established at Rockingham-Kwinana District Hospital. This multidisciplinary team provides a range of services including a young adult clinic and an insulin infusion clinic. The service has been accredited by the National Diabetes Association of Diabetes Centre.

South Metropolitan Area Health Service (SMAHS) Mental Health has established two Dialectical Behaviour Therapy groups in Fremantle and Rockingham. The programs operated for 19 weeks with the participation of six adolescent girls and their parents. Each participant received individual and group counselling as part of the program, and improvements in behaviour and communication was evident.

Healthy communities (continued)

South Metropolitan Area Health Service (continued)

Qualitative research into the factors influencing immunisation in children of Indigenous families in the south metropolitan area has been completed. Recommendations have been made on access to immunisation services, and the quality and efficiency of current services.

Construction of Community Options group homes in Kelmscott was completed in April 2008 with the official opening in June 2008.

Child and Adolescent Health Service

Aboriginal community health nurses and Aboriginal health workers have been seconded from Child and Adolescent Community Health to Princess Margaret Hospital to improve the integration of services to Aboriginal children and facilitate an effective referral system for Aboriginal children back to communities and other health services.

A review of the Child Development Service has been undertaken during 2007-08 and the information gathered is informing the development of clinical pathways and intake procedures that will improve equity and access to services across the metropolitan area.

The Child and Adolescent Health Service (CAHS) has recruited four 'healthy school' coordinators to implement an Australian Better Health Initiative funded strategy to improve physical activity and nutrition in targeted schools.

In conjunction with the Department of Health, the CAHS implemented the Commonwealth funded school human papilloma virus immunisation program.

An Aboriginal Health Team has been established in the Perth metropolitan area to strengthen responses to the community health needs of Indigenous children and their families.

The refugee health service has been expanded and a pilot integrated service team has been implemented in two primary schools in partnership with the Office of Multicultural Interests and the Department for Communities.

Dental Health Services

More than 241,000 WA school children continue to access free oral health treatment through the school dental program.

Dental Health Services actively participates with a range of community organisations including educational authorities to provide oral health input into health lifestyle promotions.

Healthy partnerships

The Metropolitan Health Service recognises the importance of partnerships and co-operative arrangements with other health service providers, government and non-government, and with academic institutions and consumer and carer groups to ensure access to quality health care, support medical and health research, and develop and share infrastructure investment.

North Metropolitan Area Health Service

A contract was signed between WA Health and a private clinic for the provision of 10 beds for voluntary public mental health patients. This has allowed patients from the Sir Charles Gairdner Hospital Emergency Department to receive care in a more appropriate clinical setting.

Access to 10 public medical beds at Hollywood Hospital has been secured. These beds will be used on an ad-hoc basis to address peak demand periods in public hospitals.

A cooperative plan involving the Joondalup Health Campus, the Department of Health and the University of Western Australia (UWA) for the expansion of academic activities at the campus has resulted in the creation of three academic positions. The plan helps meet the need for broadened clinical placement opportunities for the increased numbers of medical students at the UWA while responding to the major priorities of the Clinical Services Framework.

A new satellite dialysis unit costing $2.2 million opened in November 2007 in Stirling. This unit will provide dialysis for up to 120 patients a week who will no longer have to travel to a teaching hospital for dialysis.

A service contract with the South Perth Hospital has provided a 15 bed rehabilitation unit which allows beds at the SCGH to be used for more acute cases.

During 2007-08 the North Metropolitan Area Health Service (NMAHS) Community Advisory Council has continued to meet and encourage consumer representation and involvement in relevant Area Health Service planning and policy.

Sir Charles Gairdner Hospital is trialling the Patient Ambassador Program in association with the Health Consumers' Council. This involved the use of consumer representatives to deliver information from the 'Patient First' publications to hospital patients and carers within the outpatient setting.

South Metropolitan Area Health Service

The project to upgrade and expand renal dialysis services for the northern areas of the South Metropolitan Area Health Service (SMAHS) is progressing. The expanded service will have capacity to dialyse up to 64 patients with isolation facilities and is expected to be operational early in 2009.

The contract for a new renal dialysis service in Rockingham is progressing. This service will provide isolation facilities with a capacity to dialyse up to 48 patients and is expected to be operational in the first half of 2009.

In 2007-08 the Children and Adolescent Health Service collaborated with the Department of Child Protection to enhance the delivery of the Best Beginnings Program within the metropolitan area. This program aims to improve child health and wellbeing, parent and family functioning, and social support networks. Support is provided from a range of professionals including nurses, teachers, social workers and psychologists.

Armadale-Kelmscott Memorial Hospital has offered opportunities for rural and remote theatre nurses to attend the hospital for up-skilling/refresher programs, and is providing an Operation Theatre Consultancy service to rural and remote hospitals.

Armadale-Kelmscott Memorial Hospital has established partnerships with the University of Western Australia and the University of Notre Dame Australia to train medical students and has provided physical facilities for their academic appointments. The hospital also commenced rotation of emergency registrars between Armadale-Kelmscott Memorial Hospital and Fremantle Hospital.

Healthy partnerships (continued)

Child and Adolescent Health Service

Princess Margaret Hospital (PMH) formed partnerships with Joondalup Health Campus, Geraldton Regional Resource Centre, Swan District Hospital and Armadale-Kelmscott Memorial Hospital to enhance the throughput of patients on the ear, nose and throat waitlist, aiding the reduction of over-boundary cases at PMH.

The Child and Adolescent Health Service Community Health Unit has implemented a number of initiatives with schools in partnership with the South Metropolitan Area Health Service (SMAHS) public health units to promote a healthy lifestyle:

- under the Healthy Schools Project to develop the Maddington Kenwick Fruit and Vegie Project in Gosnells. This project aims to increase fruit and vegetable consumption in school children by making creative connections between school food gardens, canteens, and student kitchens. Students learn the connection between school health, the environment, local food systems, and environmental sustainability with the added benefit of eating the results of their efforts in their lunches whilst learning health promoting life skills;
- assisting local schools to establish and manage school food gardens;
- increasing healthy foods provided from school canteens; and
- delivering cooking and food gardening classes for children and parents.

Schools involved in these projects include Orange Grove, Maddington, East Maddington, and East Kenwick Primary Schools, Yule Brook College and Kenwick Primary School.

During 2007 health promotion partnerships also fostered the development of working partnerships and funding arrangements between a number of government and non-government organisations and local schools and includes the Maddington Kenwick Sustainable Communities Partnership, Perth City Farm, Foodbank WA, the Public Education Endowment Trust and the Maddington Kenwick Community Leaders Network.

PathWest Laboratory Medicine WA

The appointment of a Professor of Laboratory Medicine within the University of Western Australia's Medical Faculty which is jointly funded by the University and PathWest will ensure an adequate training faculty to address the predicted shortage of pathologists in WA.

The vacation employment program for undergraduate medical scientist students from the Curtin University of Technology introduced in 2006-07 is delivering benefits in training and relationship building between potential employees and PathWest.

Dental Health Services

Access to patient level information is now available to all participating private dental practitioners following a successful trial in 2006-07. This benefits the practice, the patient and Dental Health Services (DHS) as it reduces the need for confirmation of patient information and payment details with DHS.

The roll out of access to the Centrelink database by DHS has been undertaken in 2007-08 and is due for completion. This access assists patients in confirming their eligibility for subsidised dental care.

Healthy resources

The provision of health care services in a sustainable, equitable, efficient and accountable manner to deliver the best health outcome possible, in a safe working environment is a priority for all WA Health services. The management of services must also address Government policy and infrastructure reform.

Chronic disease management

Chronic Disease Management Teams aim for a 25 per cent reduction in hospital utilisation by patients that have graduated from the Chronic Disease Management Program in 2007-08. An evaluation of the program is currently underway and the final report with both qualitative and quantitative data will be available.

WoundsWest

A number of WoundsWest projects were completed or are progressing in 2007-08:

- state-wide wound prevalence survey has been completed and distributed to all health services;
- second prevalence survey was completed in April/May 2008;
- Core Wound Management module and the first of four sub-specialty modules are online, with another two planned in 2008;
- recruitment for a WoundsWest Consultant Team is in progress; and
- wound imaging and documentation system is in development. Eight trial sites have been confirmed and installation took place in March 2008. Implementation and a pilot phase took place in April 2008.

Outpatients

The administrative redesign and policy revision of the Metropolitan Outpatient Clinic appointment system has reduced average wait times for clinic appointments. In addition, the use of WA Health's call centre, 'Outpatient Direct' for the cancellation and rescheduling of appointments, referral acknowledgements and text messaging for appointment reminders at some sites is also contributing to improved outcomes and service delivery for outpatients.

HITH/RITH

'Hospital in the Home' (HITH) and 'Rehabilitation in the Home' (RITH) patient day activity has increased significantly across the metropolitan area in 2007-08 providing better care outcomes for these patients.

North Metropolitan Area Health Service

During 2007-08 over $8 million was approved for medical equipment in the North Metropolitan Area Health Service including Princess Margaret Hospital, BreastScreen WA and Dental Health Services, and items included:

- examination scopes and scope cleaning equipment;
- ventilators;
- ultrasound units and ECG monitors;
- bed replacement and bariatric equipment;
- ward based equipment;
- film digitisers;
- theatre instruments and equipment;
- neurosurgical, plastic surgery and eye microscopes; and
- a traction table and a trauma table.

South Metropolitan Area Health Service

During 2007-08 over $7 million was approved for medical equipment in the South Metropolitan Area Health Service and items included:

- ultrasound units and general medical monitors;
- cardiac monitoring equipment;
- scope replacement;
- laboratory equipment;
- theatre tables and equipment; and
- a traction table and a trauma table.

PathWest Laboratory Medicine WA

PathWest continues to investigate a fee for service model for laboratory services provided to teaching hospitals. It is expected full fee for service will be introduced in the next financial year.

The Royal College of Pathologists 'national benchmarking in pathology costs' program has been extended to all metropolitan laboratories and one regional centre.

During 2007-08 approximately $3 million was approved for PathWest for additional and replacement laboratory and analytical equipment.

Healthy leadership

Establishing and maintaining an environment that develops and provides strong leadership at all levels is a paramount objective for WA Health. It is especially vital in the delivery of quality and accessible health care in conjunction with health system reform. Health services focus on identifying potential leaders and providing them with access to leadership development programs.

Health Networks

During 2007-08 the number of health networks grew to 17 with three new networks established – the Genomics Network, the Acute Services Network, and the Women's and Newborn's Network. Clinicians and relevant staff of the Metropolitan Health Service are members of all health networks.

The Networks are now integral to health reform by leading system-wide changes. Each Network clinical lead continues to embrace their role as "change champion" and has led innovative, robust and sustainable engagement that looks at health care from a patient centered approach. Endorsement for their key roles across WA Health has seen the formalizing of the WA Leads Forum as a sub-committee of the State Health Executive Forum.

The Networks are developing or have developed evidence based models of care for their speciality areas. This process features extensive stakeholder consultation to ensure the 'models' meet the needs and aspirations of the broader community. At this stage over 20 models of care have been developed across the variety of speciality areas. The models of care outline a patient-centred approach to the continuum of care for relevant health conditions or for a population based health care framework.

North Metropolitan Area Health Service

The Neonatology Clinical Care Unit at King Edward Memorial Hospital for Women won the inaugural Director General's Choice Award at the 2007 Healthy WA Awards.

Sir Charles Gairdner Hospital has introduced a hospital-wide initiative to provide clinical coaches to supplement the role of the Staff Development Nurse during times of graduate commencement.

North Metropolitan Area Health Service (NMAHS) staff continue to actively participate in leadership opportunities such as the 'Emerging Leaders' and 'Leading 100' programs and other programs and leadership opportunities developed and implemented by the Institute of Healthy Leadership.

NMAHS senior executive staff participated in a strategic planning activity in March 2008. This resulted in the identification of strategic and operational priorities for the Area Health Service aligned with priorities for WA Health.

South Metropolitan Area Health Service

South Metropolitan Area Health Service (SMAHS) Rehabilitation in the Home (RITH) Area Manager Nicki Newton was awarded a Churchill Fellowship in 2007 to investigate the development of hospital substitution and early discharge allied health services in the United Kingdom, Sweden and Italy.

SMAHS has 28 participants in the 2008 Department of Health Emerging Leaders Program.

Child and Adolescent Health Service

The Child and Adolescent Health Service supports the development of its current and future leaders encouraging staff to participate in the 'Executive' and 'Emerging Leaders' programs for both middle and senior executive management offered by the Institute of Healthy Leadership.

Dental Health Services

Bullying and harassment prevention training has been provided for all managers and 80 per cent of other staff.

A Performance Management training program for managers/supervisors has been developed and commenced May 2008 with 25 per cent completed by 30 June 2008.

Priorities for 2008-09

WA Health's 'Strategic Directions 2005-10' recommendations, and directions provided by the health reform process will continue to drive health care in 2008-09.

Healthy workforce

WA Health continues to work to develop a sustainable workforce that can deliver the required health services for the future where WA Health is an 'employer of choice'.

Key areas of focus and priority for the North Metropolitan Area Health Service (NMAHS), South Metropolitan Area Health Service (SMAHS) and Child and Adolescent Area Health Services (CAHS) remain workforce attraction and retention, promoting work-life balance and family friendly workplace initiatives including child care strategies, developing workforce innovation, increasing the recruitment of Indigenous health professionals, workforce re-engineering (e.g. nurse practitioner roles), and transition planning for future workforce requirements. Strategies to assess workforce satisfaction, and promote leadership and management skills also remain priorities.

Particular priorities for the Metropolitan Health Service (MHS) are:

- The Women and Newborn Health Service (WNHS) will provide the In-Time 'train the trainer' course to a further four peripheral maternity units. This is a short training course to enhance clinicians skills for managing obstetric emergencies;
- The WNHS will participate in an obstetrics review in collaboration with the State Obstetric Services Unit;
- The Dental Health Service will continue the implementation of the Dental Health Workforce Plan;
- The Child and Adolescent Health Service will appoint additional outpatient nursing and medical staff to the Johanna Sewell Adolescent Oncology Ward to service the increased numbers of patients being seen in the ward; and
- The 'Assistant in Nursing' Model of Care will be developed and implemented by the Child and Adolescent Health Service.

Healthy hospitals, health services and infrastructure

The management of demand for health services will remain a critical challenge for the MHS especially for providing elective surgery capacity that meets category timeframes and managing emergency department activity. In addition, initiatives such as encouraging GP After-Hours clinic activity, increasing day and ambulatory surgery and the use of alternative care options such as the Hospital in the Home (HITH) and Rehabilitation in the Home (RITH programs will assist.

Particular priorities for the MHS are:

- SMAHS will commence the Intensive Care Unit Expansion Project with the addition of seven intensive care/high dependency beds at Fremantle Hospital;
- SMAHS is to open a vascular theatre at Royal Perth Hospital in late 2008 providing facilities for endoluminal work;
- Princess Margaret Hospital for Children will develop a process for other metropolitan hospital sites to refer patients to its HITH program;
- The Anticoagulation Service will be expanded to incorporate a daily clinic service and partnership model from June 2008 allowing direct referrals and timely review of patients for anticoagulation management and education; and
- In 2008-09 the RITH program will develop referral pathways for Swan District Hospital and the Mercy Restorative Unit, investigate clinical governance models with geriatricians and investigate direct referral processes to avoid presentations to Emergency Departments.

The Emergency Department Taskforce, announced in February 2008, developed a number of reform initiatives to address the high demand in metropolitan emergency departments with the following strategies to be implemented in 2008-09:

- a coordinated approach to the recruitment and retention of nursing staff to alleviate staff shortages and facilitate the availability of currently closed acute tertiary beds;
- a close partnership with St John Ambulance Association to reduce ramping;
- further implementation of the Clinical Services Redesign program to assist with Emergency Department activity flow;

Priorities for 2008-09 (continued)

Healthy hospitals, health services and infrastructure (continued)

- planning for additional home care packages and Care Awaiting Placement beds at Bentley Hospital and ten sub-acute beds at Bethesda Hospital to divert patients from Emergency Departments; and
- community education about appropriate use of Emergency Departments, including an Emergency Department services website which will provide information on ED attendances, admissions and ambulance diversions.

The 15 bed adult Emergency Short Stay unit at Rockingham-Kwinana District Hospital will become operational in late 2008. The Hospital will also recruit a full-time medical director for its Emergency Department.

To further assist the efficient management of referrals the Area Health Services will develop a soft copy electronic referral system based on clinical priority access criteria. Management guidelines for selected complex conditions are also to be developed to streamline the diagnostic work required to support a timely and fully utilised outpatient appointment.

The eating disorders program at Princess Margaret Hospital (PMH) will expand in 2008-09 to provide more places in the intensive day treatment, and for the in-home and outpatient therapy programs. Additional staff will be employed and new premises refurbished to accommodate the day treatment program.

Development of new services for clients with Attention and Hyperactivity Related Disorders will commence.

The Child and Adolescent Health Service will develop a paediatric burns Telehealth education program for rural clinicians.

During 2008-09 the business plan and assessment of the North Metropolitan Area Health Service (NMAHS) ambulatory care for chronic obstructive pulmonary disease service are to be completed.

Strategic planning for a diabetes ambulatory care service is to be completed by December 2008.

Healthy communities

In 2008-09, WA Health will continue to focus on improving lifestyles, preventing ill health and implementing long-term, integrated health promotion programs often in partnership with other government and non-government agencies, general practitioners and community groups. Particular programs will target chronic illness and long-term conditions, and improve the community-based management of these conditions.

Key priorities for 2008-09 are:

- NMAHS Public Health Unit will initiate community-based health promotion and disease response programs that have proven successful by the SMAHS especially for pandemic flu planning, Indigenous chronic disease management and health promotion, and sexual health disease tracing and follow up;
- South Metropolitan Area Health Service (SMAHS) Public health Unit will support the development of local government health plans aimed at chronic disease prevention and will share information, expertise and resources with local government to promote best practice and public health policy; and
- SMAHS Public Health Unit will also investigate the potential for partnerships to deliver the 'Journey of Living with Diabetes' program and continue training opportunities for Indigenous health professionals to deliver the program in Indigenous communities.

Healthy resources

A key rationale for reform in WA public health system is the need to deliver a sustainable, equitable and accountable health care service to all West Australians.

Key priorities for 2008-09 are:

- Women and Newborn Health Service will commence planning for a comprehensive ongoing online database mapping maternity services and personnel across Western Australia;
- WA Health will continue implementation of the Information and Communication Technology Strategy;
- to progress implementation of a population and output-based resource allocation model for WA Health;.
- to finalise transition planning for the expansion of the Rockingham-Kwinana District Hospital and develop a transition plan for the Fiona Stanley Hospital;

- to develop new digital mammography accreditation standards to cater for the national migration to digital imaging with BreastScreen WA programs in states and territories;
- to align current medical records identification numbers with the hospital generated unit medical record number providing the platform for electronic transfer of medical records and digital mammographic images; and
- to construct the acute mental health inpatient facility for adults and older people as part of the Rockingham-Kwinana District Hospital Campus redevelopment under the WA Health Clinical Services Framework.

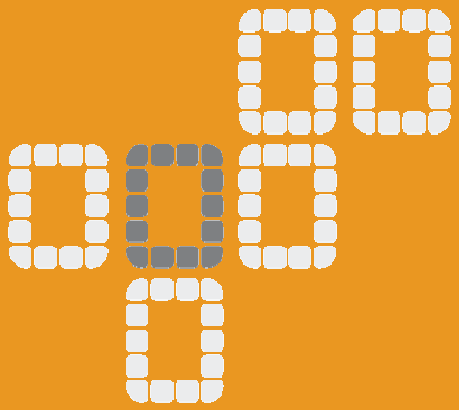
Healthy leadership

Healthy leadership is vital to delivering effective and efficient health care in the future.

The Institute of Healthy Leadership will continue its leadership initiatives including:

- facilitating leadership development programs for senior staff;
- offering Graduate Development programs for a number of health and administrative disciplines; and
- providing Service Improvement Workshops.

During 2008-09 the Health Networks will work closely with Area Health Services and other WA Health Divisions to implement the models of care which will result in significant system-wide change over the next 5-10 years.



Operations

Advertising

In accordance with section 175ZE of the *Electoral Act 1907*, the Metropolitan Health Service (MHS) incurred the following expenditure on advertising agencies, market research, polling, direct mail and media advertising. Total expenditure for MHS in 2007-08 was $3,387,238.

Table 58: Advertising expenditure for 2007-08

Summary of Advertising	Amount ($)
Advertising Agencies	3,167,832
Media Advertising Organisations	223,692
Polling Organisations	Nil
Market Research Organisations	Nil
Direct Mail Organisations	714

Expenditure Category	Recipient / Organisation	Amount	Total
Advertising Agencies			
	303 Group Pty Ltd	21,375	
	APN Educations Media Pty Ltd	13,750	
	Australasian College of Physical Scientists and Engineers in Medicine	1,720	
	Australasian Medical Publishing Co Pty Ltd	909	
	Australian and New Zealand Intensive Care Society	2,155	
	Australian Association of Social Workers	220	
	Australian Business Pages Directory	195	
	Australian College of Emergency Medicine	1,766	
	The Australian Firefighter	995	
	Australian Nursing Solutions Pty Ltd	11,000	
	Australian Physiotherapy Association	100	
	Beilby Corporation Pty Ltd	40,143	
	Bigredsky Ltd	1,600	
	Cat Fish Marketing Concepts	977	
	Concept Media	653	
	CXC Consulting Pty Ltd	642	
	Denmark Chamber of Commerce Inc	190	
	DPS Publishing Pty Ltd	297	
	Elsevier	888	
	Fast Track Media	3,463	
	Ghost Pictures Pty Ltd	62	
	Harcourt Assessment	2,330	
	Health Promotion Resources Pty Ltd	809	

Expenditure Category	Recipient / Organisation	Amount	Total
Advertising Agencies (continued)			
	Healthstaff Recruitment	9,000	
	Imatec WA Pty Ltd	825	
	Industry & Commerce	1,326	
	Jeffress Advertising	25,586	
	Kalgoorlie Boulder Chamber of Commerce Inc	45	
	Karen Laurie	78	
	Lasso Kip Pty Ltd	198	
	Marie Squires	226	
	Marketforce Express	2,545,544	
	Medform Pty Ltd	3,938	
	Media Decisions WA	403,640	
	Media Monitors Australia Pty Ltd	532	
	Medipeople Pty Ltd	2,672	
	National Australia Bank Ltd	2,208	
	The Nursing Post Pty Ltd	18,597	
	Osmosis Medical Recruitment	12,234	
	Pharmaceutical Council of Western Australia	600	
	Royal Australasian College of Medical Administrators	788	
	Royal Australasian College of Physicians	550	
	Rural Health West	5,800	
	Rural Press Regional Media (WA) Pty Ltd	353	
	Seabreeze Communications Pty Ltd	1,762	
	Sensis Pty Ltd	3,361	
	Seton Australia Pty Ltd	25	
	Snap Printing	1,272	
	Telstra Corporation Ltd	5,358	
	Testro Factoring Pty Ltd	820	
	Thoracic Society of Australian and New Zealand Inc	70	
	University of Western Australia	10,986	
	Wavelength International Pty Ltd	2,387	
	Westaff (Australia) Pty Ltd	765	
	The West Australian	47	**3,167,832**
Media Advertising Organisations			
	Australian Business Pages Directory	409	
	The Brand Agency Pty Ltd	54	

Table 58: Advertising expenditure for 2007-08 (continued)

Expenditure Category	Recipient / Organisation	Amount	Total
Media Advertising Organisations (continued)			
	City of Mandurah	315	
	College of Emergency Nursing Australasia	200	
	Community Newspaper Group Ltd	2,952	
	Concept Media	2,107	
	Country Women's Association of Western Australia Inc	2,200	
	Examiner Newspapers (WA)	264	
	Marketforce Express	67,924	
	Media Decisions WA	78,234	
	Medical Forum Magazine	1,694	
	Metropolitan Allied Health Council	242	
	Nationwide News Pty Ltd	65	
	The Nursing Post Pty Ltd	22,790	
	Osborne Park Agricultural Society Inc	715	
	OT Australia WA	285	
	Pelican Graphics Pty Ltd	1,710	
	The Perth Diocesan Trustees	264	
	Pharmaceutical Council of WA	605	
	Picton Press	110	
	Quality Press WA	1,279	
	Quokka Press	273	
	Record Newspaper	16	
	Reed Business Information Pty Ltd	1,359	
	The Royal Australasian College of Physicians	1,045	
	The Royal Australian & New Zealand College of Obstetricians and Gynaecologists	660	
	Rural Press Regional Media (WA) Pty Ltd	271	
	Seek Ltd	363	
	Sensis Pty Ltd	7,000	
	Sheridan's for Badges	57	
	St John's Books	125	
	Tour Hosts Pty Ltd	636	
	Under New Management	1,898	
	Unity of Ethiopians in Western Australia Inc	3,520	
	University of Western Australia	409	
	Wavelength International Pty Ltd	6,572	
	The West Australian	15,070	**223,692**
Direct Mail Organisations			
	The Australasian College for Emergency Medicine	714	**714**

Corruption Prevention

Government agencies are required to specifically consider the risk of corruption and misconduct by staff, and to report on risk reduction strategies in place within the agency. Within WA Health, the existence of an effective accountability mechanism is fundamental to good corporate governance.

This year WA Health carried out a total of 337 investigations of alleged misconduct.

Strategies have been introduced across WA Health in 2007-08 to assist the prevention of corruption and include:

- A Fraud and Corruption Control (FCC) Committee has been established to consider system-wide initiatives, monitor and review fraud and corruption risk assessments and monitor fraud prevention development. The FCC Committee includes representatives from all areas of WA Health;
- A Fraud and Corruption Control Plan has been established, its goals being to set an appropriate strategic framework that defines management and staff responsibilities and ensure the implementation of robust practices for the effective detection, investigation and prevention of fraud and corruption of all types that may arise in WA Health or as a result of its organisation or staff activities;
- An education awareness program is in place for the Department and all health services, and is being delivered to all staff in all disciplines and locations. Presentations were developed in consultation with appropriate external oversight agencies, including the Corruption and Crime Commission and the Office of the Public Sector Standards Commissioner;
- Reviews of all WA Health policies and supporting documents pertaining to professional standards, misconduct and the promotion of ethical behaviour have been commenced;
- Misconduct and corruption risk has been included for mandatory assessment by all units in the annual WA Health Significant Risk Assessment, and are acknowledged and addressed in the annual Significant Risk Register;
- Mechanisms have been established for ensuring an appropriate knowledge among staff is achieved in relation to awareness of compliance requirements, legislation and lawful instructions, delegation, application of the risk management process, suitable governance arrangements and improvement plans where indicated;
- Misconduct incidents are reportable to the Corporate Governance Directorate, which assesses and investigates where appropriate, provides advice to health services, and maintains liaison with relevant external agencies. Its monitoring activities inform the WA Health Executive, external authorities, the WA Health strategic risk management programs, the risk management programs of the Department of Health, all health services and Internal Audit; and
- Risk Management education, advice and support for misconduct risk management is provided by Risk Management Coordinators within the Department of Health, the health services and the Corporate Governance Directorate.

Disability Access and Inclusion Plan

The Disability Services Act 1993 was introduced to ensure that people with disabilities have the same opportunities as other West Australians. A 2004 amendment to the Act required the Department of Health to develop and implement a Disability Access and Inclusion Plan.

During 2007-08, the Metropolitan Health Service (MHS) provided a range of programs and initiatives to meet its Disability Access and Inclusion Plan (DAIP) key outcomes. Some specific initiatives for 2007-08 follow:

Outcome 1:

People with a disability have the same opportunities as other people to access the services of, and events organised by, the relevant public authority:

- Sir Charles Gairdner Hospital (SCGH) introduced universally accessible reception counters in its new Interventional Neuroradiology suite and computed tomography (CT) suite;
- Community Physiotherapy established new services for clients with disabilities such as Parkinson's disease, neurological disease, chronic obstructive pulmonary disease, frequent falls and chronic back pain;
- The Centenary Clinic for Women and Newborn Health Service outpatients has purchased a wheelchair-capable set of scales to weigh patients;
- Sit-on scales have been purchased for children with disabilities who must be weighed in the Intensive Care Unit, the Botox Ward or the Day-Stay Ward;
- The redevelopment of Rockingham-Kwinana District Hospital includes a review of all plans by the Senior Nurse (Disability) and a consumer representative is also providing valuable information to the Infrastructure Committee on consumer needs;
- The Bentley Health Service has undertaken a site-wide survey to ensure compliance with the *Disability Discrimination Act 1992* (Cth);
- A room and mobility equipment in the Princess Margaret Hospital outpatients area has been provided to address the needs of people with a disability who are attending clinics; and
- Complaint coordinators have been made aware of the requirements of people with disabilities in the Dental Health Services complaint system.

Outcome 2:

People with disabilities have the same opportunities as other people to access the buildings and other facilities of the relevant public authority:

- An upgrade to SCGH ward G74 was completed with standards compliant toilets and showers for disability access;
- Bathroom and shower modifications have been undertaken in some areas at King Edward Memorial Hospital (KEMH) to allow for access of wheelchairs and hoists;
- Where appropriate, Community Physiotherapy have relocated to venues with disability access;
- KEMH Ward 6 and the Delivery Suite have modified their negative pressure rooms to ensure that they can be accessed by bariatric patients;
- The Chronic Disease Management Team's new ambulatory care venues at Joondalup and Midland have incorporated disabled access and bathroom facilities;
- The KEMH's Mother and Baby Unit is equipped with a facility for physically disabled people;
- BreastScreen WA's metropolitan clinics provide access for patients with disabilities.
- An audit of access to North Metropolitan Area Health Service Mental Health sites was completed in July 2007 and individual service sites were advised of any deficiencies;
- Osborne Park Hospital installed new disability access signage to meet Australian standards, including marking of car bays;
- Osborne Park Hospital implemented modifications recommended during the hospital's Disability Access Audit, including relocating the pathology service to the theatre block to allow better ease of access and providing appropriate rest seating in corridors and ward entrances;
- Royal Perth Hospital's Community Advisory Council tested disability access to hospital facilities by using only maps, information boards and signage. Appropriate recommendations for change were made;

- Armadale Health Service has reaudited all transport-related infrastructure against the Transport Standard of the *Disability Discrimination Act 1992* (Cth);
- A toilet for people with disabilities was installed in the PMH Psychological Medicine Clinical Care Unit;
- Provision of electric beds on the adolescent ward at PMH allows greater independence for patients with disabilities; and
- Dental Health Services undertake regular reviews to ensure access to buildings and facilities. During 2007-08 Dental Health Services and the Town of Victoria Park commenced installation of disabled toilet facilities at the Liddell Street Clinic.

Outcome 3:

People with disabilities receive information from the relevant public authority in a format that will enable them to access the information as readily as other people are able to access it:

- MHS staff continue to receive education regarding the availability and process to access Auslan interpreters for people with hearing impairment;
- Following lodgement of the Sir Charles Gairdner Hospital Disability Access and Inclusion Plan (DAIP) 2007-2012 with the Disability Services Commission, the community was advised via newspaper and radio of the availability of copies of the plan in a range of formats;
- A number of MHS intranet websites include a link to the DSC information sheet 'Making Information Accessible';
- KEMH has upgraded all site signage to comply with the DAIP, using pictograms and Braille signage;
- The Women and Newborn Health Service patient brochure template has been changed to include the statement 'this information is available in alternate formats upon request';
- The WA Cervical Cancer Prevention Program worked together with the Disability Services Commission to produce appropriate brochures for women with intellectual disabilities. These brochures are available in plain print and also in spoken word on tape.
- BreastScreen WA's *A Guide to Breast Health* booklet has been updated. Women with intellectual, vision or hearing impairment are assisted with the use of easy to understand literature, forms, and Telephone Typewriter services as required. A presentation about the service was given to women with hearing impairment;
- The PMH Publication Committee is represented on the Disability Advisory Committee and is kept informed regarding disability access standards when reviewing and approving hospital publications and external and training resources;
- The PMH family handbook review has been completed and the booklet now includes information for people with disabilities on how to access services, seek assistance, provide feedback and lodge a complaint;
- The postnatal care magazine 'Welcome to Your New Baby' is available in alternative formats upon request. The magazine lists organisations to contact for further information and support including the Disability Services Commission and other applicable organisations;
- Child and Adolescent Community Health has established a service to translate documents into Braille on request to ensure optimal access to information for all consumers; and
- Dental Health Services makes published material available in alternative formats, such as Braille, CD-ROM, audio compact disc and large print. Telephone typewriter is also available.

Outcome 4:

People with disabilities receive the same level and quality of service from the staff of the relevant public authority as other people receive from that authority:

- The SCGH DAIP was lodged with Disability Services Commission. The hospital's DAIP Reference Group replaced the previous Disability Service Plan Reference Group and is responsible for reviewing and monitoring the implementation of the hospital's DAIP;
- A staff resource was developed in consultation with the Association for the Blind on "providing services to a person who has a vision impairment";
- Swan Kalamunda Health Service has continued the formation and development of the Health Service's DAIP Committee to focus on equitable outcomes for people with disabilities. The committee responsibilities include representing the needs of people with disabilities in the design of the Midland Health Campus;
- MHS sites have made their DAIP accessible via their Intranet services;
- The RPH Community Advisory Council reviewed and endorsed the hospital's Disability Access and Inclusion Plan;

Disability Access and Inclusion Plan (continued)

Outcome 4 (continued)

- MHS staff induction training and in-service training sessions include presentations regarding disability access and applicable DAIPs and relevant legislation;
- MHS job description forms including Dental Health Services, are being reviewed to ensure they include disability awareness in the selection criteria;
- Staff at North Metropolitan Area Health Service (NMAHS) Mental Health Service were surveyed regarding their knowledge of needs of clients with disabilities;
- NMAHS Mental Health conducted an area wide consumer survey in October 2007 in order to monitor the satisfaction rate of clients, including those with disabilities;
- PMH includes in its staff development and training sessions information on disability and childhood incontinence as well as training in sexual health of intellectually disabled teenagers; and
- The PMH Speech Pathology Department liaises with the Independent Living Centre WA to arrange hire of augmentative and assistive communication devices for children with disabilities and is seeking funding to purchase a comprehensive range of these devices. This Department also works extensively with community and disability service providers to ensure the smooth transition of children with disabilities from the acute tertiary setting to community care.

Outcome 5:

People with disabilities have the same opportunities as other people to make complaints to the relevant public authority:

- All MHS sites ensure the there are mechanisms available for people with a disability to lodge complaints. Complainants are advised of the process to be followed and in most cases sites will use a DAIP coordinator to manage the complaint submission and resolution. The MHS also ensures that access for people with disabilities to interpreters, communication aids and links to external services is available. Complaints can be made in writing, provided verbally or transcribed to accommodate the needs of the health service consumer;
- The 'Suggestions, Complaints, Compliments, Concerns' Poster at Swan Kalamunda Health Service included National Relay Service contact details to assist the hearing impaired in communicating with the Consumer Liaison Officer;
- Grievance mechanisms are in place in the Dental Health Service allowing people with disabilities to participate without impediment; and
- PathWest Laboratory Medicine WA request forms have been updated to include a prominent statement encouraging suggestions for improvement to provision of service and access for people with disabilities.

Outcome 6:

People with disabilities have the same opportunities as other people to participate in any public consultation by the relevant public authority:

- The Sir Charles Gairdner Hospital Community Advisory Council includes a consumer with a disability;
- The Women and Newborn Health Service DAIP is accessible on the public internet site and consumer feedback is invited;
- A publicity campaign for the recruitment of new Royal Perth Hospital Community Advisory Council members was advertised through the Health Consumers Council and included people with disabilities;
- Armadale Health Service has developed a register of experienced persons to provide comment on access and inclusion issues; and
- Princess Margaret Hospital has actively involved young people and parents on the Transitional Framework Working Party to improve the transition of young people with disabilities from paediatric to adult care.

The Child and Adolescent Health Service Community Advisory Council includes representatives of the disability sector and their carers. It has reviewed its terms of reference and identified the area of disability and diversity as one of its key portfolios for 2007-2008. The Council also has a representative on the Princess Margaret Hospital Disability Advisory Committee.

Employee Profile

Agencies are required to report a summary of the number of employees by category, in comparison with the preceding financial year. The table below shows the average number of full-time equivalent employees for the Metropolitan Health Service year-to-date June 2008, by category.

Table 59: Total Metropolitan Health Service FTE by category

Category	Definition	2006-07	2007-08
Administration & clerical	Includes all clerical-based occupations together with patient-facing (ward) clerical support staff.	3,314	3,476
Agency	Includes FTE associated with the following occupational categories: administration and clerical, medical support, hotel services, site services, medical salaried (excludes visiting medical practitioners) and medical sessional.	270	433
Agency nursing	Includes workers that are engaged on a 'contract-for-service' basis. Does not include workers employed by NurseWest.	162	191
Assistants in nursing	Support registered nurses and enrolled nurses in delivery of general patient care.	n/a	22
Dental nursing	Includes dental clinic assistants.	253	256
Hotel services	Includes catering, cleaning, stores/supply laundry and transport occupations.	2,357	2,405
Medical salaried	Includes all salary-based medical occupations including interns, registrars and specialist medical practitioners.	2,230	2,364
Medical sessional	Includes specialist medical practitioners that are engaged on a sessional basis.	255	262
Medical support	Includes all Allied Health and scientific/technical related occupations.	3,871	4,127
Nursing	Includes all nursing occupations. Does not include agency nurses.	7,540	7,740
Site services	Includes engineering, garden and security-based occupations.	375	383
Other categories	Captures Aboriginal and ethnic health worker related occupations.	40	38
Total		**20,667**	**21,697**

Note:
Data includes NMAHS, SMAHS, CAHS, PathWest Laboratory Medicine WA and Dental Health Service.
Data includes Peel Health Service as numbers cannot be easily extracted from SMAHS.
Data excludes the Drug and Alcohol Office.
2006-07 reported data has been realigned to reflect 2007-08 FTE definitions.

Freedom of Information

For the year ending 30 June 2008, the Metropolitan Health Service received 4438 formal applications for access to information in accordance with the *Freedom of Information Act 1992*.

Table 60: Freedom of information applications 2007-08

Applications	Number
Carried over from 2006-07	133
Received in 2007-08	4,305
Total applications received in 2007-08	4,438
Granted: full access	3,586
Granted: partial or edited access	452
Withdrawn	65
Refused	41
In progress	256
Transferred and other	38

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

- patient medical and dental records;
- patient information brochures and instruction sheets;
- policy and procedures manuals;
- engineering records, such as hospital plans and occupational safety and heath information;
- human resource records;
- financial and accounting records; and
- administrative records, for example, committee meeting minutes and business correspondence.

Industrial Relations

Please see the Department of Health Annual Report 2007-08.

Internal Audit Controls

The Corporate Governance Directorate has the role of accountability adviser and independent appraiser, reporting directly to the Director General. The Directorate provides internal audit, accountability and risk services to the Director General, Senior Management and WA Health, in support of the common objective of achieving and maintaining sound managerial control over all aspects of operations.

The Director General has assigned to the Director, Corporate Governance responsibility for developing and maintaining an effective internal audit function, and requires that management and staff within WA Health cooperate with authorised Directorate staff as necessary in the conduct of this assigned work.

Audits undertaken were generally planned audits; however, on occasion, management-initiated or special audits were also carried out. Audits were of a compliance, performance or information systems nature. External consultants were utilised to complete four out of a total of thirty-three audits completed during 2007-08.

WA Health has an overarching Audit Committee that considers matters of strategic importance and system-wide issues. This Committee is advised by and receives information from a number of sub-committees, which consider operational issues as they relate to specific areas. Sub-committees exist for the North Metropolitan Area Health Service, the Child and Adolescent Health Service, the South Metropolitan Area Health Service, the WA Country Health Service, the Department of Health and Health Corporate Network. Each sub-committee has an external chairperson, who is responsible for reporting any matters of operational importance to the WA Health Audit Committee. To ensure appropriate and timely advice is provided to the Director General, the Audit Committee also has oversight of WA Health's Strategic Audit Plan and other associated governance issues and governance-related programs.

Refer to next page for Table 61

Internal Audit Controls (continued)

Table 61: Internal Audits completed in 2007-08

Audit	Area audited
Accounts payable, supply & finance	Health Corporate Network
Accounts receivable	Health Corporate Network
Asset accounting	Health Corporate Network
Audit log integrity	WA Health
Budgeting	Health Finance, WA Country Health Service
Clinical credentialing	Child and Adolescent Health Service, Health Workforce, North Metropolitan Area Health Service, South Metropolitan Area Health Service
Corporate HR data warehouse	Health Corporate Network
Email management, archiving and security	Health Information
Financial and governance audits, Royal Perth Hospital Staff Amenities Fund	South Metropolitan Area Health Service
Financial returns	Volunteer organisations within the Metropolitan Health Service
FMA compliance	Drug and Alcohol Office, WA Country Health Service
Governance review, Wirraka Maya Health Service	Commonwealth Department of Health and Ageing
Health Accounting Manual	Health Corporate Network
Information protection	Health Information
Major capital works project management	South Metropolitan Area Health Service
Non-government organisation contract management	Health Finance
Payroll processing and follow-up	Health Corporate Network
Privately-referred non-inpatient initiative	North Metropolitan Area Health Service, Child and Adolescent Health Service; South Metropolitan Area Health Service
Records management	WA Country Health Service
Review of Health Reform Implementation Taskforce	Health Reform Implementation Taskforce
Salary packaging and fringe benefits tax reporting	Health Workforce
System control review of pharmacy stocks, Royal Perth Hospital	South Metropolitan Area Health Service
Theatre management Royal Perth Hospital	South Metropolitan Area Health Service

Major Capital Works

Please see the Department of Health Annual Report 2007-08.

Pricing Policy

The Australian Health Care Agreement (AHCA) sets the macro pricing framework for the charging of public hospital fees and charges.

Under the AHCA, where a Medicare eligible patient elects to receive medical treatment as a public patient in a public hospital, they will be treated 'free of charge'.

The only exception to this pricing policy for eligible patients is where Nursing Home Type Patients (after 35-days convalescence), may be charged a patient contribution, as determined by the Commonwealth Minister for Health and Ageing.

Private patients, compensable patients and ineligible persons may be charged an amount for public hospital services as determined by the State of Western Australia.

The one exception to the charging of health services to these chargeable classes of patients is that pharmaceutical services to admitted private patients will be provided 'free of charge' and cannot be claimed under the Pharmaceutical Benefits Scheme.

The pricing policy for the setting of public hospital accommodation charges to private patients is dictated by our ability to pass on these costs to the private health insurers.

Current arrangements with the Commonwealth allow for the Department of Health to charge both compensable and ineligible patients on the basis of full cost recovery.

Under the AHCA, eligible patients who have entered into 'third party' arrangements with compensable insurers are known as compensable patients. This includes the Australian Defence Forces, the Insurance Commission of Western Australia covering motor vehicle accident patients and WorkCover for workers' compensation patients.

The one exception with compensable patients is the charging of eligible war service veterans, who are covered under a separate Commonwealth-State agreement with the Department of Veterans' Affairs. Under this agreement the Department of Health does not charge medical treatment costs to eligible war service veteran patients, instead medical costs are fully recouped from the Department of Veterans' Affairs.

The majority of fees and charges for public hospitals are set out in the *Hospitals (Services Charges) Regulations 1984 and the Hospitals (Services Charges for Compensable Patients) Determination 2005*. The public hospital fees and charges are reviewed annually and increased in accordance with Ministerial and other approval processes. The exceptions are fees for pharmaceuticals and nursing home type patients, which are increased on advice from the Department of Health and Ageing.

Dental Health Services charges eligible patients subsidised dental care based on the Commonwealth Department of Veterans' Affairs Local Dental Officers fee schedule, with eligible patients charged either of the following co-payment rates:

- 50% of the treatment fee if the patient is the holder of a Health Care Card or Pensioner Concession Card; and
- 25% of the treatment fee if the patient is the holder of one of the above cards and in receipt of a near full pension or benefit from Centrelink or the Australian Government Department of Veterans' Affairs.

Recordkeeping

WA Health has continued to progress its Recordkeeping Plan.

All new employees in the Metropolitan Health Service (MHS) are informed of their obligations in regard to recordkeeping through induction programs and in-service training to ensure employees are kept up-to-date with recordkeeping policies and practices especially for their responsibilities under the *State Records Act 2000*.

Following is a brief summary of the recordkeeping initiatives adopted by the MHS.

The North Metropolitan Area Health Service Safety, Quality and Performance Unit is trialing a new file titling scheme.

Record keeping at Bentley Health Service has been evaluated and the archiving of secondary documentation is being considered. This will create space for new records and maintain the accessible hospital records in line with occupational safety and health standards.

Armadale Health Service maintains documents on the SMAHS Intranet site supported by Library and Web Services at Fremantle Hospital.

MHS sites perform routine medical record audits to ensure accuracy and completeness of medical records, and that sites are complying with the requirements of the WA Health Patient Information Retention and Disposal Schedule.

Rockingham-Kwinana District Hospital currently uses a paper-based traced card system that is updated for movement of every medical record. However planning is underway to implement the more efficient Medical Record Information Tracking System. The hospital has also archiving some of its corporate and patient records.

Bentley Health Service has developed an *Order of Forms* document to ensure current service provision and administration documentation is identified. The health service undertakes six-monthly documentation audits to ensure the list is correct.

Rockingham-Kwinana District Hospital has continued training new employees to ensure all staff comply with record management requirements. A review by the Information Management Committee will include the development and monitoring of performance indicators related to recordkeeping.

In collaboration with the State Records Office, PathWest Laboratory Medicine WA has reviewed and updated its recordkeeping plan. All PathWest records are maintained to National Association of Testing Authorities (NATA) accreditation standards, with many having longer retention periods than are required by the State Records Office. Compliance with requirements is assessed by NATA at regular audit intervals.

All PathWest staff are given specific training and information regarding their recordkeeping responsibilities as part of the PathWest Laboratory Medicine WA induction process. A comprehensive laboratory internal audit program is conducted as part of the laboratory accreditation requirements and this includes monitoring record management compliance.

To ensure compliance with the *State Records Act 2000*, Dental Health Services conducts an ongoing review of the processes controlling the opening, classification, security, filing, distribution, retention and disposal of records. All recordkeeping system users are made aware of their responsibilities under the Act, and new employees are made aware of their recordkeeping roles and responsibilities.

Dental Health Service managers conduct quality assurance inspections according to clinical recordkeeping standards.

Recruitment

The Metropolitan Health Service (MHS) continues to develop retention and attraction strategies and review current options for improving and supporting staff recruitment while maintaining its commitment to the recruitment, selection and appointment of applicants on merit is paramount.

Recruitment difficulties continue to occur, particularly in clinical areas such as nursing, medical, patient support services and allied health staff. Strategies include a focus on international staff recruitment especially for areas of particular clinical need and have targeted the recruitment of doctors, medical technologists and nurses from the United Kingdom.

The Health Corporate Network (HCN) now provides Employment Services across the MHS under service agreements. These services include recruitment and appointment, payroll and human resource reporting. Positions are advertised through on-line systems, HCN and health service websites, newspapers, industry specific and professional journals with an increasing emphasis on website advertising.

The MHS uses a number of initiatives to attract staff. These include employment information sessions and morning teas used to invite prospective nurses to find out more about the hospitals prior to applying for a position.

Training is also provided to staff involved in recruitment and selection and advice is provided to managers on staff planning and attraction strategies. Training topics include Public Sector Standards, relevant legislation, organisational policy, recruitment, selection and appointment procedures, child protection issues, behavioural interviewing methods and the appeals process.

Following is a brief summary of the types of recruitment plans, polices and programs provided by the Metropolitan Health Service.

North Metropolitan Area Health Service

In 2008 Patient Support Services at Sir Charles Gairdner Hospital (SCGH) placed an advertisement with Community Newspaper Group to attract applicants for a recruitment pool from which to select hotel services staff.

SCGH took part in recruitment campaigns for nursing staff from the United Kingdom in October 2007 and April 2008. The earlier campaign led to the appointment of 32 registered nurses, while nine candidates have accepted positions as a result of the later campaign.

SCGH increased the intake of graduate nurses in 2008 from 120 to 188 and has introduced innovative structures to support the graduates in the clinical environment. These include ward-based clinical coaches and graduate program staff development nurses.

At Osborne Park Hospital, recruitment initiatives included the commencement of the Graduate Enrolled Nurse Course and the expansion of the Graduate Registered Nurse Course. Recruitment priorities are nursing, specialist surgery, anaesthesiology, clinical coding and sonography.

Within the Women and Newborn Health Service (WNHS), recruitment of nurses and midwives is a very high priority. A graduate nurse brochure has been developed and sent to all universities, and a partnership has been developed with Sir Charles Gairdner Hospital to offer a more comprehensive graduate nurse program, inclusive of a six-month rotation with WNHS.

WNHS regularly advertises in specialist nursing publications as well as the major Perth Metropolitan daily newspaper. Recruitment campaigns targeting interstate or overseas candidates offer financial relocation assistance where relevant.

South Metropolitan Area Health Service

Hospitals such as Armadale-Kelmscott Memorial and Royal Perth have analysed workforce trends and interview exiting staff to identify any issues that led to the decision to leave and whether work practices might be adjusted.

Royal Perth Hospital has focussed on encouraging Enrolled Nurses to upgrade their skills to became Registered Nurses.

South Metropolitan Area Health Service (SMAHS) hospitals have also participated in the whole of health implementation of ‘Assistants in Nursing’, providing placements for 30 people at Fremantle and Kaleeya Hospitals and 15 at Bentley Mental Health Service.

Recruitment (continued)

South Metropolitan Area Health Service (continued)

Health services at Fremantle and Rockingham have started a new support program that allows second year nursing students to register as Enrolled Nurses to provide the opportunities to further develop their expertise in the clinical setting and make a contribution to the nursing workforce.

Royal Perth Hospital is strengthening its ties with the university sector by taking its portable nursing display stand to institutions, running information sessions about the hospital and introducing students to an interactive DVD featuring RPH nurses.

Bentley Health Service nursing recruitment continues to focus on attracting new staff, widening its advertising to international journals and negotiating directly with recruitment agencies.

A human resources Retention and Recruitment Committee was established to manage recruitment and retention in order to cater for the expansion of Rockingham Kwinana District Hospital.

In the latter half of 2007-08, a new SMAHS Employee Induction Handbook was created. This handbook welcomes the new employee and contains details of all relevant employee related policy, obligations and entitlements and will be provided to all new employees.

Throughout SMAHS a system review was undertaken to ensure there was compliance with the *Working with Children (Criminal Record Checking) Act 2004*, which required all employees who had commenced employment in 2006 to have lodged their Working with Children checks by 31 December 2007.

Child and Adolescent Health Service

The demand for nurses, particularly in specialty areas including Paediatric Intensive Care (PICU), Theatre, Oncology and the Emergency Department continues to exceed the supply of nurses available in the recruitment pool. Child and Adolescent Health Service (CAHS) use a multi faceted approach including recruitment, retention and remaining in contact with past staff and offering incentives to encourage them to return to work. CAHS recruitment committee has also provided opportunities for a planned approach to recruitment especially for periods of peak demand for nurses.

Princess Margaret Hospital has participated in local expositions, national and international recruitment drives to attract nurses. A targeted campaign approach has been adopted to advertising in community newspapers, interstate newspapers especially career promotions, and professional journals. Online advertising with Seek has proved to be a popular and an effective advertising medium. Rolling advertisements are employed for base grade nursing positions and a variety of initiatives aimed at retaining existing staff have been implemented.

In-house training covering recruitment and selection processes and the induction process is offered via the North Metropolitan Area Health Service Education Development Centre. Courses are designed for panel members new to public sector recruitment practices.

PathWest Laboratory Medicine WA

PathWest Laboratory Medicine WA (PathWest) created new pathology registrar training positions in 2008 to address the shortage of pathologists. In collaboration with the University of Western Australia, PathWest established the UWA School of Pathology and Laboratory Medicine. A Professor of Pathology and Laboratory Medicine was appointed and is due to commence tenure in 2008-09.

PathWest established a workforce planning committee and commissioned a PathWest Workforce Report that detailing existing and projected workforce issues. PathWest is also developing strategies to increase Indigenous representation in its regional services.

Dental Health Services

Dental Health Services (DHS) continues to experience significant difficulties in recruiting dentists to rural and remote locations and in attracting and retaining experienced dentists for other locations. DHS is developing a workforce plan that includes an enhanced remuneration package for clinical staff. Similar difficulties are being experienced with the recruitment of dental therapists and dental clinic assistants.

Specific recruitment initiatives for dentists include:

- targeted advertising to United Kingdom dentists who are registrable in Western Australia; and
- ongoing implementation of the Public Sector Dental Workforce Scheme, targeted at other overseas qualified dentists to work in rural locations.

Staff Development

In striving for excellence in health care, the Metropolitan Health Service is committed to developing the skills and expertise of staff through training and continuous professional development. Staff development facilitates personal growth, confidence and competence of staff through planned learning experiences in formal and informal settings.

Following is a brief summary of the types of staff development programs provided by the Metropolitan Health Service.

North Metropolitan Area Health Service

The North Metropolitan Area Health Service's (NMAHS) education and development programs aim to provide learning opportunities with a particular focus on the development and upgrading of skills and the support of best practice in leadership.

The Education and Development Centre (EDC), a NMAHS registered training organisation, offers a range of nationally recognised training programs. The EDC underwent an accreditation audit and has received full accreditation for a further five years.

In 2007-08, the EDC issued 76 staff with national statements of attainment for 172 units of competency. In addition, 22 staff completed 170 units of competence to graduate with full qualifications.

More than 1100 staff completed mandatory training in manual handling and about 750 staff in managing and preventing workplace aggression and violence.

In 2007-08, significant preparation has been undertaken for the launch of a new leadership development program for NMAHS staff, with accredited courses to be offered at three different levels within the leadership portfolio. These programs will commence in the second half of the 2008 calendar year.

South Metropolitan Area Health Service

Staff development departments across the South Metropolitan Area Health Service (SMAHS) carried out formal and informal learning experiences for staff in the areas of personal growth, confidence and competence.

These departments were involved in the induction of new staff, occupational training and career development. Across the campuses, ongoing development included postgraduate courses (in collaboration with universities), clinical short courses, corporate programs, computer skills, e-learning, managing aggression in the workplace, mental health programs, clinical programs and modules, graduate enrolled nurse and registered nurse study days and nursing midwifery programs.

Staff development highlights during the year included the following:

- SMAHS introduced a support program for second year Registered Nursing students encouraging them to register as Enrolled Nurses;
- The 'Assistants in Nursing' program commenced with 75 people undertaking training in the second half of 2007-08;
- Across SMAHS more undergraduates were given placements, including graduates from both Western Australian and interstate tertiary institutions;
- In association with Curtin University, Royal Perth Hospital launched the Centre of Clinical Nursing Research in June 2008 with the aim of forging links between the clinical and academic arms of the nursing profession;
- Royal Perth Hospital provided e-learning resources for Bullying and Emergency Procedures, Basic Life Support, Management of Aggression Training and Manual Handling. More than 5000 pass marks have been awarded to RPH staff during the year;
- Running Enrolled Nurse and Registered Nurse Refresher and Renewal of Registration courses twice a year after success of inaugural course in September 2007;
- Expanded training opportunities at Armadale Health Service through its Library Working Party which has created computer access points and a hard-copy library resource area; and
- SMAHS Mental Health is providing psychosocial intervention training for teams, including nursing staff, at Fremantle Hospital. This has potential for area-wide implementation.

Staff Development (continued)

Child and Adolescent Health Service

Corporate Staff Development is linked to the Education Development Centre at Sir Charles Gairdner Hospital and provides non-clinical training and development to meet the needs of all staff at the North Metropolitan Area, Child and Adolescent, and Women and Newborn Health Services. Its aim is to deliver training and development activities that are useful, relevant and timely for all staff.

The target for 2007-08 was to increase the training in performance management, workplace bullying and aggression, and emergency preparedness.

The Department of Paediatric Nursing Education at Princess Margaret Hospital offers education opportunities, clinical support and professional development. The programs and courses range from study days and short-courses, to graduate and postgraduate certificate programs. The department provides opportunities for nurses at all levels for professional development and further education that articulates with further degrees through Curtin University of Technology.

A major initiative for the Child and Adolescent Health Service during 2007-08 was the development and implementation of the inaugural Enrolled Nurse Graduate Nurse Program. In addition, a research project has been conducted to assess the job satisfaction of enrolled nurses in relation to their expanded scope of practice. This has been competed and the results presented.

The Registered Nurse Graduate Nurse Program has successfully transitioned to a Princess Margaret Hospital program, and there has been a significant increase in placements offered. The Postgraduate Paediatric Nursing Program has increased to two intakes per year, one every six months.

Plans are well underway for the development of a simulation suite facility primarily for resuscitation training collaboratively with medical and nursing staff providing a venue for training for a number of department's e.g. emergency department, Pediatric Intensive Care Unit and Theatre. Development of simulation facilities will include capacity to expand services to include simulations to provide clinical experience for the increasing number of medical and nursing students.

Paediatric Nursing Education has maintained its involvement in the Shared Health Interactive Practice Group. This group includes staff from WA hospitals and Universities who are developing web based learning materials to support the education and clinical practice of health professionals and students in WA. Outcomes in 2007-08 include development of online learning units and web space (i.e. tracheostomy learning package and DVD, IV learning package and development of an interactive patient), and the commencement of a research project aimed at identifying how well an intensive simulation experience prepares the undergraduate nursing student for clinical practice.

Postgraduate medical education

Postgraduate Medical Education (PGME) provides education, training and support mainly to prevocational doctors at Princess Margaret Hospital. However, PGME also caters for education and training for consultants and registrars at the hospital as well.

As part of the training for Resident Medical Officers, PGME coordinates protected teaching in the emergency department. Monthly Friday afternoon sessions for Registrars (and others) continue to be provided with topics such as Teaching on the Run, Communication Skills, and Research Skills. The department continues to run its successful Diploma of Child Health, currently in its twelfth year.

Developments in PGME in 2007-08 have included the progress of having the Diploma of Child Health move towards becoming an accredited Graduate Diploma of Child Health within the Australian Qualifications Training Framework. This task is anticipated to be completed by the end of 2008-09.

Seeking and developing ways to provide more innovative and interactive teaching for medical staff has been another primary aim for PGME. This has included small group work in learning Cardiac Auscultation Skills, multi-disciplinary interactive workshops, and practical skills sessions.

With the prevocational medical positions at PMH being accredited by the Postgraduate Medical Council of WA in June 2007, PGME have undertaken much work in streamlining and improving training/education needs for resident medical officers in the various training positions at the hospital.

PathWest Laboratory Medicine WA

Staff members receive job related training in PathWest protocols when they join the organisation and ongoing training is provided as required. When new processes and procedures are introduced all staff members receive appropriate training.

Staff members attend further educational courses relevant to their particular discipline and position, and are encouraged to continue their professional development. PathWest staff participate in Department of Health leadership development programs. Training programs included "New Supervisor" training for newly appointed supervisors, Conflict Management, Bullying Awareness Training, "Get in Training" and "Train the Trainer" programs to provide staff with skills to train colleagues in small groups.

Selection and interview skills training are provided to staff participating on employee selection panels.

In 2007-08 PathWest trained staff to address identified developmental needs. Training programs included conflict management training, bullying awareness training and new supervisor training.

Dental Health Services

It is the policy of Dental Health Services to implement appropriate staff development programs to ensure staff are aware of current public health (and relevant dental and medical) practices and techniques.

In 2007-08 appropriate introductory and advanced training was provided for occupational safety and health staff representatives. Training to deal with aggression in clients has been provided to School Dental Service staff. Bullying and harassment prevention training has been completed for all managers/supervisors and 80 per cent of other staff.

The "New Supervisor" course, together with training courses in conflict management and bullying awareness were conducted during 2007-08.

In addition, clinical and administrative training was provided to metropolitan and country School Dental Service staff. Patient Management System training was provided for supervisors, reception and dental laboratory staff, and support was provided to clinical staff to attend continuing education courses not available in-house.

A performance management training program for managers/supervisors commenced in May 2008.

Substantive Equality

Please see the Department of Health Annual Report 2007-08.

Sustainability

Please see the Department of Health Annual Report 2007-08.

Workers' Compensation and Rehabilitation

The Metropolitan Health Service (MHS) is committed to establishing a vibrant and positive workplace culture. A large part of delivering this commitment is ensuring the safety and health of all employees.

The MHS promotes a safe and healthy workplace by maintaining active Occupational Safety and Health (OSH) programs throughout its areas of responsibility.

Table 62: Workers' compensation claims

Employee category	Claims
Nursing Services/Dental Care Assistants	403
Administration and Clerical	127
Medical Support	65
Hotel Services	199
Maintenance	55
Medical (salaried)	9
Total	**858**

Notes:
1. "Administration and clerical" includes administration staff and executives, ward clerks, receptionists and clerical staff.
2. "Medical support" includes physiotherapists, speech pathologists, medical imaging technologists, pharmacists, occupational therapists, dieticians and social workers.
3. "Hotel services" includes cleaners, caterers and patient service assistants.

Occupational injury and illness prevention

Across the MHS, hazard and incident data is monitored and reported to identify risk areas and formulate prevention strategies. Other occupational safety and health programs and initiatives include:

- Risk management programs;
- Staff infection control screening and immunisation programs;
- Pre-employment health assessments;
- Worksite and workstation assessments;
- Contractor safety programs;
- Provision of information, education and training for staff, OSH representatives, managers and supervisors;
- Injury management programs;
- OSH input into facilities planning and procurement of equipment;
- Area Health Service OSH policies;
- Increased number of OSH representatives;
- Health promotion programs on stress management, healthy diet, safe and responsible drinking, infectious diseases vaccination, heart disease, hand care, fatigue reduction and ergonomics;
- Aggression management programs;
- Increased manual handling training for nursing and hotel services staff, a review of manual handling equipment and increased mechanical lifting aids; and
- Development of staff training needs analysis surveys.

PathWest worksite evaluations are carried out on request from managers, safety representatives or employees. Needle stick injury packs are available at all Pathwest Laboratory Medicine WA sites, and Chem Alert II provides on-line information for all chemicals on site.

A Dental Health Services occupational physician and occupational therapist assess employees and identify suitable programs and workshops to reduce strain at work with posture monitoring and exercise.

Employee rehabilitation

Injury management systems were updated and implemented in compliance with the relevant legislation. Injury management teams work together to assist an injured worker return to work as soon as medically appropriate with suitably meaningful duties within medical restrictions. Regular monitoring in liaison with the injured worker's medical practitioner, manager and the insurer ensures appropriate interventions are facilitated as required.

South Metropolitan Area Health Service injury management coordinators practise an approach that advocates and supports an injury management team-based approach and an early return to work. This is written into procedures and will be incorporated in the injury management system.

Dental Health Services employee rehabilitation programs are developed and implemented with supervisors, treating doctors and the injured employee, and are designed to meet and match an employee's capabilities and limitations. A Return to Work Program template has been developed to record medical details, duties, restrictions, timeframes and monitoring of progress.

Since July 2007 PathWest has employed a full-time Injury Management Consultant who plans, develops, implements and evaluates injury management programs to enable ill and injured employees to return to their full vocational competence. The Injury Management Consultant:

- assesses rehabilitation needs and develops return to work programs in conjunction with managers and ill/injured employees;
- carries out workplace assessments when staff report symptoms or issues;
- refers staff with non-compensable illnesses/injuries which impact on their work performance, capacity and/or attendance at work for a "fitness for work" assessment and implements rehabilitation activities and other strategies complimentary to the assessment;
- provides recommendations to assist ill and injured employees in their return to work;
- coordinates and facilitates the appropriate placement of personnel with residual disabilities; and
- refers those injured workers who have been identified as being unable to resume work in any position available within PathWest to external rehabilitation providers for further rehabilitation assistance and job placement.

Occupational Safety & Health and Injury Management Performance

The Metropolitan Health Service has an integrated risk management approach to occupational safety and health underpinned by policies, in accordance with the *Occupational Safety and Health Act 1984*.

The Metropolitan Health Service's (MHS) safety program includes:

- occupational safety and health (OSH) consultative processes involving representatives, committees, local groups and management;
- workplace hazard/incident reporting and investigation;
- workplace hazard inspections;
- monitoring of hazard and incident data;
- corporate reports on incident and OSH data;
- hazard control programs and strategies to reduce risks from hazards, for example, manual handling (loads handling and patient handling) aggression management, hazardous substances;
- staff infection control screening and imunisation programs;
- pre-employment health assessments;
- worksite and workstation assessments;
- contractor safety programs;
- provision of information, education and training for staff, OSH representatives, managers/supervisors;
- review of systems of work to minimise risk of injury; and
- OSH input into facilities planning and procurement of equipment.

To support injured workers, the MHS also has in place a comprehensive case management and return to work program in accordance with the *Workers' Compensation and Injury Management Act 1981* and the Injury Management Code of Practice (WorkCover WA).

The South Metropolitan Area Health Service (SMAHS) has an area policy for OSH as well as procedures and protocols detailing the commitment of the organisation to occupational safety and health.

SMAHS managers and supervisors have a key responsibility with regard to ensuring the health, safety and welfare of staff, volunteers, students, contractors and visitors.

Recognising the potential hazards that occur in the working environment, SMAHS takes every reasonable and practicable step to provide and maintain a safe and healthy work environment for all staff, volunteers, students, contractors and visitors.

In fulfilling this responsibility, managers and supervisors have a duty to provide and maintain so far as practicable, a working environment that is safe and without risks to health.

The SMAHS injury management procedure has the following objectives:

- Provide staff with information and education on the injury management policy and procedures of SMAHS;
- Establish a systematic approach to workplace based injury management services for all employees following work related injury, illness or disability; and
- Develop and encourage the expectation that it is normal practice following work related illness, injury or disability for employees to return to work as soon as practicable, to appropriate employment.

The MHS is committed to the process of consulting with employees in promoting workplace safety and demonstrates this by establishing workplace Occupational Safety and Health Committees in accordance with the *Occupational Safety and Health Act 1984*.

The Safety and Health Committee facilitates communication about workplace safety and meets a minimum of once per quarter. The Safety and Health Committee:

- facilitates consultation and cooperation between an employer and the employees in initiating, developing, and implementing measures designed to ensure the safety and health of employees at the workplace; and
- keeps itself informed as to current standards relating to safety.

OSH committees, including elected employee representatives, meet on a regular basis to discuss and resolve OSH issues that may have been brought to their attention in the workplace. Committee member details are communicated to all employees and a newsletter is distributed to all staff on OSH issues that have arisen during meetings as well as some safety and health tips.

The development and implementation of OSH and injury management policies by Dental Health Services (DHS) reflects its commitment to providing a safe and healthy workplace for all employees. These policies are available to all employees via the Human Resources Policy Manual and outline the organisation's objectives and processes.

DHS complies with the requirements of the *Workers' Compensation and Injury Management Act 1981* through the injury management policy which provides guidelines for the management of work-related injury and disease. The policy also contains return to work program templates which have been developed per the requirements of the Act and records medical details, duties, restrictions, timeframes and monitoring of employees' progress.

Evaluation forms are provided to the supervisor and employee to ensure ongoing development and feedback to management.

PathWest Laboratory Medicine WA (PathWest) is committed to providing a safe work environment and safe systems of work to ensure the well being of all staff and visitors to the workplace. When a staff member sustains a work related injury or illness, PathWest is committed to providing injury management support with a focus on safe and early return to meaningful work.

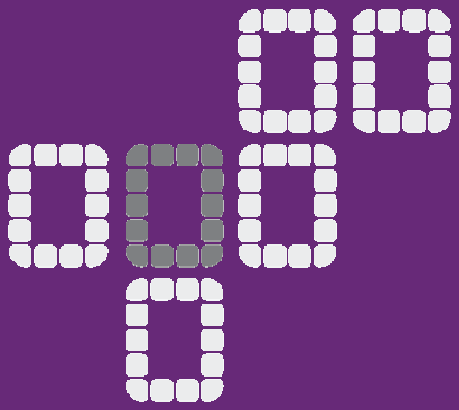
PathWest has established formal Safety Committees and staff safety representatives facilitate on-going consultation with all staff on safety issues. A formal hazard / incident reporting system allows for the early identification and mitigation of hazards within the workplace, and regular safety audits assist in maintaining high safety standards.

Hazard and incident data is monitored to identify risk areas and formulate prevention strategies. Needle stick injury packs, providing required forms and information in the event of an incident, are available at all PathWest sites. Chem Alert II is in operation across all PathWest sites. This system provides on-line information for all chemicals on site.

All PathWest sites operate in compliance with the injury management requirements of the *Workers' Compensation and Injury Management Act 1981*.

Table 63: Occupational safety and health incidence and severity

Health service	2007-08 fatalities	2007-08 lost time injury/disease incidence rate	2007-08 lost time injury severity rate
Child and Adolescent Health Service	0	2.12	12.50
Dental Health Services	0	2.00	0.00
North Metropolitan Area Health Service	0	6.76	12.84
PathWest	0	0.61	0.00
South Metropolitan Area Health Service	0	3.51	26.06



Financial Statements

Certification Statement

THE MINISTER FOR HEALTH IN HIS CAPACITY AS THE DEEMED BOARD OF METROPOLITAN PUBLIC HOSPITALS
CERTIFICATION OF FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2008

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 Management Act 2006* from proper accounts and records to present fairly the financial transactions for the financial year ending 30 June 2008 and the financial position as at 30 June 2008.

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.

John Leaf
Chief Finance Officer

Date: 17 September 2008

Dr Peter Flett
Accountable Authority

Date: 17 September 2008

Audit Opinion

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 AND KEY PERFORMANCE INDICATORS
FOR THE YEAR ENDED 30 JUNE 2008

I have audited the accounts, financial statements, controls and key performance indicators of The Minister for Health in his Capacity as the Deemed Board of Metropolitan Public Hospitals .

The financial statements comprise the Balance Sheet as at 30 June 2008, and the Income Statement, Statement of Changes in Equity and Cash Flow Statement of the Metropolitan Public Hospitals for the year then ended, a summary of significant accounting policies and other explanatory Notes.

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

Director General's Responsibility for the Financial Statements and Key Performance Indicators
The Director General is responsible for keeping proper accounts, and the preparation and fair presentation of the financial statements in accordance with Australian Accounting Standards (including the Australian Accounting Interpretations) and the Treasurer's Instructions, and the key performance indicators. This responsibility includes establishing and maintaining internal controls relevant to the preparation and fair presentation of the financial statements and key performance indicators that are free from material misstatement, whether due to fraud or error; selecting and applying appropriate accounting policies; making accounting estimates that are reasonable in the circumstances; and complying with the Financial Management Act 2006 and other relevant written law.

Summary of my Role
As required by the Auditor General Act 2006, my responsibility is to express an opinion on the financial statements, controls and key performance indicators based on my audit. This was done by testing selected samples of the audit evidence. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my audit opinion. Further information on my audit approach is provided in my audit practice statement. Refer "http://www.audit.wa.gov.au/pubs/Audit-Practice-Statement.pdf".

An audit does not guarantee that every amount and disclosure in the financial statements and key performance indicators 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 and key performance indicators.

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 and Key Performance Indicators for the year ended 30 June 2008

Audit Opinion

In my opinion,

(i) the financial statements are based on proper accounts and present fairly the financial position of The Minister for Health in his Capacity as the Deemed Board of Metropolitan Public Hospitals at 30 June 2008 and its financial performance and cash flows for the year ended on that date. They are in accordance with Australian Accounting Standards (including the Australian Accounting Interpretations) and the Treasurer's Instructions,

(ii) the controls exercised by the Metropolitan Public Hospitals provide reasonable assurance that the receipt, expenditure and investment of money, the acquisition and disposal of property, and the incurring of liabilities have been in accordance with legislative provisions; and

(iii) the key performance indicators of the Metropolitan Public Hospitals are relevant and appropriate to help users assess the Metropolitan Public Hospitals' performance and fairly represent the indicated performance for the year ended 30 June 2008

GLEN CLARKE
ACTING AUDITOR GENERAL
22 September 2008

Financial Statements

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

Income Statement

For the year ended 30th June 2008

	Note	2008 $000	2007 $000
COST OF SERVICES			
Expenses			
Employee benefits expense	7	1,953,909	1,738,887
Fees for visiting medical practitioners		41,274	37,162
Patient support costs	8	439,404	407,829
Finance costs	9	9,409	9,787
Depreciation and amortisation expense	10	60,708	61,592
Asset impairment losses		-	2,645
Capital user charge	11	-	105,081
Loss on disposal of non-current assets	12	1,470	639
Repairs, maintenance and consumable equipment	13	68,694	61,912
Other expenses	13	220,886	185,999
Total cost of services		**2,795,754**	**2,611,533**
INCOME			
Revenue			
Patient charges	14	141,445	124,084
Commonwealth grants and contributions	15	2,502	3,414
Other grants and contributions	15	8,013	8,843
Donations revenue	16	6,484	13,071
Interest revenue		15,557	13,090
Commercial activities	17	4,009	4,104
Other revenues	18	139,565	117,408
Total revenue		317,575	284,014
Total income other than income from State Government		**317,575**	**284,014**
NET COST OF SERVICES		**2,478,179**	**2,327,519**
INCOME FROM STATE GOVERNMENT			
Service appropriations	19	2,480,032	2,312,981
Assets assumed / (transferred)	20	3,314	19
Liabilities assumed by the Treasurer	21	5	11,391
Resources received free of charge	22	1,566	1,566
Total income from State Government		**2,484,917**	**2,325,957**
SURPLUS/(DEFICIT) FOR THE PERIOD		**6,738**	**(1,562)**

The Income Statement should be read in conjunction with the notes to the financial statements.

The 2007 comparatives are a combination of the Metropolitan Health Services (excluding Peel) and Peel Health Service figures. Please refer to note 56 for comparatives.

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

Balance Sheet
As at 30th June 2008

	Note	2008	2007
ASSETS		**$000**	**$000**
Current Assets			
Cash and cash equivalents	23	40,392	26,138
Restricted cash and cash equivalents	24	67,970	78,248
Restricted other financial assets	25	6,650	-
Receivables	26	89,033	72,185
Inventories	28	19,290	19,086
Other current assets	29	6,304	5,075
Total Current Assets		229,639	200,732
Non-Current Assets			
Amounts receivable for services	27	410,413	309,673
Property, plant and equipment	30	1,933,536	1,667,391
Intangible assets	32	21	37
Total Non-Current Assets		2,343,970	1,977,101
Total Assets		**2,573,609**	**2,177,833**
LIABILITIES			
Current Liabilities			
Payables	33	146,738	114,461
Borrowings	34	7,979	7,745
Provisions	35	316,642	281,995
Other current liabilities	36	(5)	103
Total Current Liabilities		471,354	404,304
Non-Current Liabilities			
Borrowings	34	136,113	144,092
Provisions	35	75,002	68,436
Other non-current liabilities	36	1,325	1,315
Total Non-Current Liabilities		212,440	213,843
Total Liabilities		**683,794**	**618,147**
NET ASSETS		**1,889,815**	**1,559,686**
EQUITY			
Contributed equity	37	1,282,339	1,132,185
Reserves	38	720,349	547,112
Accumulated surplus/(deficiency)	39	(112,873)	(119,611)
TOTAL EQUITY		**1,889,815**	**1,559,686**

The Balance Sheet should be read in conjunction with the notes to the financial statements.

The 2007 comparatives are a combination of the Metropolitan Health Services (excluding Peel) and Peel Health Service figures. Please refer to note 56 for comparatives.

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

Statement of Changes in Equity
For the year ended 30th June 2008

	Note	2008 $000	2007 $000
Balance of equity at start of period		1,559,686	1,381,227
CONTRIBUTED EQUITY	37		
Balance at start of period		1,132,185	1,036,110
Capital contribution		153,595	96,075
Distributions to owners		(3,441)	-
Balance at end of period		**1,282,339**	**1,132,185**
RESERVES	38		
Asset Revaluation Reserve			
Balance at start of period		547,112	433,347
Gains/(losses) from asset revaluation		173,237	113,765
Balance at end of period		**720,349**	**547,112**
ACCUMULATED SURPLUS	39		
Balance at start of period		(119,611)	(88,228)
Change in accounting policy		-	(29,821)
Restated balance at start of period		(119,611)	(118,049)
Surplus/(deficit) for the period		6,738	(1,562)
Balance at end of period		**(112,873)**	**(119,611)**
Balance of equity at end of period		**1,889,815**	**1,559,686**
Total income and expense for the period (a)		179,975	112,203

(a) The aggregate net amount attributable to each category of equity is:
2008: ($000) surplus $6,738 plus gains from asset revaluation $173,237
2007: ($000) deficit $1,562 plus gains from asset revaluation $113,765.

The Statement of Changes in Equity should be read in conjunction with the notes to the financial statements.

The 2007 comparatives are a combination of the Metropolitan Health Services (excluding Peel) and Peel Health Service figures. Please refer to note 56 for comparatives.

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

Cash Flow Statement
For the year ended 30th June 2008

	Note	2008 $000 Inflows (Outflows)	2007 $000 Inflows (Outflows)
CASH FLOWS FROM STATE GOVERNMENT			
Service appropriations		2,373,159	2,105,733
Capital contributions		147,150	81,113
Holding account drawdowns		-	934
Net cash provided by State Government	40(c)	2,520,309	2,187,780
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Supplies and services		(759,596)	(692,336)
Employee benefits		(1,888,289)	(1,687,263)
Finance costs		(3,424)	(3,486)
GST payments on purchases		(156,202)	(135,406)
Receipts			
Receipts from customers		130,757	119,957
Commonwealth grants and contributions		2,502	3,519
Other grants and subsidies		7,897	8,807
Donations		3,246	4,829
Interest received		15,175	13,102
GST receipts on sales		10,909	12,830
GST refunds from taxation authority		142,391	120,738
Other receipts		140,733	116,943
Net cash (used in) / provided by operating activities	40(b)	(2,353,901)	(2,117,766)
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments for purchase of non-current physical assets		(153,674)	(73,652)
Proceeds from sale of non-current physical assets	12	247	280
Receipts from term deposits		6,100	1,963
Purchase of term deposits		(12,750)	-
Net cash (used in) / provided by investing activities		(160,077)	(71,409)
CASH FLOWS FROM FINANCING ACTIVITIES			
Repayment of borrowings		(2,355)	(2,495)
Net cash (used in) / provided by financing activities		(2,355)	(2,495)
Net increase / (decrease) in cash and cash equivalents		3,976	(3,890)
Cash and cash equivalents at the beginning of period		104,386	108,276
CASH AND CASH EQUIVALENTS AT THE END OF PERIOD	40(a)	108,362	104,386

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

The 2007 comparatives are a combination of the Metropolitan Health Services (excluding Peel) and Peel Health Service figures. Please refer to note 56 for comparatives.

Notes to the Financial Statements
For the year ended 30th June 2008

Note 1 Australian equivalents to International Financial Reporting Standards

General

The Health Service's financial statements for the year ended 30 June 2008 have been prepared in accordance with Australian equivalents to International Financial Reporting Standards (AIFRS), which comprise a Framework for the Preparation and Presentation of Financial Statements (the Framework) and Australian Accounting Standards (including the Australian Accounting Interpretations).

In preparing these financial statements the Health Service has adopted, where relevant to its operations, new and revised Standards and Interpretations from their operative dates as issued by the Australian Accounting Standards Board (AASB) and formerly the Urgent Issues Group (UIG).

Early adoption of standards

The Health Service cannot early adopt an Australian Accounting Standard or Australian Accounting Interpretation unless specifically permitted by Treasurer's Instruction 1101 'Application of Australian Accounting Standards and Other Pronouncements'. No Standards and Interpretations that have been issued or amended but are not yet effective have been early adopted by the Health Service for the annual reporting period ended 30 June 2008.

Note 2 Summary of significant accounting policies

(a) General Statement

The financial statements constitute a general purpose financial report which has been prepared in accordance with the Australian Accounting Standards, the Framework, Statements of Accounting Concepts and other authoritative pronouncements of the Australian Accounting Standards Board 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 Management Act and the Treasurer's instructions are legislative provisions governing the preparation of financial statements and take precedence over the Accounting Standards, the Framework, Statements of Accounting Concepts and other authoritative pronouncements of the Australian Accounting Standards Board.

Where modification is required and has a material or significant financial effect upon the reported results, details of that modification and the resulting financial effect are disclosed in the notes to the financial statements.

(b) Basis of Preparation

The financial statements have been prepared on the accrual basis of accounting using the historical cost convention, modified by the revaluation of land and buildings which have been measured at fair value .

The accounting policies adopted in the preparation of the financial statements have been consistently applied throughout all periods presented unless otherwise stated.

The financial statements are presented in Australian dollars and all values are rounded to the nearest thousand dollars ($'000).

The judgements that have been made in the process of applying the Health Service's accounting policies that have the most significant effect on the amounts recognised in the financial statements are disclosed at note 3 'Judgements made by management in applying accounting policies'.

The key assumptions made concerning the future, and other key sources of estimation uncertainty at the balance sheet date that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are disclosed at note 4 'Key sources of estimation uncertainty'.

(c) Consolidation of the Annual Reports of the Peel Health Service and the Metropolitan Health Service

The Minister has approved consolidation of the Annual Reports of the Peel Health Service and the Metropolitan Health Service under section 24 (3) of the Hospitals and Health Services Act 1927. For several years the Peel Health Service has been operating as a business unit of the South Metropolitan Health Service, with operational reporting and accountability through the Metropolitan Health Service to the Minister.

(d) Contributed Equity

UIG Interpretation 1038 'Contributions by Owners Made to Wholly-Owned Public Sector Entities' requires transfers in the nature of equity contributions to be designated by the Government (the owner) as contributions by owners (at the time of, or prior to transfer) before such transfers can be recognised as equity contributions. Capital contributions (appropriations) have been designated as contributions by owners by Treasurer's Instruction (TI) 955 'Contributions by Owners made to Wholly Owned Public Sector Entities' and have been credited directly to Contributed Equity.

Transfer of net assets to/from other agencies are designated as contributions by owners where the transfers are non-discretionary and non-reciprocal. (See note 37 'Contributed Equity').

(e) Income

Revenue recognition

Revenue is measured at the fair value of consideration received or receivable. Revenue is recognised as follows:

Sale of goods
Revenue is recognised from the sale of goods and disposal of other assets when the significant risks and rewards of ownership control transfer to the purchaser and can be measured reliably.

Rendering of services
Revenue is recognised on delivery of the service to the client.

Interest
Revenue is recognised as the interest accrues. The effective interest method, which is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset to the net carrying amount of the financial asset, is used where applicable.

Service Appropriations
Service Appropriations are recognised as revenues at nominal value 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 to the bank account or credited to the holding account held at Treasury (See note 19 'Service Appropriations').

Grants, donations, gifts and other non-reciprocal contributions
Revenue is recognised at fair value when the Health Service obtains control over the assets comprising the contributions, usually when cash is received.

Other non-reciprocal contributions that are not contributions by owners are recognised at their fair value. Contributions of services are only recognised when a fair value can be reliably determined and the services would be purchased if not donated.

Where contributions recognised as revenues during the reporting period were obtained on the condition that they be expended in a particular manner or used over a particular period, and those conditions were undischarged as at the balance sheet date, the nature of, and amounts pertaining to, those undischarged conditions are disclosed in the notes.

Gains

Gains may be realised or unrealised and are usually recognised on a net basis. These include gains arising on the disposal of non-current assets and some revaluations of non-current assets.

(f) Borrowing Costs

Borrowing costs are recognised as an expense in the period in which they are incurred.

(g) Property, Plant and Equipment

Capitalisation/Expensing of assets
Items of property, plant and equipment costing $5,000 or more are recognised as assets and the cost of utilising assets is expensed (depreciated) over their useful lives. Items of property, plant and equipment costing less than $5,000 are immediately expensed direct to the Income Statement (other than where they form part of a group of similar items which are significant in total).

Initial recognition and measurement
All items of property, plant and equipment are initially recognised at cost.

For items of property, plant and equipment acquired at no cost or for nominal cost, the cost is their fair value at the date of acquisition.

Subsequent measurement
After recognition as an asset, the revaluation model is used for the measurement of land and buildings and the cost model for all other property, plant and equipment. Land and buildings are carried at fair value less accumulated depreciation on buildings and accumulated impairment losses. All other items of property, plant and equipment are stated at historical cost less accumulated depreciation and accumulated impairment losses.

Where market-based evidence is available, the fair value of land and buildings (non-clinical sites) is determined on the basis of current market buying values determined by reference to recent market transactions.

Where market-based evidence is not available, the fair value of land and buildings (clinical sites) is determined on the basis of existing use. This normally applies where buildings are specialised or where land use is restricted. Fair value for existing use assets is determined by reference to the cost of replacing the remaining future economic benefits embodied in the asset, ie. the depreciated replacement cost.

When buildings are revalued, the accumulated depreciation is eliminated against the gross carrying amount of the asset and the net amount restated to the revalued amount.

Independent valuations of land and buildings are provided annually by the Western Australian Land Information Authority (Valuation Services) and recognised with sufficient regularity to ensure that the carrying amount does not differ materially from the asset's fair value at the balance sheet date.

The most significant assumptions in estimating fair value are made in assessing whether to apply the existing use basis to assets and in determining estimated useful life. Professional judgement by the valuer is required where the evidence does not provide a clear distinction between market type assets and existing use assets.

Refer to note 30 'Property, plant and equipment' for further information on revaluations.

(g) Property, Plant and Equipment (continued)

Derecognition
Upon disposal or derecognition of an item of property, plant and equipment, any revaluation reserve relating to that asset is retained in the asset revaluation reserve.

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

Land is not depreciated. Depreciation on buildings is calculated using the diminishing value method. Depreciation on plant and equipment is calculated using the diminishing value with a straight-line switch method under which the cost amounts of the assets are allocated on average on a diminishing value basis over the first half of their useful lives and a straight line basis for the second half of the useful lives.

The assets' useful lives are reviewed annually. Expected useful lives for each class of depreciable asset are:

Buildings	50 years
Leasehold improvements	Term of the lease
Computer equipment	4 to 7 years
Furniture and fittings	10 to 15 years
Motor vehicles	4 to 10 years
Medical equipment	5 to 25 years
Other plant and equipment	5 to 25 years

Works of art controlled by the Health Service are classified as property, plant and equipment, which are anticipated to have very long and indefinite useful lives. Their service potential has not, in any material sense, been consumed during the reporting period and so no depreciation has been recognised.

(h) Intangible Assets

Capitalisation/Expensing of assets
Acquisitions of intangible assets costing $5,000 or more and internally generated intangible assets costing $5,000 or more are capitalised. The cost of utilising the assets is expensed (amortised) over their useful life. Costs incurred below these thresholds are immediately expensed directly to the Income Statement.

All acquired and internally developed intangible assets are initially recognised at cost. For assets acquired at no cost or for nominal cost, the cost is their fair value at the date of acquisition.

The cost model is applied for subsequent measurement requiring the asset to be carried at cost less any accumulated amortisation and accumulated impairment losses.

Amortisation for intangible assets with finite useful lives is calculated for the period of the expected benefit (estimated useful life) on the diminishing value basis using rates which are reviewed annually. All intangible assets controlled by the Health Service have a finite useful life and zero residual value. The expected useful lives for each class of intangible asset are:

Computer Software	5 years

Software that is an integral part of the related hardware is treated as property, plant and equipment. Software that is not an integral part of the related hardware is treated as an intangible asset.

(i) Impairment of Assets

Property, plant and equipment and intangible assets are tested for any indication of impairment at each balance sheet date. Where there is an indication of impairment, the recoverable amount is estimated. Where the recoverable amount is less than the carrying amount, the asset is considered impaired and is written down to the recoverable amount and an impairment loss is recognised. As the Health Service is a not-for-profit entity, unless an asset has been identified as a surplus asset, the recoverable amount is the higher of an asset's fair value less costs to sell and depreciated replacement cost.

The risk of impairment is generally limited to circumstances where an asset's depreciation is materially understated, where the replacement cost is falling or where there is a significant change in useful life. Each relevant class of assets is reviewed annually to verify that the accumulated depreciation/amortisation reflects the level of consumption or expiration of asset's future economic benefits and to evaluate any impairment risk from falling replacement costs.

Intangible assets with an indefinite useful life and intangible assets not yet available for use are tested for impairment at each balance sheet date irrespective of whether there is any indication of impairment.

The recoverable amount of assets identified as surplus assets is the higher of fair value less costs to sell and the present value of future cash flows expected to be derived from the asset. Surplus assets carried at fair value have no risk of material impairment where fair value is determined by reference to market-based evidence. Where fair value is determined by reference to depreciated replacement cost, surplus assets are at risk of impairment and the recoverable amount is measured. Surplus assets at cost are tested for indications of impairment at each balance sheet date.

(j) Non-current Assets Classified as Held for Sale

Non-current assets held for sale are recognised at the lower of carrying amount and fair value less costs to sell and are presented separately from other assets in the Balance Sheet. Assets classified as held for sale are not depreciated or amortised.

(k) Leases

Leases of property, plant and equipment, where the Health Service has substantially all of the risks and rewards of ownership, are classified as finance leases.

Finance lease rights and obligations are initially recognised, at the commencement of the lease term, as assets and liabilities equal in amount to the fair value of the leased item or, if lower, the present value of the minimum lease payments, determined at the inception of the lease. The assets are disclosed as leased assets, and are depreciated over the period during which the Health Service is expected to benefit from their use. Minimum lease payments are apportioned between the finance charge and the reduction of the outstanding lease liability, according to the interest rate implicit in the lease.

Leases in which the lessor retains significantly all of the risks and rewards of ownership are classified as operating leases. Operating lease payments are expensed on a straight line basis over the lease term as this represents the pattern of benefits derived from the leased items.

(l) Financial Instruments

In addition to cash, the Health Service has two categories of financial instrument:
- Loans and receivables (cash and cash equivalents, receivables); and
- Financial liabilities measured at amortised cost.

These have been disaggregated into the following classes:

Financial Assets
* Cash and cash equivalents
* Restricted cash and cash equivalents
* Receivables
* Amounts receivable for services

Financial Liabilities
* Payables
* WATC borrowings
* Other borrowings

Initial recognition and measurement of financial instruments is at fair value which normally equates to the transaction cost or the face value. Subsequent measurement is at amortised cost using the effective interest method.

The fair value of short-term receivables and payables is the transaction cost or the face value because there is no interest rate applicable and subsequent measurement is not required as the effect of discounting is not material.

(m) Cash and Cash Equivalents

For the purpose of the Cash Flow Statement, cash and cash equivalent (and restricted cash and cash equivalent) assets comprise cash on hand and short-term deposits with original maturities of three months or less that are readily convertible to a known amount of cash and which are subject to insignificant risk of changes in value.

(n) Accrued Salaries

Accrued salaries (refer note 33) represent the amount due to employees but unpaid at the end of the financial year, as the pay date for the last pay period for that financial year does not coincide with the end of the financial year. Accrued salaries are settled within a fortnight of the financial year end. The Health Service considers the carrying amount of accrued salaries to be equivalent to its net fair value.

(o) Amounts Receivable for Services (Holding Account)

The Health Service receives funding on an accrual basis that recognises the full annual cash and non-cash cost of services. The appropriations are paid partly in cash and partly as an asset (Holding Account receivable) that is accessible on the emergence of the cash funding requirement to cover items such as leave entitlements and asset replacement.

See also note 19 'Service appropriations' and note 27 'Amounts receivable for services'.

(p) Inventories

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

Inventories not held for resale are valued at cost unless they are no longer required in which case they are valued at net realisable value. (See Note 28 ' Inventories').

(q) Receivables

Receivables are recognised and carried at original invoice amount less an allowance for any uncollectible amounts (i.e. impairment). The collectability of receivables is reviewed on an ongoing basis and any receivables identified as uncollectible are written-off. The allowance for uncollectible amounts (doubtful debts) is raised when there is objective evidence that the Health Service will not be able to collect the debts.

The carrying amount is equivalent to fair value as it is due for settlement within 30 days from the date of recognition. (See note 2(l) 'Financial instruments' and note 26 'Receivables').

(r) Payables

Payables are recognised at the amounts payable when the Health Service becomes obliged to make future payments as a result of a purchase of assets or services. The carrying amount is equivalent to fair value as they are generally settled within 30 days. See note 2(i) 'Financial instruments and note 33 'Payables'.

(s) Borrowings

All loans are initially recognised at cost being the fair value of the net proceeds received. Subsequent measurement is at amortised cost using the effective interest rate method. (See note 2(l) 'Financial instruments' and note 34 'Borrowings').

(t) Provisions

Provisions are liabilities of uncertain timing or amount and are recognised where there is a present legal or constructive obligation as a result of a past event and when the outflow of resources embodying economic benefits is probable and a reliable estimate can be made of the amount of the obligation. Provisions are reviewed at each balance sheet date. See note 35 'Provisions'.

Provisions - Employee Benefits

Annual Leave and Long Service Leave
The liability for annual and long service leave expected to be settled within 12 months after the balance sheet date is recognised and measured at the undiscounted amounts expected to be paid when the liabilities are settled. Annual and long service leave expected to be settled more than 12 months after the balance sheet date is measured at the present value of amounts expected to be paid when the liabilities are settled. Leave liabilities are in respect of services provided by employees up to the balance sheet date.

When assessing expected future payments consideration is given to expected future wage and salary levels including non-salary components such as employer superannuation contributions. In addition, the long service leave liability also considers the experience of employee departures and periods of service.

The expected future payments are discounted using market yields at the balance sheet date on national government bonds with terms to maturity that match, as closely as possible, the estimated future cash outflows.

All annual leave and unconditional long service leave provisions are classified as current liabilities as the Health Service does not have an unconditional right to defer settlement of the liability for at least 12 months after the balance sheet date.

Sick Leave
Liabilities for sick leave are recognised when it is probable that sick leave paid in the future will be greater than the entitlement that will accrue in the future.

Past history indicates that on average, sick leave taken each reporting period is less than the entitlement accrued. This is expected to continue in future periods. Accordingly, it is unlikely that existing accumulated entitlements will be used by employees and no liability for unused sick leave entitlements is recognised. As sick leave is non-vesting, an expense is recognised in the Income Statement for this leave as it is taken.

Deferred Leave
The provision for deferred leave relates to Health Service employees who have entered into an agreement to self-fund an additional twelve months leave in the fifth year of the agreement. In the fifth year they will receive an amount equal to 80% of the salary they were otherwise entitled to in the fourth year of deferment. The provision recognises the value of salary set aside for employees to be used in the fifth year. The liability has been calculated on current remuneration rates in respect of services provided by the employees up to the balance sheet date and includes related on-costs. Deferred leave is reported as a non-current provision until the fifth year.

Superannuation
The Government Employees Superannuation Board (GESB) administers the following superannuation schemes.

Employees may contribute to the Pension Scheme, a defined benefit pension scheme now closed to new members or the Gold State Superannuation Scheme (GSS), a defined benefit lump sum scheme also closed to new members.

The Health Service has no liabilities under the Pension or the GSS Schemes. The liabilities for the unfunded Pension Scheme and the unfunded GSS Scheme transfer benefits due to members who transferred from the Pension Scheme, are assumed by the Treasurer. All other GSS Scheme obligations are funded by concurrent contributions made by the Health Service to the GESB. The concurrently funded part of the GSS Scheme is a defined contribution scheme as these contributions extinguish all liabilities in respect of the concurrently funded GSS Scheme obligations.

Employees commencing employment prior to 16 April 2007 who were not members of either the Pension or the GSS Schemes became non-contributory members of the West State Superannuation Scheme (WSS). Employees commencing employment on or after 16 April 2007 became members of the GESB Super Scheme (GESBS). Both of these schemes are accumulation schemes. The Health Service makes concurrent contributions to GESB on behalf of employees in compliance with the Commonwealth Government's Superannuation Guarantee (Administration) Act 1992. These contributions extinguish the liability for superannuation charges in respect of the WSS and GESBS Schemes.

The GESB makes all benefit payments in respect of the Pension and GSS Schemes, and is recouped by the Treasurer for the employer's share.

(See also note 2(u) 'Superannuation Expense').

(t) Provisions (continued)

Provisions - Other

Employment on-costs
Employment on-costs, including workers' compensation insurance, are not employee benefits and are recognised separately as liabilities and expenses when the employment to which they relate has occurred. Employment oncosts are included as part of 'Other expenses' and are not included as part of the Health Service's 'Employee benefits expense'. Any related liability is included in 'Employment on-costs provision'. (See note 13 'Repairs and other expenses' and note 35 'Provisions').

(u) Superannuation Expense

The following elements are included in calculating the superannuation expense in the Income Statement:

(a) Defined benefit plans - Change in the unfunded employer's liability (i.e. current service cost and, actuarial gains and losses) assumed by the Treasurer in respect of current employees who are members of the Pension Scheme and current employees who accrued a benefit on transfer from that Scheme to the Gold State Superannuation Scheme (GSS); and

(b) Defined contribution plans - Employer contributions paid to the GSS (concurrent contributions), the West State Superannuation Scheme (WSS), and the GESB Super Scheme (GESBS).

Defined benefit plans - in order to reflect the true cost of services, the movements (i.e. current service cost and, actuarial gains and losses) in the liabilities in respect of the Pension Scheme and the GSS transfer benefits are recognised as expenses. As these liabilities are assumed by the Treasurer (refer note 2(t)), a revenue titled 'Liabilities assumed by the Treasurer' equivalent to the expense is recognised under Income from State Government in the Income Statement. (See note 21 'Liabilities assumed by the Treasurer').

The superannuation expense does not include payment of pensions to retirees, as this does not constitute part of the cost of services provided in the current year.

The GSS Scheme is a defined benefit scheme for the purposes of employees and whole-of-government reporting. However, apart from the transfer benefit, it is a defined contribution plan for agency purposes because the concurrent contributions (defined contributions) made by the agency to GESB extinguishes the agency's obligations to the related superannuation liability.

(v) Resources Received Free of Charge or for Nominal Cost

Resources received free of charge or for nominal cost that can be reliably measured are recognised as income and as assets or expenses as appropriate, at fair value.

(w) Comparative Figures

Comparative figures are, where appropriate, reclassified to be comparable with the figures presented in the current financial year.

(x) Trust Accounts

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.

Details of Trust Accounts are reported as a note to the financial statements (refer to Note 52).

Note 3 Judgements made by management in applying accounting policies

Judgements are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances.

The judgements that have been made in the process of applying accounting policies that have the most significant effect on the amounts recognised in the financial statements include:

Buildings

A number of buildings that are located on the land of local government agencies have been recognised in the financial statements. The Health Service believes that, based on past experience, its occupancy in these buildings will continue to the end of their useful life.

Note 4 Key sources of estimation uncertainty

The key estimates and assumptions made concerning the future, and other key sources of estimation uncertainty at the balance sheet date that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year include:

Buildings

In order to estimate fair value on the basis of existing use, the depreciated replacement costs are determined on the assumption that the buildings will be used for the same functions in the future. A major change in utilisation of the buildings may result in material adjustment to the carrying amounts.

Note 4 Key sources of estimation uncertainty (continued)

Employee benefits provision

In estimating the non-current long service leave liabilities, employees are assumed to leave the Health Service each year on account of resignation or retirement at 10.6%. This assumption was based on an analysis of the turnover rates exhibited by employees over the past five years. Employees with leave benefits to which they are fully entitled are assumed to take all available leave uniformly over the following five years or to age 65 if earlier.

Note 5 Disclosure of changes in accounting policy and estimates

Initial application of an Australian Accounting Standard

The Health Service has applied the following Australian Accounting Standards and Australian Accounting Interpretations effective for annual reporting periods beginning on or after 1 July 2007 that impacted on the Health Service:

1) AASB 7 'Financial Instruments: Disclosures' (including consequential amendments in AASB 2005-10 'Amendments to Australian Accounting Standards [AASB 132, AASB 101, AASB 114, AASB 117, AASB 133, AASB 139, AASB 1, AASB 4, AASB 1023 & AASB 1038]'). This Standard requires new disclosures in relation to financial instruments and while there is no financial impact, the changes have resulted in increased disclosures, both quantitative and qualitative, of the Health Service's exposure to risks, including enhanced disclosure regarding components of the Health Service's financial position and performance, and changes to the way of presenting certain items in the notes to the financial statements.

The following Australian Accounting Standards and Interpretations are not applicable to the Health Service as they have no impact or do not apply to not-for-profit entities:

AASB Standards and Interpretations	
101	'Presentation of Financial Statements' (relating to the changes made to the Standard issued in October 2006)
2005-10	'Amendments to Australian Accounting Standards (AASB 132, AASB 101, AASB 114, AASB 117, AASB 133, AASB 139, AASB 1, AASB 4, AASB 1023, & AASB 1038)'
2007-1	'Amendments to Australian Accounting Standards arising from AASB Interpretation 11 [AASB 2]'
2007-4	'Amendments to Australian Accounting Standards arising from ED 151 and Other Amendments (AASB 1, 2, 3, 4, 5, 6, 7, 102, 107, 108, 110, 112, 114, 116, 117, 118, 119, 120, 121, 127, 128, 129, 130, 131, 132, 133, 134, 136, 137, 138, 139, 141, 1023 & 1038)'. The amendments arise as a result of the AASB decision to make available all options that currently exist under IFRSs and that certain additional Australian disclosures should be eliminated. The Treasurer's instructions have been amended to maintain the existing practice when the Standard was first applied and as a consequence there is no financial impact.
2007-5	'Amendments to Australian Accounting Standard – Inventories Held for Distribution by Not-for-Profit Entities [AASB 102]'
2007-7	'Amendments to Australian Accounting Standards [AASB 1, AASB 2, AASB 4, AASB 5, AASB 107 & AASB 128]'
ERR	Erratum 'Proportionate Consolidation [AASB 101, AASB 107, AASB 121, AASB 127, Interpretation 113]'
Interpretation 10	'Interim Financial Reporting and Impairment'
Interpretation 11	'AASB 2 – Group and Treasury Share Transactions'
Interpretation 1003	'Australian Petroleum Resource Rent Tax'

Voluntary changes in accounting policy

Effective from 1 July 2007, the Health Service has increased its asset capitalisation threshold from $1,000 to $5,000 for plant and equipment and intangible assets. The change in asset capitalisation policy does not apply to land and buildings.

Retrospective application of the change in accounting policy has resulted in assets below the $5,000 threshold amounting to $29,821,000 being expended against the opening balance of accumulated surplus/(deficiency) as at 1 July 2006. The amounts of adjustments for each of the financial periods prior to 2006-07 have not been disclosed, as it is impracticable to trace back acquisitions, disposals, depreciation and amortisation of these assets.

The comparatives for property, plant and equipment, depreciation and amortisation expense, loss on disposal of non-current assets, and repairs, maintenance and consumable equipment expense have been restated to disclose the effect of the policy change (See note 41 'Changes in accounting policy').

Future impact of Australian Accounting Standards not yet operative

The Health Service cannot early adopt an Australian Accounting Standard or Australian Accounting Interpretation unless specifically permitted by Treasurer's Instruction 1101 'Application of Australian Accounting Standards and Other Pronouncements'. Consequently, the Health Service has not applied the following Australian Accounting Standards and Australian Accounting Interpretations that have been issued and which may impact the Health Service but are not yet effective. Where applicable, the Health Service plans to apply these Standards and Interpretations from their application date:

Note 5 Disclosure of changes in accounting policy and estimates (continued)

Title	Operative for reporting periods beginning on/after
AASB 101 'Presentation of Financial Statements' (September 2007). This Standard has been revised and will change the structure of the financial statements. These changes will require that owner changes in equity are presented separately from non-owner changes in equity. The Health Service does not expect any financial impact when the Standard is first applied.	1 January 2009
Review of AAS 27 'Financial Reporting by Local Governments', 29 'Financial Reporting by Government Departments' and 31 'Financial Reporting by Governments'. The AASB has made the following pronouncements from its short term review of AAS 27, AAS 29 and AAS 31:	
AASB 1004 'Contributions' (December 2007).	1 July 2008
AASB 1050 'Administered Items' (December 2007).	1 July 2008
AASB 1051 'Land Under Roads' (December 2007).	1 July 2008
AASB 1052 'Disaggregated Disclosures' (December 2007).	1 July 2008
AASB 2007-9 'Amendments to Australian Accounting Standards arising from the review of AASs 27, 29 and 31 [AASB 3, AASB 5, AASB 8, AASB 101, AASB 114, AASB 116, AASB 127 & AASB 137] (December 2007).	1 July 2008
Interpretation 1038 'Contributions by Owners Made to Wholly-Owned Public Sector Entities (revised) (December 2007).	1 July 2008
The existing requirements in AAS 27, AAS 29 and AAS 31 have been transferred to the above new and existing topic-based Standards and Interpretation. These requirements remain substantively unchanged. AASB 1050, AASB 1051 and AASB 1052 only apply to government departments. The other Standards and Interpretation make some modifications to disclosures and provide additional guidance (for example, Australian Guidance to AASB 116 'Property, Plant and Equipment' in relation to heritage and cultural assets has been introduced), otherwise, there will be no financial impact.	
AASB 3 'Business Combinations' (March 2008).	1 July 2009
AASB 8 'Operating Segments'.	1 January 2009
AASB 123 'Borrowing Costs' (June 2007). This Standard has been revised to mandate the capitalisation of all borrowing costs attributable to the acquisition, construction or production of qualifying assets. The Health Service already capitalises borrowing costs directly attributable to buildings under construction, therefore, this will be no impact on the financial statements when the Standard is first applied.	1 January 2009
AASB 127 'Consolidated and Separate Financial Statements' (March 2008).	1 July 2009
AASB 1049 'Whole of Government and General Government Sector Financial Reporting'.	1 July 2008
AASB 2007-2 'Amendments to Australian Accounting Standards arising from AASB Interpretation 12 [AASB 1, AASB 117, AASB 118, AASB 120, AASB 121, AASB 127, AASB 131 & AASB 139]' – paragraphs 1 to 8.	1 January 2008
AASB 2007-3 'Amendments to Australian Accounting Standards arising from AASB 8 [AASB 5, AASB 6, AASB 102, AASB 107, AASB 119, AASB 127, AASB 134, AASB 136, AASB 1023 & AASB 1038]'.	1 January 2009
AASB 2007-6 'Amendments to Australian Accounting Standards arising from AASB 123 [AASB 1, AASB 101, AASB 107, AASB 111, AASB 116 & AASB 138 and Interpretations 1 & 12]'.	1 January 2009
AASB 2007-8 'Amendments to Australian Accounting Standards arising from AASB 101'.	1 January 2009
AASB 2008-1 'Amendments to Australian Accounting Standard - Share-based Payments: Vesting Conditions and Cancellations'.	1 January 2009
AASB 2008-2 'Amendments to Australian Accounting Standards – Puttable Financial Instruments and Obligations arising on Liquidation [AASB 7, AASB 101, AASB 132, AASB 139 & Interpretation 2]'.	1 January 2009
AASB 2008-3 'Amendments to Australian Accounting Standards arising from AASB 3 and AASB 127 [AASBs 1, 2, 4, 5, 7, 101, 107, 112, 114, 116, 121, 128, 131, 132, 133, 134, 136, 137, 138, 139 and Interpretations 9 & 107]'.	1 July 2009

Note 5 Disclosure of changes in accounting policy and estimates (continued)

Title	Operative for reporting periods beginning on/after
Interpretation 4 'Determining whether an Arrangement contains a Lease' (February 2007).	1 January 2008
Interpretation 12 'Service Concession Arrangements'.	1 January 2008
Interpretation 13 'Customer Loyalty Programmes'.	1 July 2008
Interpretation 14 'AASB 119 – The Limit on a Defined Benefit Asset, Minimum Funding Requirements and their Interaction'.	1 January 2008
Interpretation 129 'Service Concession Arrangements: Disclosures'.	1 January 2008

Note 6 Services of the Health Service

Information about the Health Service's services and, the expenses and revenues which are reliably attributable to those services are set out in Note 55. The key services of the Health Service are:

Admitted Patient Services
Admitted patient services are provided for the care of inpatients in public hospitals (excluding specialised mental health wards) and public patients treated in private facilities under contract to WA Health. Care during an admission to hospital can be for periods of one or more days. Care includes medical and surgical treatment, renal dialysis, oncology services, mental health and obstetric care.

Specialised Mental Health Services
Specialised mental health services include authorised mental health units that are hospitals or hospital wards devoted to the specialised treatment and care of patients with psychiatric, mental or behavioural disorders. Specialised mental health care is also provided in designated mental health wards in acute hospitals.

Hospital in the Home Services
Hospital in the Home (HITH) is the delivery of short-term acute services in the patient's home for conditions that traditionally required hospital admission and inpatient treatment. HITH services are based on daily home visits by nurses with medical governance usually by a hospital-based doctor. Patients who may receive HITH services include those who can be safely cared for without constant monitoring, such as those who may require regular intravenous drug treatments or wound dressings.

Emergency Department Services
Emergency department services are provided by some metropolitan hospitals. Emergency services are provided to treat those people with sudden onset of illness or injury of such severity and urgency that they need immediate medical help which is either not available from their general practitioner, or for which their general practitioner has referred them for treatment. Emergency departments provide a range of services from immediate resuscitation to urgent medical advice. An emergency department presentation may result in an admission or treatment without admission.

Non-admitted Patient Services
Medical officers, nurses and allied health staff provide non-admitted services. Services include outpatient health and medical care as well as similar emergency services as described for metropolitan emergency department but provided in smaller country hospitals.

Prevention and Promotion Services
Prevention and promotion services include genomics, the management and development of health information, Aboriginal health, breast screening services, child and community health and health promotion.

Dental Health Services
Dental health services include the school dental service, providing dental health assessment and treatment for school children; the adult dental service, for financially and/or geographically disadvantaged people; and the provision of specialist and general dental and oral health care by the Oral Health Centre of Western Australia to holders of a Health Care Card. Services are provided through government funded dental clinics, itinerant services and through private dental practitioners participating in the metropolitan, country and orthodontic patient dental subsidy schemes.

Aged Care Assessment Services
Aged care assessment services determine eligibility for, and the level of care required by frail aged people. They include assessments for those who require permanent care in an appropriate residential aged care facility including the Care Awaiting Placement program, and eligibility for community-based aged care services.

Community Mental Health Services
Community mental health care provides a range of community-based services for people with mental health disorders, which may include emergency assessment and treatment; case management, psycho-geriatric assessment and day programs provided in either a clinic or home environment. Service providers include both government and non-government service agencies. Contracted non-government non-clinical services also provide support to long-term mental health patients living in the community.

Chronic Illness and Continuing Care Support
Chronic illness and continuing care support services are provided to people with a chronic condition, enabling them to remain healthy at home. The services offered include the chronic disease management program. These services reduce unplanned and avoidable admissions and presentations to emergency departments as well as reducing length of stay for patients requiring inpatient care.

Note 7 Employee benefits expense	2008 $000	2007 $000
Salaries and wages (a)	1,599,764	1,407,946
Superannuation - defined contribution plans (b)	147,141	131,536
Superannuation - defined benefit plans (c) (d)	5	11,391
Annual leave and time off in lieu leave (e)	164,663	148,620
Long service leave (e)	42,336	39,394
	1,953,909	1,738,887

(a) Includes the value of the fringe benefit to the employees. The fringe benefits tax component is included at note 13 'Repairs and other expenses'.

(b) Defined contribution plans include West State, Gold State and GESB Super Scheme (contributions paid).

(c) Defined benefit plans include Pension scheme and Gold State (pre-transfer benefit).

(d) An equivalent notional income is also recognised. (See note 2(t) 'Superannuation expense' and 21 'Liabilities assumed by the Treasurer')

For most of the Metropolitan Health Services, decreases in liabilities occurred in 2007-08. In accordance with Treasurer's Instruction TI 1102, where there have been decreases in liabilities (i.e. actuarial gains exceed the current service cost for the period), the net gains should not be included in superannuation expense.

(e) Includes a superannuation contribution component.

Employment on-costs expense is included at note 13 'Repairs and other expenses'. The employment on-costs liability is included at note 35 'Provisions'.

Note 8 Patient support costs		
Medical supplies and services	335,546	317,218
Domestic charges	20,735	17,806
Fuel, light and power	22,631	19,932
Food supplies	17,880	15,271
Patient transport costs	4,537	2,959
Purchase of external services	38,075	34,643
	439,404	407,829

Note 9 Finance costs		
Finance lease finance charges	-	8
Interest paid	9,409	9,779
	9,409	9,787

Note 10 Depreciation and amortisation		
Depreciation		
Buildings	29,951	30,506
Leasehold improvements	457	419
Leased assets	-	118
Computer equipment	2,687	3,566
Furniture and fittings	995	1,043
Motor vehicles	426	511
Medical equipment	24,498	23,475
Other plant and equipment	1,680	1,937
	60,694	61,575
Amortisation		
Intangible assets	14	17
Total depreciation and amortisation	60,708	61,592

Note 11 Capital user charge		
	-	105,081

The charge was a levy applied by Government for the use of its capital. The final charge was levied in 2006-07.

Note 12 Net gain / (loss) on disposal of non-current assets

	2008 $000	2007 $000
Cost of disposal of non-current assets		
Property, plant and equipment	(1,717)	(919)
Proceeds from disposal of non-current assets:		
Property, plant and equipment	247	280
Net gain/(loss)	(1,470)	(639)

See note 30 'Property, plant and equipment'.

Note 13 Repairs and other expenses

Repairs, maintenance and consumable equipment	68,694	61,912
	68,694	61,912
Communications	13,276	13,532
Computer services	11,742	11,548
Employment on-costs (a)	43,957	34,446
Insurance	14,730	16,892
Legal expenses	981	5,531
Motor vehicle expenses	4,405	3,781
Operating lease expenses	11,493	10,715
Printing and stationery	12,377	10,952
Rental of property	8,702	5,837
Doubtful debts expense	3,032	(1,771)
Purchase of external services	77,734	57,655
Other	18,457	16,881
	220,886	185,999
	289,580	247,911

(a) Includes workers' compensation insurance, fringe benefit tax and staff development costs. The on-costs liability associated with the recognition of annual and long service leave liability is included at note 35 'Provisions'. Superannuation contributions accrued as part of the provision for leave are employee benefits and are not included in employment on-costs.

Note 14 Patient charges

Inpatient charges	83,620	72,641
Outpatient charges	17,720	15,565
Pathology services	40,105	35,878
	141,445	124,084

Note 15 Grants and contributions

Commonwealth grants and contributions		
Nursing homes	-	16
Australian University Commission	362	314
Other grants	2,140	3,084
	2,502	3,414
Other grants and contributions		
Lotteries Commission	30	83
Disability Services Commission - CAEP	3,151	2,429
Other grants	4,832	6,331
	8,013	8,843

Note 16 Donations revenue

General public contributions	6,484	13,071
	6,484	13,071

Note 17 Commercial activities

Sales:		
Coffee Shop Sales Revenue	6,271	5,873
Car Parking Fees Revenue	750	955
	7,021	6,828
Cost of Sales	(3,012)	(2,724)
Trading Profit/(Loss) (a)	4,009	4,104

(a) Gross profit/(loss) only. Does not include salaries or other costs.

Notes to the Financial Statements
For the year ended 30th June 2008

Note 18 Other revenues	2008 $000	2007 $000
Services to external organisations	93,702	76,121
Use of hospital facilities	11,155	9,935
Rent from commercial properties	1,509	1,225
Rent from residential properties	325	311
Boarders' accommodation	1,687	1,370
RiskCover insurance premium rebate	11,451	8,840
Other	19,736	19,606
	139,565	117,408

Note 19 Service appropriations

Appropriation revenue received during the year:		
Service appropriations	2,480,032	2,312,981

Service appropriations are accrual amounts reflecting the net cost of services delivered. The appropriation revenue comprises a cash component and a receivable (asset). The receivable (holding account) comprises the depreciation expense for the year and any agreed increase in leave liability during the year.

Note 20 Assets assumed / (transferred)

The following assets have been assumed from / (transferred to) other state government agencies during the financial year:		
- Building for dental clinic	3,314	-
- Computers and equipment	-	19
Total assets assumed / (transferred)	3,314	19

Where the Treasurer or other entity has assumed a liability, the Health Service recognises revenues equivalent to the amount of the liability assumed and an expense relating to the nature of the event or events that initially gave rise to the liability. From 1 July 2002 non-discretionary non-reciprocal transfers of net assets (i.e. restructuring of administrative arrangements) have been classified as Contributions by Owners under Treasurer's Instruction 955 and are taken directly to equity. Discretionary non-reciprocal transfer of assets between State Government agencies are reported as Assets assumed/ (transferred).

Note 21 Liabilities assumed by the Treasurer

The following liabilities have been assumed by the Treasurer during the financial year:		
- Superannuation	5	11,391

The assumption of the superannuation liability by the Treasurer is a notional income to match the notional superannuation expense reported in respect of current employees who are members of the Pension Scheme and current employees who have a transfer benefit entitlement under the Gold State Superannuation Scheme (The notional superannuation expense is disclosed at note 7 'Employee benefits expense').

Note 22 Resources received free of charge

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

Department of Treasury and Finance		
- Integrated procurement services	1,566	1,566
	1,566	1,566

Where assets or services have been received free of charge or for nominal cost, the Health Service recognises revenues equivalent to the fair value of the assets and/or the fair value of those services that can be reliably determined and which would have been purchased if not donated, and those fair values shall be recognised as assets or expenses, as applicable. The exception occurs where the contribution of assets or services are in the nature of contributions by owners, in which case the Health Service makes the adjustment direct to equity.

Note 23 Cash and cash equivalents

Cash on hand	137	142
Cash at bank	23,497	14,739
Deposits at call	16,758	11,257
	40,392	26,138

Note 24 Restricted cash and cash equivalents

	2008 $000	2007 $000
Cash assets held for specific purposes		
Cash at bank	520	88
Deposits at call	36,125	36,023
Other short - term deposits	31,325	42,137
	67,970	78,248

Restricted cash and cash equivalents are assets, the uses of which are restricted, by specific legal or other externally imposed requirements. Examples include: medical research grants, donations for the benefit of patients and medical education & scholarships.

Note 25 Restricted other financial assets

Investments greater than 3 months	6,650	-

Note 26 Receivables

Current		
Patient fee debtors	44,866	33,016
Other receivables	24,097	21,618
Less: Allowance for impairment of receivables	(4,984)	(3,822)
Accrued revenue	11,067	10,288
	75,046	61,100
GST receivable	13,987	11,085
	89,033	72,185
Reconciliation of changes in the allowance for impairment of receivables:		
Balance at start of year	3,822	5,674
Doubtful debts expense recognised in the income statement	3,032	(348)
Amounts written off during the year	(1,869)	(1,504)
Balance at end of year	4,985	3,822

Credit Risk

Ageing of receivables past due but not impaired based on the information provided to senior management, at the balance sheet date:

Not more than 3 months	16,662	17,717
More than 3 months but less than 1 year	12,897	8,883
More than 1 year	14,477	14,067
	44,036	40,667
Receivables individually determined as impaired at the balance sheet date:		
Carrying amount, before deducting any impairment loss	4,293	2,762
Impairment loss	(4,293)	(2,762)
	-	-

The Health Service has determined that $4,293,000 (2007: $2,762,000) receivables are individually impaired. Formal write off approval is either being sought, or will be sought in 2008-09. It is expected that none of the amount owing will be recovered.

The Health Service does not hold any collateral as security or other credit enhancements relating to receivables.

See also note 2(q) 'Receivables' and note 54 'Financial instruments'.

Note 27 Amounts receivable for services

Non-current	410,413	309,673
	410,413	309,673

This asset represents the non-cash component of service appropriations which is held in a holding account at the Department of Treasury and Finance. It is restricted in that it can only be used for asset replacement or payment of leave liability. See note 2(o) 'Amounts receivable for services'.

Note 28 Inventories

Current		
Supply stores - at cost	3,412	3,526
Pharmaceutical stores - at cost	14,158	13,803
Engineering stores - at cost	1,720	1,757
	19,290	19,086

See note 2(p) 'Inventories'.

Note 29 Other current assets	2008 $000	2007 $000
Prepayments	6,336	5,093
Other current assets	(32)	(18)
	6,304	5,075

Note 30 Property, plant and equipment

Land		
At fair value (a)	606,865	470,668
	606,865	470,668
Buildings		
Clinical:		
At fair value	1,032,605	1,020,279
Accumulated depreciation	(2,402)	(30,367)
	1,030,203	989,912
Non-Clinical:		
At fair value	9,087	6,466
Accumulated depreciation	(198)	-
	8,889	6,466
Total land and buildings	1,645,957	1,467,046
Leasehold improvements		
At cost	4,989	4,205
Accumulated depreciation	(1,090)	(633)
	3,899	3,572
Leased assets		
At capitalised cost	325	325
Accumulated depreciation	(325)	(325)
	-	-
Computer equipment		
At cost	24,728	27,855
Accumulated depreciation	(20,414)	(21,327)
	4,314	6,528
Furniture and fittings		
At cost	14,647	14,501
Accumulated depreciation	(6,974)	(6,764)
	7,673	7,737
Motor vehicles		
At cost	3,287	3,825
Accumulated depreciation	(2,540)	(2,752)
	747	1,073
Medical equipment		
At cost	254,137	229,833
Accumulated depreciation	(127,353)	(112,083)
Accumulated impairment losses	(3,881)	(4,609)
	122,903	113,141
Other plant and equipment		
At cost	22,621	21,975
Accumulated depreciation	(14,109)	(13,522)
	8,512	8,453
Works in progress		
Buildings under construction (at cost)	118,321	54,088
Other Work in Progress (at cost)	19,970	3,968
	138,291	58,056
Art Works		
At cost	1,240	1,785
Total of property, plant and equipment	1,933,536	1,667,391

Note 30 Property, plant and equipment (continued)	2008 $000	2007 $000

(a) Land and buildings were revalued as at 1 July 2007 by the Western Australian Land Information Authority (Valuation Services). The valuations were performed during the year ended 30 June 2008 and recognised at 30 June 2008. In undertaking the revaluation, fair value was determined by reference to market values for land: $62,399,600 and buildings: $9,087,000. For the remaining balance, fair value of land and buildings was determined on the basis of depreciated replacement cost. See note 2(g) 'Property, Plant and Equipment'.

Valuation Services, the Office of the Auditor General and the Department of Treasury and Finance assessed the valuations globally to ensure that the valuations provided (as at 1 July 2007) were compliant with fair value at 30 June 2008.

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

Land		
Carrying amount at start of year	470,668	352,401
Additions	3,800	7,874
Disposals	-	(926)
Transfer from/(to) other reporting entities	(2,340)	-
Revaluation increments / (decrements)	134,737	111,319
Carrying amount at end of year	606,865	470,668
Buildings		
Carrying amount at start of year	996,378	1,007,241
Additions	6,491	1,990
Transfers from Work in Progress	25,765	15,501
Disposals	(306)	(54)
Transfer from/(to) other reporting entities	2,215	-
Revaluation increments / (decrements)	38,500	2,446
Depreciation	(29,951)	(30,506)
Transfer between asset classes	-	(230)
Write-off of assets	-	(10)
Carrying amount at end of year	1,039,092	996,378
Leasehold improvements		
Carrying amount at start of year	3,572	3,435
Additions	784	326
Depreciation	(457)	(419)
Transfer between asset classes	-	230
Carrying amount at end of year	3,899	3,572
Leased assets		
Carrying amount at start of year	-	118
Depreciation	-	(118)
Carrying amount at end of year	-	-
Computer equipment		
Carrying amount at start of year	6,528	7,608
Additions	1,338	2,482
Disposals	(865)	-
Transfer from/(to) other reporting entities	-	4
Depreciation	(2,687)	(3,566)
Carrying amount at end of year	4,314	6,528
Furniture and fittings		
Carrying amount at start of year	7,737	8,543
Additions	981	343
Disposals	(82)	-
Transfer from/(to) other reporting entities	-	(6)
Depreciation	(995)	(1,043)
Transfer between asset classes	32	(100)
Carrying amount at end of year	7,673	7,737

Note 30 Property, plant and equipment (continued)	2008 $000	2007 $000
Motor vehicles		
Carrying amount at start of year	1,073	839
Additions	335	808
Disposals	(235)	(63)
Depreciation	(426)	(511)
Carrying amount at end of year	747	1,073
Medical equipment		
Carrying amount at start of year	113,141	104,145
Additions	34,121	34,356
Transfers from Work in Progress	313	1,947
Disposals	(125)	(1,304)
Transfer from/(to) other reporting entities	(9)	16
Impairment losses (a)	-	(2,645)
Depreciation	(24,498)	(23,475)
Transfer between asset classes	(40)	101
Carrying amount at end of year	122,903	113,141
Other plant and equipment		
Carrying amount at start of year	8,453	8,974
Additions	1,724	1,425
Transfer from/(to) other reporting entities	7	(8)
Depreciation	(1,680)	(1,937)
Transfer between asset classes	8	(1)
Carrying amount at end of year	8,512	8,453
Works in progress		
Carrying amount at start of year	58,056	32,742
Additions	108,375	42,762
Write-down of assets	(2,062)	-
Transfers from Work in Progress	(26,078)	(17,448)
Carrying amount at end of year	138,291	58,056
Art Works		
Carrying amount at start of year	1,785	1,758
Additions	21	27
Disposals	(566)	-
Carrying amount at end of year	1,240	1,785
Total property, plant and equipment		
Carrying amount at start of year	1,667,391	1,527,804
Additions	157,970	92,393
Write-down of assets	(2,062)	-
Disposals	(2,179)	(2,347)
Transfer from/(to) other reporting entities	(127)	6
Revaluation increments / (decrements)	173,237	113,765
Impairment losses (a)	-	(2,645)
Depreciation	(60,694)	(61,575)
Write-off of assets	-	(10)
Carrying amount at end of year	1,933,536	1,667,391

(a) Impairment loss recognised in the Income Statement.

Note 31 Impairment of Assets

There were no indications of impairment to property, plant and equipment, and intangible assets at 30 June 2008.

The Health Service held no goodwill or intangible assets with an indefinite useful life during the reporting period and at balance sheet date there were no intangible assets not yet available for use.

All surplus assets at 30 June 2008 have either been classified as assets held for sale or written off.

Note 32 Intangible assets	2008 $000	2007 $000
Computer software		
At cost	77	79
Accumulated amortisation	(56)	(42)
	21	37

Reconciliation

Reconciliation of the carrying amount of intangible assets at the beginning and end of the current financial year is set out below.

Computer software		
Carrying amount at start of year	37	97
Disposals	(2)	(43)
Amortisation expense	(14)	(17)
Carrying amount at end of year	21	37

Note 33 Payables

Current		
Trade creditors	52,856	46,967
Other creditors	337	276
Accrued expenses	20,638	18,566
Accrued salaries	71,300	46,898
Accrued interest	1,607	1,754
	146,738	114,461

(See also note 2(r) 'Payables' and note 54 'Financial instruments')

Note 34 Borrowings

Current		
Western Australian Treasury Corporation loans (a)	4,937	4,828
Department of Treasury and Finance loans (b)	3,042	2,917
	7,979	7,745
Non-current		
Western Australian Treasury Corporation loans (a)	89,202	94,139
Department of Treasury and Finance loans (b)	46,911	49,953
	136,113	144,092
Total borrowings	144,092	151,837

(a) 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.

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

Note 35 Provisions

Current		
Employee benefits provision		
Annual leave (a)	165,934	148,074
Time off in lieu leave (a)	38,763	35,080
Long service leave (b)	111,562	98,513
Deferred salary scheme	383	328
	316,642	281,995
Non-current		
Employee benefits provision		
Long service leave (b)	73,470	67,123
Deferred salary scheme	1,532	1,313
	75,002	68,436
Total Provisions	391,644	350,431

(a) Annual leave liabilities and time off in lieu leave liabilities have been classified as current as there is no unconditional right to defer settlement for at least 12 months after balance sheet date. Assessments indicate that actual settlement of the liabilities will occur as follows:

Within 12 months of balance sheet date	126,892	112,793
More than 12 months after balance sheet date	77,805	70,361
	204,697	183,154

Note 35 Provisions (continued)

	2008 $000	2007 $000
(b) Long service leave liabilities have been classified as current where there is no unconditional right to defer settlement for at least 12 months after balance sheet date. Assessments indicate that actual settlement of the liabilities will occur as follows:		
Within 12 months of balance sheet date	27,839	25,184
More than 12 months after balance sheet date	157,193	140,452
	185,032	165,636

(c) The settlement of annual and long service leave liabilities give rise to the payment of employment on-costs including workers compensation insurance. The provision is the present value of expected future payments. The associated expense, apart from the unwinding of the discount (finance cost), is included at note 13 'Repairs and other expenses'.

Note 36 Other liabilities

Current		
Income received in advance	-	116
Refundable deposits	297	262
Other	(302)	(275)
	(5)	103
Non-Current		
Other	1,325	1,315
	1,325	1,315

Note 37 Contributed equity

Equity represents the residual interest in the net assets of the Health Service. The Government holds the equity interest in the Health Service on behalf of the community. The asset revaluation reserve represents that portion of equity resulting from the revaluation of non-current assets.

Balance at start of the year	1,132,185	1,036,110
Contributions by owners		
Capital contributions (a)	153,595	96,075
Total contributions by owners	153,595	96,075
Distributions to owners		
Transfer of net assets to other agencies (b)	(3,441)	-
Total distributions to owners	(3,441)	-
Balance at end of year	1,282,339	1,132,185

(a) Capital Contributions (appropriations) and non-discretionary (non-reciprocal) transfers of net assets from other State government agencies have been designated as contributions by owners in Treasurer's Instruction 955 'Contribution by Owners Made to Wholly Owned Public Sector Entities' and are credited directly to equity.

(b) UIG Interpretation 1038 'Contribution by Owners Made to Wholly-Owned Public Sector Entities' requires that where the transferee accounts for a transfer as a contribution by owner, the transferor must account for the transfer as a distribution to owners. Consequently, non-discretionary (non-reciprocal) transfers of net assets to other State government agencies are distribution to owners and are debited directly to equity.

Note 38 Reserves

Asset revaluation reserve (a)		
Balance at start of year	547,112	433,347
Net revaluation increments (b) :		
Land	134,737	111,319
Buildings	38,500	2,446
Balance at end of year	720,349	547,112

(a) The asset revaluation reserve is used to record increments and decrements on the revaluation of non-current assets.

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

Notes to the Financial Statements
For the year ended 30th June 2008

Note 39 Accumulated surplus/(deficit)	2008 $000	2007 $000
Balance at start of year	(119,611)	(88,228)
Result for the period	6,738	(1,562)
Change in accounting policy	-	(29,821)
Balance at end of year	(112,873)	(119,611)

Note 40 Notes to the Cash Flow Statement

a) **Reconciliation of cash**

Cash assets at the end of the financial year as shown in the Cash Flow Statement is reconciled to the related items in the Balance Sheet as follows:

Cash and cash equivalents (see note 23)	40,392	26,138
Restricted cash and cash equivalents (see note 24)	67,970	78,248
	108,362	104,386

b) **Reconciliation of net cash flows to net cost of services used in operating activities**

Net cash used in operating activities (Cash Flow Statement)	(2,353,901)	(2,117,766)
Increase/(decrease) in assets:		
GST receivable	2,903	838
Other current receivables	15,107	6,514
Inventories	204	841
Prepayments	1,229	1,358
Decrease/(increase) in liabilities:		
Doubtful debts provision	(1,162)	1,852
Payables	(32,276)	1,472
Current provisions	(34,648)	(31,140)
Non-current provisions	(6,565)	(8,369)
Income received in advance	116	36
Other liabilities	(8)	625
Non-cash items:		
Depreciation and amortisation expense (note 10)	(60,708)	(61,592)
Net gain / (loss) from disposal of non-current assets (note 12)	(1,470)	(639)
Interest paid by Department of Health	(6,133)	(6,316)
Capital user charge paid by Department of Health (note 11)	-	(105,081)
Donation of non-current assets	3,238	8,238
Asset Impairment Losses	-	(2,645)
Superannuation liabilities assumed by the Treasurer (note 21)	(5)	(11,391)
Resources received free of charge (note 22)	(1,566)	(1,567)
Write down of property, plant and equipment (note 30)	(2,062)	-
Adjustment for other non-cash items	(472)	(2,788)
Net cost of services (Income Statement)	(2,478,179)	(2,327,519)

c) **Notional cash flows**

Service appropriations as per Income Statement	2,480,032	2,312,981
Capital contributions credited directly to Contributed Equity (Refer Note 37)	153,595	96,075
Holding account drawdowns credited to Amounts Receivable for Services	-	1,653
	2,633,627	2,410,709
Less notional cash flows:		
Items paid directly by the Department of Health for the Health Service and are therefore not included in the Cash Flow Statement:		
Interest paid to WA Treasury Corporation	(2,975)	(3,021)
Repayment of interest-bearing liabilities to WA Treasury Corporation	(2,473)	(4,721)
Interest paid to Department of Treasury & Finance	(3,157)	(3,295)
Repayment of interest-bearing liabilities to Department of Treasury & Finance	(2,917)	(2,781)
Capital user charge	-	(105,081)
Accrual appropriations	(100,740)	(95,850)
Capital works expenditure	(1,056)	(10,587)
Other non cash adjustments to service appropriations	-	2,407
	(113,318)	(222,929)
Cash Flows from State Government as per Cash Flow Statement	2,520,309	2,187,780

At the balance sheet date, the Health Service had fully drawn on all financing facilities, details of which are disclosed in the financial statements.

Note 41 Voluntary changes in accounting policy

Effective from 1 July 2007, the Health Service has increased its asset capitalisation threshold from $1,000 to $5,000 for plant and equipment and intangible assets (See note 5 'Voluntary changes in accounting policy'). Retrospective application of the change in accounting policy has resulted in an amount of $29,821,000 being expended against the opening balance of accumulated surplus/(deficiency) as at 1 July 2006. The adjustments relating to the 2006-07 financial year are as follows:

Reconciliation of equity at the end of the last reporting period under previous asset capitalisation policy : 30 June 2007

	Before policy change		After policy change
	30th June 2007	Adjustment	30th June 2007
	$000	$000	$000
Assets			
Current Assets	200,732	-	200,732
Non-Current Assets (a)	2,009,542	(32,441)	1,977,101
Total Assets	2,210,274	(32,441)	2,177,833
Liabilities			
Current Liabilities	404,304	-	404,304
Non-Current Liabilities	213,843	-	213,843
Total Liabilities	618,147	-	618,147
Total Equity (b)	1,592,127	(32,441)	1,559,686
Accumulated surplus/(deficiency)			
Opening balance	*(88,228)*	*(29,821)*	(118,049)
Surplus/(Deficit) for the period	*1,058*	*(2,620)*	(1,562)
Closing balance	*(87,170)*	*(32,441)*	*(119,611)*
(a) Property, plant and equipment	*1,699,832*	*(32,441)*	*1,667,391*
(b) Accumulated surplus/(deficiency)	*(87,170)*	*(32,441)*	*(119,611)*

Reconciliation of income statement for the year ended 30 June 2007

	Before policy change		After policy change
	30th June 2007	Adjustment	30th June 2007
	$000	$000	$000
Expenses (a)	2,608,913	2,620	2,611,533
Total income other than income from State Government	284,014	-	284,014
Net cost of services	2,324,899	2,620	2,327,519
Income from State Government	2,325,957	-	2,325,957
Surplus/(Deficit) for the period	1,058	(2,620)	(1,562)
(a) Depreciation and amortisation expense	*68,971*	*(7,379)*	*61,592*
Loss on disposal of non-current assets	*1,372*	*(733)*	*639*
Repairs, maintenance and consumable equipment	*51,180*	*10,732*	*61,912*
	121,523	*2,620*	*124,143*

Reconciliation of cash flow statement for the year ended 30 June 2007

	Before policy change		After policy change
	30th June 2007	Adjustment	30th June 2007
	$000	$000	$000
Cash flows from State Government	2,187,780	-	2,187,780
Utilised as follows:			
Net cash (used in) / provided by -			
Operating activities (a)	(2,107,034)	(10,732)	(2,117,766)
Investing activities (b)	(82,141)	10,732	(71,409)
Financing activities	(2,495)	-	(2,495)
Net increase / (decrease) in cash and cash equivalents	(3,890)	-	(3,890)
Cash and cash equivalents at the beginning of period	108,276	-	108,276
Cash and cash equivalents at the end of period	104,386	-	104,386
(a) Payments for supplies and services	(681,604)	(10,732)	(692,336)
(b) Payments for purchase of non-current physical assets	(84,384)	10,732	(73,652)

Note 42 Revenue, public and other property written off or presented as gifts	2008 $000	2007 $000
a) Revenue and debts written off under the authority of the Accountable Authority.	2,477	1,393
b) Public and other property written off under the authority of the Accountable Authority.	252	481
c) Revenue and debts written off under the authority of the Minister.	-	111
d) Public and other property written off under the authority of the Minister.	-	-
e) Gifts of public property provided by the Health Service.	51	-

Note 43 Losses of public monies and other property

Losses of public moneys and public or other property through theft or default	137	401
Less amount recovered	(85)	(270)
Net losses	52	131

Note 44 Resources provided free of charge

During the year the following resources were provided to other agencies free of charge for functions outside the normal operations of the Health Service:

Ministry of Justice - dental treatment to inmates	581	390
Disability Services Commission - dental treatment to clients	344	256
	925	646

Note 45 Remuneration of members of the Accountable Authority and senior officers

Remuneration of members of the Accountable Authority

The Director General of Health is the Accountable Authority for The Minister for Health in his Capacity as the Deemed Board of Metropolitan Public Hospitals. The number of members of the Accountable Authority, whose total of fees, salaries, superannuation and other benefits for the financial year fall within the following bands are:

$170,001 - $180,000	1	-
$500,001 - $510,000	1	-
$610,000 - $620,000	-	1
Total	2	1

Remuneration of senior officers

The number of senior officers other than senior officers reported as members of the Accountable Authority, whose total of fees, salaries, superannuation, non-monetary benefits and other benefits for the financial year, fall within the following bands are:

$40,001 - $50,000	1	-
$70,001 - $80,000	1	-
$80,001 - $90,000	1	-
$100,001 - $110,000	-	1
$130,001 - $140,000	-	1
$140,001 - $150,000	-	1
$150,001 - $160,000	2	1
$160,001 - $170,000	2	-
$180,001 - $190,000	-	2
$210,001 - $220,000	1	-
$240,001 - $250,000	1	-
$300,001 - $310,000	-	1
$310,001 - $320,000	-	1
$330,001 - $340,000	1	
$340,001 - $350,000	-	2
$360,001 - $370,000	-	1
$620,001 - $630,000	-	1
Total	10	12
	$000	**$000**
The total remuneration of senior officers is:	1,639	3,191

The total remuneration includes the superannuation expense incurred by the Health Service in respect of senior officers other than senior officers reported as members of the Accountable Authority.

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

Notes to the Financial Statements
For the year ended 30th June 2008

Note 46 Remuneration of auditor	2008 $000	2007 $000
Remuneration payable to the Auditor General for the financial year is as follows:		
Auditing the accounts, financial statements and performance indicators	620	566

Note 47 Commitments

a) **Capital expenditure commitments**

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

Within 1 year	111,819	72,264
Later than 1 year, and not later than 5 years	112,965	76,200
	224,784	148,464
The capital commitments include amounts for:		
- Buildings	198,551	141,211

The capital expenditure commitments are all inclusive of GST.

b) **Operating lease commitments:**

Commitments in relation to non-cancellable leases contracted for at the balance sheet date but not recognised in the financial statements, are payable as follows:

Within 1 year	7,440	5,947
Later than 1 year, and not later than 5 years	27,232	16,873
Later than 5 years	9,881	9,108
	44,553	31,928

The operating lease commitments are all inclusive of GST.

c) **Other expenditure commitments:**

Other expenditure commitments contracted for at the balance sheet date but not recognised as liabilities, are payable as follows:

Within 1 year	42,017	44,911
Later than 1 year, and not later than 5 years	24	7,969
	42,041	52,880

The other expenditure commitments are all inclusive of GST.

Note 48 Contingent liabilities and contingent assets

Contingent Liabilities

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

(a) Litigation in progress

Pending litigation that are not recoverable from RiskCover insurance and may affect the financial position of the Health Service	22,712	22,990
Number of claims	15	19

Contaminated Sites

Under the Contaminated Sites Act 2003, the Health Service is required to report known and suspected contaminated sites to the Department of Environment and Conservation (DEC). In accordance with the Act, DEC classifies these sites on the basis of the risk to human health, the environment and environmental values. Where sites are classified as *contaminated – remediation required* or *possibly contaminated – investigation required*, the Health Service may have a liability in respect of investigation or remediation expenses.

During the year the Health Service reported three suspected contaminated sites to DEC. Two sites have been classified "report not substantiated" and one site classified "possibly contaminated - investigation required". The Health Service is unable to assess the likely outcome of the classification process, and accordingly, it is not practicable to estimate the potential financial effect or to identify the uncertainties relating to the amount or timing of any outflows. Whilst there is no possibility of reimbursement of any future expenses that may be incurred in the remediation of these sites, the Health Service may apply for funding from the Contaminated Sites Management Account to undertake further investigative work or to meet remediation costs that may be required.

Contingent Assets

At the balance sheet date, the Health Service is not aware of any contingent assets.

Notes to the Financial Statements
For the year ended 30th June 2008

Note 49 Events occurring after balance sheet date

	2008 $000	2007 $000

There were no events occurring after the balance sheet date which had significant financial effects on these financial statements.

Note 50 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 had no related bodies during the financial year.

Note 51 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.

Public Health\Women's Health Programs	3,894	3,771

Note 52 Administered trust accounts

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

a) The Health Service administers a trust account for the purpose of holding patients' private moneys.

A summary of the transactions for this trust account is as follows:

Opening Balance	106	111
Add Receipts	1,407	1,325
	1,513	1,436
Less Payments	(1,384)	(1,330)
Closing Balance	129	106

b) The Health Service administers a trust account for salaried medical practitioners under the rights to private practice scheme.

A summary of the transactions for this trust account is as follows:

Opening Balance	331	334
Add Receipts	6,670	3,876
	7,001	4,210
Less Payments	(6,868)	(3,879)
Closing Balance	133	331

c) Other trust accounts - not controlled by the Health Service

RF Shaw Foundation	1,019	961
RPH Private Trust Account	777	125
Fremantle Hospital Chapel	5	4
King Edward/Princess Margaret Hospitals Special Purpose Trust	516	568
	2,317	1,658
Opening Balance	1,658	1,507
Add Receipts	2,468	2,622
	4,126	4,129
Less Payments	(1,810)	(2,471)
Closing Balance	2,316	1,658

Notes to the Financial Statements

For the year ended 30th June 2008

Note 53 Explanatory Statement

(A) Significant variances between actual results for 2007 and 2008

Significant variations between actual results with the corresponding items of the preceding reporting period are detailed below. Significant variations are those greater than 10% or that are 4% or more of the current year's Total Cost of Services.

	Note	2008 Actual $000	2007 Actual $000	Variance $000
Expenses				
Employee benefits expense	(a)	1,953,909	1,738,887	215,022
Fees for visiting medical practitioners	(b)	41,274	37,162	4,112
Patient support costs		439,404	407,829	31,575
Finance costs		9,409	9,787	(378)
Depreciation and amortisation expense	(c)	60,708	61,592	(884)
Asset impairment losses	(d)	-	2,645	(2,645)
Capital user charge	(e)	-	105,081	(105,081)
Loss on disposal of non-current assets	(f)	1,470	639	831
Repairs, maintenance and consumable equipment	(g)	68,694	61,912	6,782
Other expenses	(h)	220,886	185,999	34,887
Income				
Patient charges	(i)	141,445	124,084	17,361
Commonwealth grants and contributions	(j)	2,502	3,414	(912)
Other grants and contributions	(k)	8,013	8,843	(830)
Donations revenue	(l)	6,484	13,071	(6,587)
Interest revenue	(m)	15,557	13,090	2,467
Commercial activities		4,009	4,104	(95)
Other revenues	(n)	139,565	117,408	22,157
Service appropriations	(o)	2,480,032	2,312,981	167,051
Assets assumed / (transferred)	(p)	3,314	19	3,295
Liabilities assumed by the Treasurer	(q)	5	11,391	(11,386)
Resources received free of charge		1,566	1,566	-

(a) Employee benefits expense
Employee benefits expense rose because of activity and service delivery issues and cost of award increases for nursing, medical, maintenance and hotel services staff.

(b) Fees for visiting medical practitioners
Fees for visiting medical officers increased as a result of increases in activity levels at hospitals.

(c) Depreciation and amortisation expense
Depreciation expense decreased due to the change in capitalisation value from $1,000 to $5,000. This decreased the total pool of capitalised items on which depreciation is charged.

(d) Asset impairment losses
Asset impairment losses are zero, as no items were subject to impairment in 2007/08.

(e) Capital user charge
The capital user charge was discontinued in 2006-07.

(f) Loss on disposal of non-current assets
The value of assets disposed in 2007-08 was greater than in 2006-07.

(g) equipment
Expenditure rose on medical equipment, computer equipment and furniture and fittings.

Note 53 Explanatory Statement (continued)

(A) Significant variances between actual results for 2007 and 2008 (continued)

(h) Other expenses
Other expenses have increased to accommodate new external services contracts and workers compensation insurance premium increases.

(i) Patient charges
Patient charges have risen as a result of increased private patient admissions.

(j) Commonwealth grants and contributions
Commonwealth grants have reduced from 2006-07 levels.

(k) Other grants and contributions
Fewer one-off grants received in 2007-08 than in 2006-07.

(l) Donations revenue
There was a reduction in public donations received compared to 2006-07.

(m) Interest revenue
Investment interest rates were higher in 2007-08 than in 2006-07.

(n) Other revenues
Recoveries under formal agreements have increased, as has the RiskCover insurance premium rebate.

(o) Service appropriations
Service appropriations match rises and falls in operational costs.

(p) Assets assumed/transferred
Transfer of a dental clinic into the health service from the WA Country Health Service.

(q) Liabilities assumed by the Treasurer
There were net gains in the Pension Scheme and GSS Scheme in 2007-08, so the Treasurer was not obliged to assume any liabilities.

(B) Significant variations between estimates and actual results for 2008

Significant variations between the estimates and actual results for income and expenses are detailed below. Significant variations are considered to be those greater than 10% of the budget estimates.

	Note	2008 Actual $000	2008 Estimates $000	Variance $000
Operating expenses				
Employee benefits expense	(a)	1,953,909	1,596,303	357,606
Other goods and services		841,845	841,140	705
Total expenses		2,795,754	2,437,443	358,311
Less: Revenues	(b)	(317,575)	(235,375)	(82,200)
Net cost of services		2,478,179	2,202,068	276,111

(a) Employee benefits expense
Employee expenses were greater than originally estimated due to salary and the corresponding superannuation expense increases.

(b) Revenues
Revenues were higher than anticipated from private patients, prosthesis, pathology and investment interest.

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Notes to the Financial Statements
For the year ended 30th June 2008

Note 54 Financial instruments

a) **Financial risk management objectives and policies**

Financial instruments held by the Health Service are cash and cash equivalents, restricted cash and cash equivalents, borrowings, receivables and payables. The Health Service has limited exposure to financial risks. The Health Service's overall risk management program focuses on managing the risks identified below.

Credit risk
Credit risk arises when there is the possibility of the Health Service's receivables defaulting on their contractual obligations resulting in financial loss to the Health Service. The Health Service measures credit risk on a fair value basis and monitors risk on a regular basis.

The maximum exposure to credit risk at balance sheet date in relation to each class of recognised financial assets is the gross carrying amount of those assets inclusive of any provisions for impairment as shown in the table at Note 54(c).

Credit risk associated with the Health Service's financial assets is minimal because the main receivable is the amounts receivable for services (holding account). For receivables other than government, the Health Service trades only with recognised, creditworthy third parties. The Health Service has policies in place to ensure that sales of products and services are made to customers with an appropriate credit history. In addition, receivable balances are monitored on an ongoing basis with the result that the Health Service's exposure to bad debts is minimal. There are no significant concentrations of credit risk.

All debts are individually reviewed, on a timely basis at 30, 60, 90 and 120 days. In circumstance where a third party is responsible for payment, or there are legal considerations, payment of accounts can be delayed considerably. The expectation is that unpaid debts will be referred to an external debt collection service within six months of the account being raised.

Provision for impairment of financial assets is calculated based on past experience, and current and expected changes in client credit ratings. For financial assets that are either past due or impaired, refer to Note 26 'Receivables'.

Liquidity risk
The Health Service is exposed to liquidity risk through its normal course of operations. Liquidity risk arises when the Health Service is unable to meet its financial obligations as they fall due.

The Health Service has appropriate procedures to manage cash flows including drawdowns of appropriations by monitoring forecast cash flows to ensure that sufficient funds are available to meet its commitments.

Market risk
The Health Service does not trade in foreign currency and is not materially exposed to other price risks (for example, equity securities or commodity prices changes). The Health Service's exposure to market risk for changes in interest rates relate primarily to the long-term debt obligations. The Health Service's borrowings are all obtained through the Western Australian Treasury Corporation (WATC) and the Department of Treasury and Finance (DTF) and are at fixed rates with varying maturities. The risk is managed by WATC and DTF through portfolio diversification and variation in maturity dates. The Health Service's exposure to interest rate risk is detailed in the Interest rate sensitivity analysis table at note 54(c).

b) **Categories of financial instruments**

In addition to cash, the carrying amounts of each of the following categories of financial assets and financial liabilities at the balance sheet date are as follows:

	2008 $000	2007 $000
Financial Assets		
Cash and cash equivalents	40,392	26,138
Restricted cash and cash equivalents	67,970	78,248
Restricted other financial assets	6,650	-
Loans and receivables (a)	485,459	370,773
Financial Liabilities		
Financial liabilities measured at amortised cost	290,830	266,298

(a) The amount of loans and receivables excludes GST recoverable from the ATO (statutory receivable).

Note 54 Financial instruments (continued)

c) **Financial instrument disclosures**

Credit risk, liquidity risk and interest rate risk exposure
The following table details the exposure to liquidity risk and interest rate risk as at the balance sheet date. The Health Service's maximum exposure to credit risk at the balance sheet date is the carrying amount of the financial assets as shown on the following table. The table is based on information provided to senior management of the Health Service. The contractual maturity amounts in the table are representative of the undiscounted amounts at the balance sheet date. An adjustment for discounting has been made where material.

	Weighted average effective interest rate	Variable interest rate	Non-interest bearing	Contractual maturity dates: Within 1 year	1-2 years	2-3 years	3-4 years	4-5 years	More than 5 years	Total
As at 30th June 2008	**%**	**$000**	**$000**	**$000**	**$000**	**$000**	**$000**	**$000**	**$000**	**$000**
Financial Assets										
Cash and cash equivalents	7.4%	40,255	137							40,392
Restricted cash and cash equivalents	7.6%	36,125		31,845						67,970
Restricted other financial assets	8.1%	-		6,650						6,650
Receivables (a)			75,046							75,046
Amounts receivable for services			410,413							410,413
		76,380	485,596	38,495	-	-	-	-	-	600,471
Financial Liabilities										
Payables			146,738							146,738
Borrowings										
- W A Treasury Corporation loans	6.4%			4,937	2,586	2,644	2,703	2,764	78,505	94,139
- Department of Treasury & Finance loans	6.1%			3,042	3,182	3,328	3,491	3,642	33,268	49,953
		-	146,738	7,979	5,768	5,972	6,194	6,406	111,773	290,830

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Note 54 Financial instruments (continued)

	Weighted average effective interest rate	Variable interest rate	Non-interest bearing	Contractual maturity dates: Within 1 year	1-2 years	2-3 years	3-4 years	4-5 years	More than 5 years	Total
As at 30th June 2007	**%**	**$000**	**$000**	**$000**	**$000**	**$000**	**$000**	**$000**	**$000**	**$000**
Financial Assets										
Cash and cash equivalents	6.4%	25,996	142							26,138
Restricted cash and cash equivalents	6.4%	42,225	-	36,023						78,248
Receivables (a)			61,100							61,100
Amounts receivable for services			309,673							309,673
		68,221	370,915	36,023	-	-	-	-	-	475,159
Financial Liabilities										
Payables			114,461							114,461
Borrowings										
- W A Treasury Corporation loans	6.2%			4,828	4,884	5,020	5,133	5,248	73,854	98,967
- Department of Treasury & Finance loans	6.0%			2,917	3,059	3,192	3,330	3,492	36,880	52,870
		-	114,461	7,745	7,943	8,212	8,463	8,740	110,734	266,298

(a) The amount of receivables excludes GST recoverable from the ATO (statutory receivable).

The amounts disclosed are the contractual undiscounted cash flows of each class of financial liabilities.

Note 54 Financial instruments (continued)

Interest rate sensitivity analysis
The following table represents a summary of the interest rate sensitivity of the Health Service's financial assets and liabilities at the balance sheet date on the surplus for the period and equity for a 1% change in interest rates. It is assumed that the change in interest rates is held constant throughout the reporting period.

		-1% change		+1% change	
As at 30th June 2008	Carrying Amount $000	Profit $000	Equity $000	Profit $000	Equity $000
Financial Assets					
Cash and cash equivalents	40,392	(404)	(404)	404	404
Restricted cash and cash equivalents	67,970	(680)	(680)	680	680
Restricted other financial assets	6,650	(67)	(67)	67	67
Financial Liabilities					
Borrowings					
- W A Treasury Corporation loans	94,139	941	941	(941)	(941)
- Department of Treasury & Finance	49,953	500	500	(500)	(500)
Total Increase/(Decrease)		290	290	(290)	(290)

		-1% change		+1% change	
As at 30th June 2007	Carrying Amount $000	Profit $000	Equity $000	Profit $000	Equity $000
Financial Assets					
Cash and cash equivalents	26,138	(261)	(261)	261	261
Restricted cash and cash equivalents	78,248	(782)	(782)	782	782
Financial Liabilities					
Borrowings					
- W A Treasury Corporation loans	98,967	990	990	(990)	(990)
- Department of Treasury & Finance	52,870	529	529	(529)	(529)
Total Increase/(Decrease)		476	476	(476)	(476)

Fair values
All financial assets and liabilities recognised in the balance sheet, whether they are carried at cost or fair value, are recognised at amounts that represent a reasonable approximation of fair value unless otherwise stated in the applicable notes.

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Notes to the Financial Statements

For the year ended 30th June 2008

Note 55 Schedule of Income and Expenses by Services

	Admitted Patient Services		Specialised Mental Health		Hospital in the Home		Emergency Department		Non-Admitted Patient		Prevention & Promotion	
	2008 $000	2007 $000	2008 $000	2007 $000	2008 $000	2007 $000	2008 $000	2007 $000	2008 $000	2007 $000	2008 $000	2007 $000
COST OF SERVICES												
Expenses												
Employee benefits expense	1,210,447	1,095,324	118,016	98,595	14,459	8,521	101,994	87,814	290,546	258,746	69,168	51,819
Fees for visiting medical practitioners	25,570	23,409	2,493	2,107	305	182	2,155	1,877	6,137	5,530	1,461	1,107
Patient support costs	272,211	256,893	26,540	23,124	3,252	1,998	22,937	20,595	65,339	60,685	15,555	12,153
Finance costs	5,830	6,165	568	555	70	48	491	494	1,399	1,456	333	292
Depreciation and amortisation expense	37,608	38,798	3,667	3,492	449	302	3,169	3,110	9,027	9,165	2,149	1,835
Asset impairment losses	-	1,664	-	150	-	13	-	134	-	394	-	79
Capital user charge	-	66,190	-	5,958	-	515	-	5,307	-	15,636	-	3,131
Loss on disposal of non-current assets	909	403	89	36	11	3	77	32	219	95	52	19
Repairs, maintenance and consumable equipment	42,556	38,998	4,149	3,510	508	303	3,586	3,127	10,215	9,213	2,432	1,845
Other expenses	136,838	117,161	13,342	10,546	1,635	911	11,530	9,393	32,846	27,677	7,819	5,543
Total cost of services	1,731,969	1,645,005	168,864	148,073	20,689	12,796	145,939	131,883	415,728	388,597	98,969	77,823
INCOME												
Revenue												
Patient charges	87,627	78,162	8,543	7,036	1,047	608	7,383	6,266	21,033	18,464	5,007	3,698
Commonwealth grants and contributions	1,548	2,150	151	194	19	17	131	172	372	508	89	102
Other grants and contributions	4,963	5,569	484	501	59	43	418	447	1,192	1,316	284	264
Donations revenue	4,017	8,234	392	741	48	64	338	660	964	1,945	230	390
Interest revenue	9,639	8,246	940	742	115	64	812	661	2,313	1,948	551	390
Commercial activities	2,484	2,585	242	233	30	20	209	207	596	611	142	122
Other revenues	86,461	73,956	8,430	6,657	1,033	575	7,285	5,929	20,753	17,470	4,941	3,499
Total income other than income from State Government	196,739	178,902	19,182	16,104	2,351	1,391	16,576	14,342	47,223	42,262	11,244	8,465
NET COST OF SERVICES	**1,535,230**	**1,466,103**	**149,682**	**131,969**	**18,338**	**11,405**	**129,363**	**117,541**	**368,505**	**346,335**	**87,725**	**69,358**
INCOME FROM STATE GOVERNMENT												
Service appropriations	1,536,380	1,456,945	149,794	131,146	18,352	11,334	129,458	116,806	368,781	344,172	87,793	68,927
Assets assumed / (transferred)	2,053	12	200	1	25	-	173	1	493	3	117	1
Liabilities assumed by the Treasurer	4	7,176	-	646	-	56	-	575	1	1,695	-	339
Resources received free of charge	969	986	95	89	12	8	82	79	233	233	55	47
Total income from State Government	1,539,406	1,465,119	150,089	131,882	18,389	11,398	129,713	117,461	369,508	346,103	87,965	69,314
SURPLUS/(DEFICIT) FOR THE PERIOD	**4,176**	**(984)**	**407**	**(87)**	**51**	**(7)**	**350**	**(80)**	**1,003**	**(232)**	**240**	**(44)**

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Notes to the Financial Statements
For the year ended 30th June 2008

Note 55 Schedule of Income and Expenses by Services

	Dental Health		Aged Care Assessment		Community Mental Health		Chronic Illness & Continuing Care		Total	
	2008 $000	2007 $000	2008 $000	2007 $000	2008 $000	2007 $000	2008 $000	2007 $000	2008 $000	2007 $000
COST OF SERVICES										
Expenses										
Employee benefits expense	38,492	36,517	20,907	14,259	84,800	82,597	5,080	4,695	1,953,909	1,738,887
Fees for visiting medical practitioners	813	780	442	305	1,791	1,765	107	100	41,274	37,162
Patient support costs	8,656	8,564	4,702	3,344	19,070	19,372	1,142	1,101	439,404	407,829
Finance costs	185	206	101	80	408	465	24	26	9,409	9,787
Depreciation and amortisation expense	1,196	1,293	650	505	2,635	2,926	158	166	60,708	61,592
Asset impairment losses	-	56	-	22	-	126	-	7	-	2,645
Capital user charge	-	2,207	-	862	-	4,991	-	284	-	105,081
Loss on disposal of non-current assets	29	13	16	5	64	30	4	2	1,470	639
Repairs, maintenance and consumable equipment	1,353	1,300	735	508	2,981	2,941	179	167	68,694	61,912
Other expenses	4,351	3,906	2,363	1,525	9,586	8,835	574	502	220,886	185,999
Total cost of services	55,075	54,842	29,916	21,415	121,335	124,048	7,268	7,050	2,795,754	2,611,533
INCOME										
Revenue										
Patient charges	2,786	2,606	1,513	1,017	6,139	5,894	368	335	141,445	124,084
Commonwealth grants and contributions	49	72	27	28	109	162	7	9	2,502	3,414
Other grants and contributions	158	186	86	73	348	420	21	24	8,013	8,843
Donations revenue	128	274	69	107	281	621	17	35	6,484	13,071
Interest revenue	306	275	166	107	675	622	40	35	15,557	13,090
Commercial activities	79	86	43	34	174	195	10	11	4,009	4,104
Other revenues	2,749	2,466	1,493	963	6,057	5,577	363	317	139,565	117,408
Total income other than income from State Government	6,255	5,965	3,397	2,329	13,783	13,491	826	766	317,575	284,014
NET COST OF SERVICES	**48,820**	**48,877**	**26,519**	**19,086**	**107,552**	**110,557**	**6,442**	**6,284**	**2,478,179**	**2,327,519**
INCOME FROM STATE GOVERNMENT										
Service appropriations	48,857	48,573	26,536	18,966	107,633	109,867	6,448	6,245	2,480,032	2,312,981
Assets assumed / (transferred)	65	-	35	-	144	1	9	-	3,314	19
Liabilities assumed by the Treasurer	-	239	-	93	-	541	-	31	5	11,391
Resources received free of charge	31	33	17	13	68	74	4	4	1,566	1,566
Total income from State Government	48,953	48,845	26,588	19,072	107,845	110,483	6,461	6,280	2,484,917	2,325,957
SURPLUS/(DEFICIT) FOR THE PERIOD	**133**	**(32)**	**69**	**(14)**	**293**	**(74)**	**19**	**(4)**	**6,738**	**(1,562)**

Notes to the Financial Statements
For the year ended 30th June 2008

Note 56 Comparatives

Reconciliation of Financial Statements for 2006-07

	2007 MHS $000	2007 Peel $000	2007 Consolidated $000
COST OF SERVICES			
Expenses			
Employee benefits expense	1,729,248	9,639	1,738,887
Fees for visiting medical practitioners	36,909	253	37,162
Patient support costs	406,816	1,013	407,829
Finance costs	9,787	-	9,787
Depreciation and amortisation expense	61,416	176	61,592
Asset impairment losses	2,645	-	2,645
Capital user charge	104,577	504	105,081
Loss on disposal of non-current assets	639	-	639
Repairs, maintenance and consumable equipment	61,606	306	61,912
Other expenses	185,103	896	185,999
Total cost of services	**2,598,746**	**12,787**	**2,611,533**
INCOME			
Revenue			
Patient charges	117,886	6,198	124,084
Commonwealth grants and contributions	3,414	-	3,414
Other grants and contributions	8,600	243	8,843
Donations revenue	13,046	25	13,071
Interest revenue	13,076	14	13,090
Commercial activities	4,104	-	4,104
Other revenues	122,829	(5,421)	117,408
Total revenue	282,955	1,059	284,014
Total income other than income from State Government	**282,955**	**1,059**	**284,014**
NET COST OF SERVICES	**2,315,791**	**11,728**	**2,327,519**
INCOME FROM STATE GOVERNMENT			
Service appropriations	2,301,287	11,694	2,312,981
Assets assumed / (transferred)	(33)	52	19
Liabilities assumed by the Treasurer	11,386	5	11,391
Resources received free of charge	1,566	-	1,566
Total income from State Government	**2,314,206**	**11,751**	**2,325,957**
SURPLUS/(DEFICIT) FOR THE PERIOD	**(1,585)**	**23**	**(1,562)**

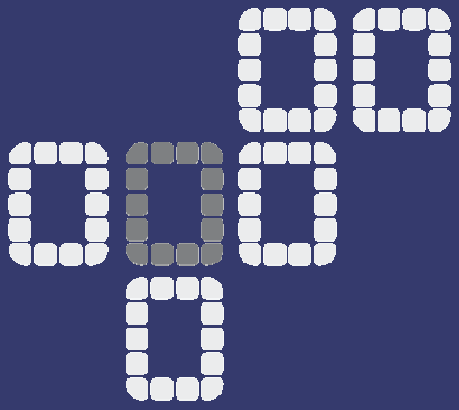
Notes to the Financial Statements
For the year ended 30th June 2008

Note 56 Comparatives continued

	2007 MHS $000	2007 Peel $000	2007 Consolidated $000
ASSETS			
Current Assets			
Cash and cash equivalents	26,121	17	26,138
Restricted cash and cash equivalents	78,160	88	78,248
Receivables	72,101	84	72,185
Inventories	19,086	-	19,086
Other current assets	5,075	-	5,075
Total Current Assets	200,543	189	200,732
Non-Current Assets			
Amounts receivable for services	309,353	320	309,673
Property, plant and equipment	1,657,450	9,941	1,667,391
Intangible assets	37	-	37
Total Non-Current Assets	1,966,840	10,261	1,977,101
Total Assets	**2,167,383**	**10,450**	**2,177,833**
LIABILITIES			
Current Liabilities			
Payables	113,626	835	114,461
Borrowings	7,745	-	7,745
Provisions	280,348	1,647	281,995
Other current liabilities	102	1	103
Total Current Liabilities	401,821	2,483	404,304
Non-Current Liabilities			
Borrowings	144,092	-	144,092
Provisions	68,069	367	68,436
Other non-current liabilities	1,315	-	1,315
Total Non-Current Liabilities	213,476	367	213,843
Total Liabilities	**615,297**	**2,850**	**618,147**
NET ASSETS	**1,552,086**	**7,600**	**1,559,686**
EQUITY			
Contributed equity	1,130,217	1,968	1,132,185
Reserves	545,522	1,590	547,112
Accumulated surplus/(deficiency)	(123,653)	4,042	(119,611)
TOTAL EQUITY	**1,552,086**	**7,600**	**1,559,686**

Notes to the Financial Statements
For the year ended 30th June 2008

Note 56 Comparatives continued	2007 MHS $000	2007 Peel $000	2007 Consolidated $000
	Inflows (Outflows)	Inflows (Outflows)	Inflows (Outflows)
CASH FLOWS FROM STATE GOVERNMENT			
Service appropriations	2,094,863	10,870	2,105,733
Capital contributions	80,762	351	81,113
Holding account drawdowns	934	-	934
Net cash provided by State Government	2,176,559	11,221	2,187,780
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Supplies and services	(690,326)	(2,010)	(692,336)
Employee benefits	(1,677,942)	(9,321)	(1,687,263)
Finance costs	(3,486)	-	(3,486)
GST payments on purchases	(135,406)	-	(135,406)
Receipts			
Receipts from customers	119,904	53	119,957
Commonwealth grants and contributions	3,519	-	3,519
Other grants and subsidies	8,564	243	8,807
Donations	4,804	25	4,829
Interest received	13,088	14	13,102
GST receipts on sales	12,830	-	12,830
GST refunds from taxation authority	120,738	-	120,738
Other receipts	116,227	716	116,943
Net cash (used in) / provided by operating activities	(2,107,486)	(10,280)	(2,117,766)
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments for purchase of non-current physical assets	(72,512)	(1,140)	(73,652)
Proceeds from sale of non-current physical assets	280	-	280
Receipts from term deposits	1,963	-	1,963
Net cash (used in) / provided by investing activities	(70,269)	(1,140)	(71,409)
CASH FLOWS FROM FINANCING ACTIVITIES			
Repayment of borrowings	(2,495)	-	(2,495)
Net cash (used in) / provided by financing activities	(2,495)	-	(2,495)
Net increase / (decrease) in cash and cash equivalents	(3,691)	(199)	(3,890)
Cash and cash equivalents at the beginning of period	107,971	305	108,276
CASH AND CASH EQUIVALENTS AT THE END OF PERIOD	104,280	106	104,386



Appendices

Appendix 1: Abbreviations

ABHI	Australian Better Health Initiative
ACAT	Aged Care Assessment Team
ACEM	Australian College for Emergency Medicine
AHS	Area Health Service
AIDS	Acquired Immunodeficiency Syndrome
AMI	Acute Myocardial Infarction
AR-DRGs	Australian Refined National Diagnostic Related Groups
ASI	Ambulatory Surgery Initiative
BSWA	BreastScreen WA
CAHS	Child and Adolescent Health Service
CAMHS	Child and Adolescent Mental Health Service
CAP	Care Awaiting Placement
CCU	Clinical Care Unit
CDMTs	Chronic Disease Management Teams
COAG	Council of Australian Governments
COPMI	Children of Parents with Mental Illness
CPI	Consumer Price Index
DAIP	Disability Access and Inclusion Plan
DAO	Drug and Alcohol Office
DHS	Dental Health Service
DOH	Department of Health
DMFT	Decayed, Missing or Filled Teeth
DMS	Document Management Systems
ED	Emergency Department
EDC	Education and Development Centre
EEO	Equal Employment Opportunity
EN	Enrolled Nurse
FH	Fremantle Hospital
FMA	Financial Management Act 2006
FNOF	Fractured Neck of Femur
FTE	Full Time Equivalent
GP	General Practitioner
HACC	Home and Community Care
HITH	Hospital in the Home
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus

ICT	Information Communications Technology
IM	Information Management
KEMH	King Edward Memorial Hospital
MeRITS	Medical Record Information Tracking System
MHERL	Mental Health Emergency Response Line
MHS	Metropolitan Health Service
NMAHS	North Metropolitan Area Health Service
OPH	Osborne Park Hospital
OPSSC	Office of the Public Sector standards Commissioner
OSH	Occupational Safety & Health
PATS	Patient Assisted Travel Scheme
PMH	Princess Margaret Hospital
PRNI	Privately Referred Non-Inpatient
PYLL	Person Years of Life Lost
RKDH	Rockingham/Kwinana District Hospital
RPH	Royal Perth Hospital
SCGH	Sir Charles Gairdner Hospital
SKHS	Swan Kalamunda Health Service
SMAHS	South Metropolitan Area Health Service
SONM	School of Nursing and Midwifery
SSP	Site Structure Plan
SRN	Senior Registered Nurse
SQuIRe	Safety and Quality Investment in Reform
TNA	Training Needs Analysis
TOPAS	The Open Patient Administration System
TTY	Teletypewriter
UWA	University of WA