South West Health Board

Annual Report 2001/2002

Department of Health
Government of Western Australia

Statement of Compliance

To the Hon Bob Kucera MLA

MINISTER FOR HEALTH

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

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

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

ANNUAL REPORT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Mike Daube
DIRECTOR GENERAL

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Address and Location

South West Health Service
18 West St
BUSSELTON WA 6280

☎ *(08) 9754 0555*
(08) 9754 0544

Mission Statement

Our Mission
To lead in the creation of healthier communities through the provision and coordination of a comprehensive range of quality, affordable and accessible health care services for the population.

Broad Objectives

The objectives of the South West Health Service are:

- To actively engage the community as partners to develop a shared sense of responsibility, direction and priorities.
- To work in partnership with other agencies to improve health services and outcomes, and promote healthy public policy.
- To develop new and innovative models of service delivery.
- To improve access to services and increase self-sufficiency.
- To develop and retain a skilled and committed health work force.

Enabling Legislation

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

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

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

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

Ministerial Directives

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

Submission of Annual Report

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

Statement of Compliance with Public Sector Standards

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

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

Such processes include:

- Education sessions on standards for all new and existing employees in 2001/2002.
- Codes of conduct and ethics are issued and signed receipts returned with initial employment pack for all employees whether permanent, temporary or casual status.
- Any suspected or reported breaches of standards or codes are incorporated into health services formal Grievance and Disciplinary Policy and dealt with in accordance with policy and/or external reporting guidelines.

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

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

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

Michael H. Moodie
CHIEF EXECUTIVE OFFICER
SOUTH WEST HEALTH BOARD
06 December 2002

Advertising and Sponsorship — Electoral Act 1907

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

CLASS OF EXPENDITURE	1999/2000 $	2000/2001 $	2001/2002 $
Advertising Agencies			
AA Media	4,738.00	3,778.00	–
Australian Asian College	750.00	750.00	–
Australian Physiotherapy	–	33.00	–
Boyup Brook Gazette	150.00	–	–
Collie Health Service	–	120.00	–
Dietitians Association	150.00	–	–
Farm Weekly	87.00	–	–
Local Link	399.00	195.00	–
Marketforce Production	134,279.00	125,462.00	79,023.00
Nannup Post and Rail	90.00	598.00	–
Pacific Access	182.00	412.00	–
Ray White Real Estate	435.00	–	–
Roy Weston Real Estate	135.00	–	–
Rural Press Regional Media	9,406.00	4,474.00	–
Seabreeze Communication	1,920.00	480.00	–
South African Medical Journal	–	–	3,412.00
South West Printing and Publishing	24,907.00	12,265.00	1,900.00
WACOSS	59.00	–	–
Walpole Weekly	30.00	20.00	–
West Australian	60.00	155.00	–
Market Research Organisations	–	–	–
Polling Organisations	–	–	–
Direct Mail Organisations	–	–	–
Media Advertising Organisations	–	–	–
TOTAL	**$177,777.00**	**$148,742.00**	**$84,335.00**

Freedom of Information Act 1992

The South West Health Service received and dealt with 206 formal applications under the Freedom of Information guidelines during 2001/2002.

Formal applications are defined as requests which:

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

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

The types of documents held by the South West Health Service include:

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

South West Health is working towards the production of a single information statement for the South West Health Board. The information statement will include a detailed description of the Freedom of Information process including policies and procedures and delegation responsibilities in accordance with the *Freedom of Information Act 1992*.

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

Freedom of Information Coordinator
South West Health Service
18 West St
BUSSELTON WA 6280

South West Health Service

Key Operations and Achievements

- The interim report and recommendations of the Bunbury Health Taskforce were accepted.
- The Board commenced a formal process of establishing community consultation.

Interim Report and Recommendations of the Bunbury Health Taskforce

In November 2001 the Minister for Health, Hon. R. Kucera, announced the Government's acceptance of the interim report and recommendations of the Bunbury Health Taskforce, which had been established by the Government to undertake a review of the Bunbury Regional Hospital and to identify solutions to regional and local health problems.

A key recommendation in the Taskforce Report was the establishment of an area health authority or area structure for the South West through the amalgamation of the Bunbury, Harvey/Yarloop, Vasse Leeuwin, Warren Blackwood and Wellington Health Service Boards and the creation of a South West Health Board with the Minister for Health as the Board.

The arrangements for the dissolution of the existing Boards and the creation of a South West Health Board were published in the Government Gazette in December 2001 with the new arrangements to apply from 1 January 2002.

An additional recommendation in the Taskforce Report was the appointment of the Chief Executive Officer for South West Health. In November 2001 the Director General of the Department of Health announced the appointment of Michael Moodie as the inaugural CEO.

Community Consultation

Since March 2001 the South West Health Board, in accordance with the Bunbury Taskforce Report recommendation 'South West Health Board to establish a formal consultative framework to enable community participation in health service policy setting', commenced a formal process of establishing community consultation.

This process has resulted in a series of separate workshops being run across south-west communities to elicit views and options as to what sort of mechanisms can be put in place to determine how best to consult with the community. These workshops involved the former board members, key local stakeholders, local government representatives and representatives of the Aboriginal communities.

Following the discussions, the overall consensus was to recommend holding a South West Health Forum before the year's end. The purpose of this would be to assist South West Health Board to establish some broad principles which will act as a value base that the Health Service can use in its overall planning and decision making. These principles would not be about priority setting or decision making but about establishing some broad guidelines to address future directions for the health of the communities across the South West.

Bunbury Acute Care Services

Key Operations and Achievements

- The Acute Care Service division of Bunbury Regional Hospital has continued to develop.
- Two paediatricians, three consultant physicians and medical officers for the Emergency Department have been recruited.
- The increase in activity targets was met for the year.
- A Theatre Management System has been introduced.
- The Hospital Sterilising Service Unit has introduced an instrument and tray tracking system.
- Nursing staff and medical officers in the Critical Care area have been further developing their skills.
- General Medical, Paediatric and Surgical units continue to develop.

Acute Care Service

The Acute Care Service division of Bunbury Regional Hospital has continued to develop and maintain quality focus activities in relation to the provision of patient care. Since January 2002, Bunbury Regional Hospital has been identified as the base hospital for the South West Health Service.

Specialist Staff Recruited

In meeting the service demands of the area, a move toward employing specialist services has taken place. Recently two paediatricians, three consultant physicians and medical officers for the Emergency Department have been recruited as salaried officers to join the Bunbury staff.

Increase in Activity Targets

The increase in activity targets was met for the 2001/2002 year. There has been a notable increase in trauma with a general increase across most other specialties.

Theatre Management System

A Theatre Management System has been introduced assisting in the provision of data through which improved information can be obtained in relation to theatre activity. As a result, areas can be targeted with the aim of improving theatre efficiency and effectiveness. Theatre management has also taken on the daily management responsibility of day procedure and endoscopy.

Instrument and Tray Tracking System

The Hospital Sterilising Service Unit has introduced an instrument and tray tracking system. This system was the largest of its type in Australia at the time of installation. Every instrument in circulation can be pinpointed at a given time and tracked from patient to servicing and storage. With the increased activity from both the private and public sectors, the tracking system has proven to be a highly effective resource.

Improved Staff Skills
Nursing staff and medical officers in the critical care area have been further developing their skills in order to meet the demands of a base hospital and the increasing complexity of presenting cases. The higher level of acuity being provided reduces the frequency of transfers to tertiary facilities.

Units Continue to Develop
General medical, paediatric and surgical units continue to develop and support junior trainee staff while providing a high level of technical expertise and standard of care. Clinical pathways are being developed for several surgical procedures while the stroke pathway is being further refined. The maternity unit is continuing to provide a variety of care options for new parents and demonstrating a comprehensive service from conception to returning to the community post delivery. Activity is increasing on an annual basis and the unit is rapidly becoming the referral centre for the South West. This unit supports training programs for students and new graduate midwives while providing opportunities for rural midwives to upskill in this field.

The Staff Development Team continues to provide a high standard of educational and developmental support to staff. Training program initiatives have been developed and funding sought to provide regional and district hospital staff with a training opportunity that is supported by clinical instruction. Patient care assistants, ward clerks, medical records, reception, security, cleaners, volunteers and coordinators of patient care all continue to ensure that patients and community visitors are welcomed and their stay eased during the period of hospitalisation.

Clinical Services

Key Operations and Achievements

- The Accident and Incident Management System was implemented.
- A Clinical Audit project was funded by the Department.

AIMS Implemented
The implementation of the Accident and Incident Management System has been supplemented with specific training in Incident Investigation, which is notable for its funding under the Australian Council for Safety and Quality of Health Care Safety Innovations in Practice program. It has been very well received by participants.

Clinical Audit Project
A Clinical Audit project was funded by the Department of Health under the Safety and Quality Plan. It has allowed the development of a methodology suitable for smaller hospitals which will be extended to other parts of the South West in due course.

South West Population Health Unit

Key Operations and Achievements

- The restructure of the South West Region's health services led to a split management regime over the year.
- The employment of a full-time business manager has led to improvement in processes and systems.
- A three-month project resulted in the collection and presentation of epidemiological profiles.
- Activities have occurred in all program areas.

Restructure of Services

The restructure of the South West Region's health services meant the unit was managed by Vasse Leeuwin Health Board for six months of the financial year and six months by the South West Health Service.

Full-Time Business Manager

The employment of a full-time business manager has led to improvement in the processes and systems of human resource, business and information technology management. However the key positions of Director–Public Health Physician, Disease Control Coordinator, Manager–Program Coordination and Building Capacity Coordinator all became vacant during this year, creating a challenge for continuity of services and corporate history and the need for an organisational restructure.

Epidemiological Profiles

A three-month project resulted in the collection and presentation of epidemiological profiles, relevant to health services and other agencies, with SWPHU expected to take an even greater role in the creation and dissemination of health data to health service providers. A review of the Registered Training Organisation status at SWPHU has resulted in the proposed expansion of the RTO within SWAHS. The RTO successfully met the requirement of the Training Accreditation Council Monitoring and completed an internal audit to satisfy Australian Quality Training Framework Standards.

Program Activities

Activities have occurred in all program areas, including setting up a regional Hepatitis C network, developing an on-call disease control roster for after hours, dealing with a major measles outbreak, a need assessment for the needle and syringe program in the South West, delivery of health promotion training, collaboration with the Cancer Foundation to deliver programs aimed at improving child nutrition, a diabetes management book for people with diabetes, a research project aimed at increasing physical activity in the workplace, alcohol, other drugs and tobacco strategies targeting young people, Stay on Your Feet training and farm injury surveillance.

Mental Health

Key Operations and Achievements

- There have been major improvements in the quality of care and services.
- A program was planned, developed and implemented to improve the social and mental health of timber communities affected by changes in the industry.
- Partnerships developed between the Greater Bunbury Division of General Practice and the South West Mental Health Service.
- A trial based on continuity of care for psychiatric admissions from the community into the Acute Psychiatric Unit was conducted by community-based psychiatrists.
- Suicide prevention workshops (introduction and advanced workshops) were coordinated by SWMH for the region.
- Mid-level medical staff to support community and inpatient programs were recruited.

Major Improvements

There have been major improvements in the quality of care and services within the organisation over the past 12 months.

Social and Mental Health Program for Timber Communities

A program was planned, developed and implemented to improve the social and mental health of timber communities affected by changes in that industry, including a partnership with the local community health service.

New Partnerships

Partnerships developed between the Greater Bunbury Division of General Practice and the South West Mental Health Service on a number of projects, such as the development of a shared care model of acute psychiatric patients.

Continuity of Care for Psychiatric Admissions Trial

A trial based on continuity of care for psychiatric admissions from the community into the Acute Psychiatric Unit was conducted by community-based psychiatrists. Key areas of the Consumer Participation Policy including representation on the management team, training for consumers and carers and joint projects such as Mental Health Week planning were implemented.

Suicide Prevention Workshops

Suicide prevention workshops (introduction and advanced workshops) were coordinated by SWMH for the region, in conjunction with the Ministerial Council for Suicide Prevention. In-depth Mental Health Review has provided the opportunity for SWMH to review the service against the National Mental Health Service.

Mid-Level Medical Staff Recruited

Mid-level medical staff to support community and inpatient programs were recruited. Integration developed between the Child and Adolescent Mental Health Service and Adult teams in the Lower South West.

Busselton District Hospital

Key Operations and Achievements

- Busselton Hospital continues to participate in the ACHS Evaluation and Quality Improvement Program.
- The Emergency Department has been serviced by salaried medical officers
- Busselton Hospital is seeking funding to upgrade the Emergency Department.

Evaluation and Quality Improvement Program
Busselton Hospital continues to participate in the ACHS Evaluation and Quality Improvement Program and the annual holiday renal dialysis program.

Salaried Medical Officers
The Busselton Hospital Emergency Department has been serviced by salaried medical officers since August 2001.

Emergency Department Upgrade
Busselton Hospital is seeking funding in the new capital works budget to upgrade the Emergency Department, as there are significant work site and security issues.

Harvey Yarloop Health Service

Key Operations and Achievements

- Ongoing restructuring has occurred as part of the consultative process.
- The Health Service conducted a Community Health Survey.
- The Director of Nursing/Health Service Manager resigned.

Ongoing Restructuring
The management of Harvey Yarloop Health Service has seen this period as one of consolidation following the major reconfiguration of the health service in the previous financial year. Ongoing restructuring has occurred as part of the consultative process and has resulted in significant efficiencies within the laundry and other support areas.

Community Health Survey
The Harvey Yarloop Health Service conducted a Community Health Survey. Funding for the survey was gained through the state-wide New Vision for Community Health initiative, aimed to determine the local community's views of currently provided services and areas where improvements or additional services were required. The survey highlighted a need for more residential aged care, health promotion and early intervention programs. Numerous recommendations have been acted upon by the Health Service.

Resignation
The Director of Nursing/Health Service Manager resigned from the Health Service after six years service.

Bridgetown Hospital

Key Operations and Achievements

- Bridgetown Hospital continued to provide good quality health service to the community.
- The Special Repairs and Equipment program provided funding for new equipment.
- The hospital suffered storm damage in April and May.
- The Fire Warning System was upgraded.

Quality Service
Bridgetown Hospital continued to provide the same good quality health service to the community.

New Equipment
At the end of the financial year, the Special Repairs and Equipment program provided funding for three new beds, a paediatric cot, sphigmomachines for each bed, theatre instruments and equipment, oximeter, heatkeepers, and sundry items. A huge upgrade in linen supplies was also funded through the program.

Storm Damage
A significant event was the storm damage in April and May which resulted in a number of internal areas of the hospital being flooded. A Department of Health structural survey was done. The report has been sent to the CEO and Director for Corporate Services. Recommendations included replacing the roof; however no action has been taken to date.

Fire Warning System
The Fire Warning System upgrade was funded by the Department of Health.

Margaret River Hospital

Key Operations and Achievements

- Budget provision has been confirmed for the redevelopment and remodelling of the Hospital.
- The Hospital underwent its second successful Accreditation Review with the Australian Council on HealthCare Standards.
- The Hospital continues to work with the community networks and stakeholders to facilitate the Healthy Communities Project.
- A Hospital Community Referral form was introduced to facilitate movement of patients from the hospital into the community.
- The Hospital participated in planning and management of the influx of school leavers arriving for Schoolies Week.

Redevelopment and Remodelling

Budget provision has been confirmed for the redevelopment and remodelling of the Margaret River District Hospital. Consultants have visited the site and are preparing a report.

Accreditation Review

The Margaret River District Hospital underwent its second successful Accreditation Review with the Australian Council on HealthCare Standards in August 2001, gaining a four-year accreditation. The hospital was previously accredited in 1998. The results were excellent, with several commendations.

Healthy Communities Project

Margaret River District Hospital continues to work with the community networks and stakeholders to facilitate the Healthy Communities Project using the model outlined in the *Healthy Communities* paper.

Hospital Community Referral Form

A Hospital Community Referral form was introduced to facilitate movement of patients from the hospital into the community. This was made possible by the introduction of a common referral process. Following the successful implementation, use of the form has been adopted by doctors' surgeries.

Schoolies Week

The Hospital participated in planning and management of the influx of school leavers arriving in Margaret River for Schoolies Week in November 2001. Margaret River Safer WA coordinated the planning, which also involved police, youth workers and the Shire Council. Despite large numbers of school leavers, there were only a few incidents. Planning for 2002 is ongoing.

Collie Health Service

Key Operations and Achievements

- The Health Service continued to deliver a high standard of care.
- Centenary Celebrations were held in November.
- An extensive upgrade began on the nurses quarters.
- Staff attended many study days and seminars.
- New equipment was purchased throughout the year.

High Standard of Care

Collie Health Service continued to deliver a high standard of care to the community of Collie and environs.

Centenary Celebrations

The main project for the first half of the year was the Centenary Celebrations held in November 2001. A small but dedicated team of past and present staff members coordinated the day when more than 500 people visited the site. It was a huge success and memorabilia gathered for the occasion is now archived for future reference.

Nurses Quarters Upgrade

An extensive upgrade was commenced on the existing nurses quarters and painting and refurbishment began.

Study Days and Seminars

Staff development was ongoing throughout the year with staff attending many study days and seminars. Several staff have attended Rural Health Support Education and Training programs in Bunbury involving skills updates in aggression management, alcohol and other drugs, stress management and occupational safety and health

New Equipment

New equipment was purchased throughout the year including a theatre steriliser, pan sterilisers for Hillview, new instruments for theatre and, through public donations, vital signs machines for the wards.

Nannup Health Service

Key Operations and Achievements

- The Health Service held the official opening in October 2001 for the redevelopment of acute care and multipurpose services.
- The Health Service received a donation from a past resident's family with a request to develop a remembrance garden.
- The Health Service continues its accreditation status with ACHS.

Redevelopment of Acute Care and Multipurpose Services

Nannup Health Service held the official opening on 30 October 2001 for the redevelopment of acute care and multipurpose services, including a new Emergency Department with ambulance entry, three acute beds, a palliative/respite suite and purpose-built allied health room, child health/primary health rooms and doctor's surgery area. Nannup Health Service continues to work towards becoming a Multipurpose Service and became the sponsor for Nannup Community Care and Meals on Wheels, integrating the staff and service provision within Nannup Health Service.

Donation for a Remembrance Garden

Nannup Health Service received a donation from a past resident's family with a request to develop a remembrance garden. This has been achieved with staff and community members donating time and resources to complete this project. The Friends of the Hospital continue to support the Health Service with donations of items for residents' and clients' benefit, including a music system for the residents and decor for the Andrews Suite.

ACHS Accreditation

Nannup Health Service continues its accreditation status with ACHS and underwent a successful periodic review in November 2001.

Wellington Primary Health

Key Operations and Achievements

- A joint function with the local Collie general practitioners was organised and facilitated to provide a formal and supportive environment for the GPs to network with our primary health professionals.
- Further development of the breast care nurse service resulted in referrals from other towns in the South West.
- Continued improvements were made to the clinical pathways of alcohol and other drug patients.
- Public health programs gained significant media exposure.
- The Health Service was able to demonstrate useful data regarding referrals in the Monitoring Outcomes project.

Joint Function to Promote Networking

A joint Christmas in July function with the local Collie general practitioners was organised and facilitated. This event provided a formal and supportive environment for the GPs to network with our primary health professionals. The aim was to improve our working relationships with the GPs and to share information about current primary health services, programs and new initiatives. This provided a forum to make decisions about future health program needs, improving clinical pathways and referral processes in a collaborative manner. It was agreed to organise this event annually. The primary health service in Collie has seen a marked increase in more appropriate referrals from GPs, and has resulted in improved clinical management of patients.

Breast Care Nurse Service

Further development of the breast care nurse service for women with breast cancer, resulted in referrals being received from other towns in the South West. With these referrals there is a definite need to increase this service.

Improvements to Clinical Pathways

Continued improvements were made to the clinical pathways of alcohol and other drug patients in the acute and community settings resulting in improved service provision and access for the Collie community.

Public Health Programs

Programs which gained significant media exposure included Food for Thought for the general public, men's health with one of the local football clubs, and Life Keep It which focused primarily on seniors.

Monitoring Outcomes Project

The Health Service was able to demonstrate some particularly useful data with the referrals to primary health intervention from the acute setting in the Monitoring Outcomes project. Primary health staff worked extensively with the acute care nursing staff to establish more efficient referral to primary health clinicians, resulting in shorter acute care episodes and improved health condition management.

Major Capital Projects

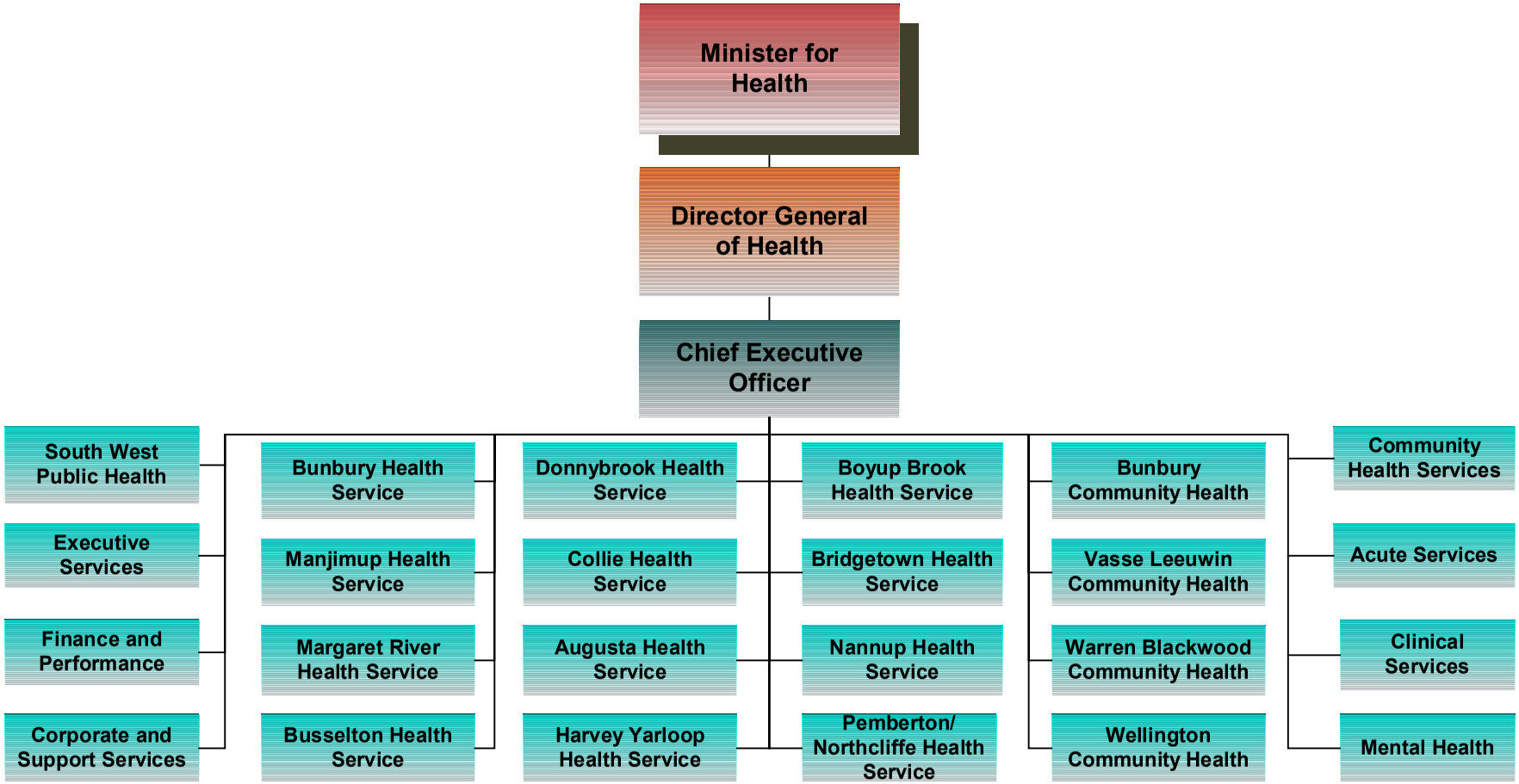
Projects Completed during the Year

PROJECT DESCRIPTION	Actual Total Cost	Estimated Total Cost
Finalisation of the Pemberton Hospital Upgrade	$121,024.00	$121,000.00

Projects in Progress

There were no major capital projects still in progress at 30 June 2002.

Organisational Chart



Accountable Authority

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

Senior Officers

Senior officers of the South West Health Service Board and their areas of responsibility are listed below:

Area of Responsibility	Title	Name	Basis of Appointment
Overall responsibility	Chief Executive Officer	Michael Moodie	Permanent
Finance and Performance	Director Finance and Performance	Hugh Thomson	Permanent
Corporate and Support Services	Director Corporate and Support Services	John McCredden	Permanent
Community Health Services	Director Community Health Services	Anne Donaldson	Permanent
Acute Services	Director Acute Services	Noel Carlin	Permanent
Public Health	Director South West Public Health	Philip Moore	Acting
Clinical Services	Director Clinical Services	Dr Jon Mulligan	Permanent
Mental Health	Director Mental Health	David Naughton	Permanent
Executive Services	Director Executive Services	Jeff Travers	Permanent
Health Service Management	Health Service Manager Bunbury Regional Hospital	Marilyn Horner	Permanent
Health Service Management	Health Service Manager Margaret River District Hospital	Fran Temby	Permanent
Health Service Management	Health Service Manager Donnybrook District Hospital	Meg Woodhouse	Secondment
Health Service Management	Health Service Manager Augusta District Hospital	Helen Smith	Permanent
Health Service Management	Health Service Manager Boyup Brook District Hospital	Graham Bergin	Permanent
Health Service Management	Health Service Manager Nannup District Hospital	Cindy Stainton	Secondment

Area of Responsibility	Title	Name	Basis of Appointment
Health Service Management	Health Service Manager Warren District Hospital	Duncan Corbett	Permanent
Health Service Management	Health Service Manager Busselton District Hospital	Wendy McDonald	Permanent
Health Service Management	Health Service Manager Collie District Hospital	Louise Julian	Secondment
Health Service Management	Health Service Manager Harvey Yarloop Health Service	Derrick Simpson	Permanent
Health Service Management	Health Service Manager Bridgetown District Hospital	Linda Jackson	Permanent
Health Service Management	Health Service Manager Pemberton District Hospital/ Northcliffe Nursing Post	Gordon Palmer	Permanent
Community Health Management	Community Health Manager Bunbury Community Health	Jaynie Sands	Secondment
Community Health Management	Community Health Manager Vasse Leeuwin Community Health	Michael Bradley	Permanent
Community Health Management	Community Health Manager Warren Blackwood Community Health	Sharon McBride	Permanent
Community Health Management	Community Health Manager Wellington Community Health	Simone Pearson	Permanent

Pecuniary Interests

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

Demography

The following table shows population figures for each local authority within the South West Health Service region. The South West Health Service delivers services to communities covered by these local authorities

LOCAL AUTHORITY	Population as at 1996*	Population as at 2001*	Projected Population as at 2006*
Augusta–Margaret River	8,122	10,266	11,901
Boyup Brook	1,746	1,655	1,702
Bridgetown–Greenbushes	4,033	4,217	4,399
Bunbury	27,680	30,540	29,998
Busselton	18,175	23,337	27,002
Capel	6,003	7,112	7,801
Collie	9,026	9,056	9,101
Dardanup	6,675	9,001	12,596
Donnybrook–Balingup	4,251	4,673	4,801
Harvey	15,578	18,611	20,698
Manjimup	10,258	10,246	10,800
Nannup	1,161	1,211	1,399

*Data sources:

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

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

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

The demographics within the South West Health Region can be quite diverse. Rural communities differ in size from regional centres to small towns. The region is one of the fastest growing populations of regional Western Australia and the population is estimated to reach 157,300 in 2011.

The South West has the most diverse regional economy of Western Australia. Extensive mineral wealth has made the region a major world producer of alumina and mineral sands. The economy is also based on strong agricultural and horticultural industries, timber and forest products, viticulture, retailing and tourism.

The increase in population and the tourist influx during holiday periods places pressure on the resources of the Health Service.

Available Services

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

Direct Patient Services
Accident and Emergency
Acute Medical
Acute Surgical
Domiciliary Midwifery
Extended Care Services
Nursing Home Type Care
Obstetrics
Orthopaedics
Paediatric
Palliative Care
Respite Care
Same Day Surgery

Community Services
Corporate Services
Engineering and Maintenance
Financial Services
Health Promotion
Medical Records
Patient Assisted Travel
Purchasing and Supply
Sterilising Services
Support Services

Medical Support Services
Audiology
Dietetics
Medical Imaging
Occupational Therapy
Pathology (service agreement with Pathcentre)
Pharmacy
Physiotherapy
Podiatry
Social Work
Speech Pathology

Other Support Services
Alcohol and Other Drugs Project
Breast Care Service
Child Health
Community Depression Project
Community Mothers Program
Continence Advisor
Early Discharge for Obstetric Patients
Home Care
Immunisation
Injury Prevention
Integrated Diabetes Project
Meals on Wheels
Positive Parenting Program
Primary Health Care
Respite and Transport
School Health

Other Services

Alcohol and Other Drugs
Breast and Cervical Cancer
Capacity Building
Emergency Response Planning
Food Surveillance
Health Information and Advice
Health Planning
Immunisation Coordination
HIV/AIDS and Blood Borne Viruses
Injury Control
Mosquito Borne Disease Control
Notifiable Disease Surveillance
Nutrition
Physical Activity
Policy Development
Research and Development
Sexual Health
Tobacco Prevention
Water Surveillance

Disability Services

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

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

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

- The Disability Service Plan for the Health Service is under review from the last three-year plan which ended in January 2002. The aim of the new DSP is to identify and prioritise newly identified areas of need or review areas not progressed with the previous plan. The Occupational Safety and Health Committee has the delegated responsibility for progressing the plan. Relevant Health Service employees will be delegated specific tasks to undertake in order to meet planned strategies within timeframes.

Outcome 2: Access to buildings and facilities is improved.

- The South West Health Service was established on 1 January 2002 and an audit and assessment of all facilities is proposed for 2002/2003. A requirement to report on disability access issues will be incorporated into the audit process.

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

- Information about services is available in alternative formats.

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

- Training programs targeted specifically at customer services personnel have been conducted.

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

- Community consultation and engagement processes are currently being undertaken and people with disabilities are targeted to participate in these processes.

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

Cultural Diversity and Language Services

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

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

- The admission processes in place at the Health Service assist in identifying language and cultural issues that a client may have on admission. The Health Service uses the Translation and Interpreter Service as required.

Youth Services

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

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

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

Programs and Initiatives
The South West Health Service has run numerous programs targeting youth groups and introduced a number of innovations such as:

- The Health Service has 16.3 FTE invested in the school health program throughout the South West. The role incorporates immunisation and screening, counselling, support and referral of high risk students in a case management framework. The role extends to building capacity with education services. Recent emphasis has been on alcohol and other drugs in partnership with the South West Population Health Unit.
- The South West Health Board runs a child and adolescent mental health program throughout the area. Five mental health clinicians provide services to all school-aged children in the area.

- Bunbury Primary Health Service has developed and conducted two health promotion and early intervention programs to address aspects of mental health for the local community. The Balancing Out program is a stress management program co-facilitated by mental health and community health staff, conducted over six weeks for groups of 12 participants. Another group titled Me is a health promotion program targeting young people with low self-esteem to develop strategies to improve their self-esteem. This program is co-facilitated between social work services and occupational therapy services.
- The community of Greater Bunbury has entered its third year of the Investing in our Youth Project. This intersectoral forum incorporates local government, education, health, welfare agencies and Edith Cowan University as partners. Education has taken the lead role in this initiative. The project to date has surveyed youth (3000) in the Greater Bunbury community (≅30 per cent return rate) to determine risk factors, which in turn has enabled the forum to investigate specific protective factors for youth in our community. All Investing in our Youth research documents and meeting minutes are available on our website: www.investinginouryouth.com.au

Employee Profile

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

CATEGORY	1999/2000	2000/2001	2001/2002
Nursing Services	534.76	550.44	518.92
Administration and Clerical*	171.72	184.46	195.65
Medical Support*	108.66	113.92	114.97
Hotel Services*	229.73	211.59	232.79
Maintenance	24.90	26.83	23.15
Medical (salaried)	9.49	11.12	15.92
Other	1.19	0	0
TOTAL	**1080.45**	**1098.36**	**1101.40**

*Note these categories include the following:

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

Recruitment Practices

Attendance at the annual nursing Expo last year paid dividends for the South West Health Service, improving the recruitment of new graduates for the 2001/2002 Graduate Registered Nurse program.

Increased usage of web-based recruitment sites has increased our range and placement of advertisements. In particular, the Nursing and Allied Health website improved our success rate in recruiting Registered Nurses.

Retention strategies have involved procuring Registered Nursing and Allied Health staff from other sites and offering mileage allowances as an incentive to assist with staff shortages. Additional discretionary study leave and assistance was offered to retain and retrain staff in hard-to-recruit to areas.

Recruitment of medical staff into emergency medicine and psychiatry remains difficult and the Health Service relies on the extensive usage of recruitment agencies.

Staff Development

The development of the South West Health Service has provided the opportunity to maximise available resources in the provision of best practice staff education and training activities.

By coordinating health service education and training activities within the South West Region a South West Area Health training program is under development with the aim of ensuring a continuing emphasis on:

- Addressing essential minimum competencies in safe practice and the effective use of the training and development expertise of staff within the South West region.
- The efficient use of resources to ensure skill gaps are identified and addressed.
- The ongoing capacity of health workers in the South West to provide quality services to external and internal customers.

An important aspect of the South West Health Service staff development program is attainment of Registered Training Organisation status under the Australian Quality Training Framework. RTO status will enable best practice in flexible training and assessment to meet identified health industry standards with the opportunity to grant nationally recognised qualifications.

Industrial Relations Issues

Negotiations in relation to all major Enterprise Agreements and Awards have been successfully concluded with input from management and staff from South West Health Service. Restructuring of services and administrative supports is continuing in consultation with staff and the relevant unions.

An area-wide Industrial Consultative Committee has been established comprising representatives of management, staff and unions.

South West Health Service has also finalised the voluntary severance scheme which formed part of an across-government initiative to reduce staffing levels.

Workers' Compensation and Rehabilitation

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

CATEGORY	1999/2000	2000/2001	2001/2002
Nursing Services	49	50	54
Administration and Clerical*	7	5	8
Medical Support*	0	0	0
Hotel Services*	20	22	23
Maintenance	1	3	1
Medical (salaried)	0	0	0
Other	0	0	1
TOTAL	**77**	**80**	**87**

*Note these categories include the following:

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

The South West Health Service injury management policy endeavours to maximise the outcome and minimise the risk for both the employee and the employer, reducing lost time through injury by applying initial treatment in a timely manner that increases the outcome potential.

Induction and orientation assist with the risks associated with new and existing employees and has reduced the Health Service's exposure.

In 2001/2002 intensive manual handling (manutension) sessions have been run by qualified trainers for many employees who have a large proportion of manual handling within the scope of their roles. All new staff are afforded this training during the compulsory induction sessions. One-on-one training was given to staff considered to be at risk (current workers compensation claims and new staff declaring previous injury). Any new staff member who declared a previous injury was assessed and forwarded for review when necessary to medical practitioners or specialists.

Early rehabilitation interventions for injured workers continue to prove valuable in effective return-to-work programs. A combination of in-house and externally provided programs was used depending on the nature and severity of the injury.

Equity and Diversity Outcomes

Our Policy
The ability of an organisation to provide high quality health services to the general public is closely related to workforce diversity. That diversity needs to be tapped for planning, decision-making and service delivery.

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

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

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

- Policies are in place and employees have access to policy within departments.
- Our Policy states that the Health Service recognises the need to provide a safe working environment, free from all forms of discrimination and harassment, which promotes a challenging and rewarding career for every employee. The Health Service encourages all employees to take action when confronted with, or having witnessed any form of discrimination or harassment.

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

- Job descriptions issued to potential employees state in the selection criteria that employees must have 'Current knowledge and commitment to the principles and practices of Equal Opportunity, Disability Services, Occupational Safety and Health and Risk Management in all aspects of service delivery.' All Human Resources policies and codes of conduct are underpinned by the relevant acts. Employees are required to participate in education sessions on preventative discrimination in the workplace and how to deal with such practices if they arise.

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

- EEO employee data is stored electronically and updated on a monthly basis. Data trends are monitored by management to ensure the diversity of the workforce is catered for. Data are reported to the Equal Opportunity Commission annually.

EEO Indicators

The following table indicates strategic plans or processes the Department of Health aims to have in place across the health system to achieve equity and diversity in the workplace, and the level to which the South West Health Service has been able to meet these goals:

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

Marketing

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

- Use of local press and radio to inform the community on health issues and new service developments.
- Health promotion activities at local agricultural shows.
- Health promotional pamphlets produced by community health and South West Population Health for distribution throughout the community.
- Be Active competitions and programs encouraging the community to take part in regular exercise.
- Community consultation workshops involving former board members, key local stakeholders, local government representatives and representatives of the Aboriginal communities.

The South West Health Service recognises the importance of establishing a climate of good community relations and has actively sought to raise the profile of the hospitals, community health and related services.

Publications

There were no publications produced by the South West Health Service during the reporting period.

Research and Development

The South West Health Service carried out no major research and development programs during 2001/2002.

Evaluations

The South West Health Service carried out no major evaluations during 2001/2002.

Risk Management

Our Policy

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

Strategies and Initiatives

Successful risk management strategies initiated during 2001/2002 include:

- The South West Health Board has established a risk management group to combine the programs of the five health services prior to the creation of the South West Health Board.
- The Quality and Risk Coordinating Group is in the process of collecting information on all existing risk management programs from across the Health Service with a view to adopting a streamlined approach that suits the needs of the organisation in its new structure and Treasurer's Instruction 109.
- Policies and procedures will be consistently applied and a risk register and assessment tool will be implemented that allows inherent risks to be identified, assessed and treated.

Future Direction

The South West Health Service will continue to review its risk management and quality improvement processes in keeping with the above policy.

Internal Audit Controls

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

The Health Service has established a system of internal controls to provide reasonable assurance that assets are safeguarded, proper accounting records are maintained and financial information is reliable. An Audit Committee was established to oversee the operation of internal audit functions and to ensure that management addresses any findings made by the Health Service's internal and external audit.

Waste Paper Recycling

This year the Bunbury Health Service recycled a total of 13.76 tonnes of waste paper. This compares with 10.90 tonnes in 2000/2001. Health Services within the Vasse Leeuwin Network operate a recycling program with waste paper being collected regularly by contractors and service clubs. The paper collected is not weighed. At other Health Services which do not have facilities in the community for recycling paper, bags of shredded paper are collected by staff and the community for composting. Non-confidential used paper is reused for notepaper.

Pricing Policy

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

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

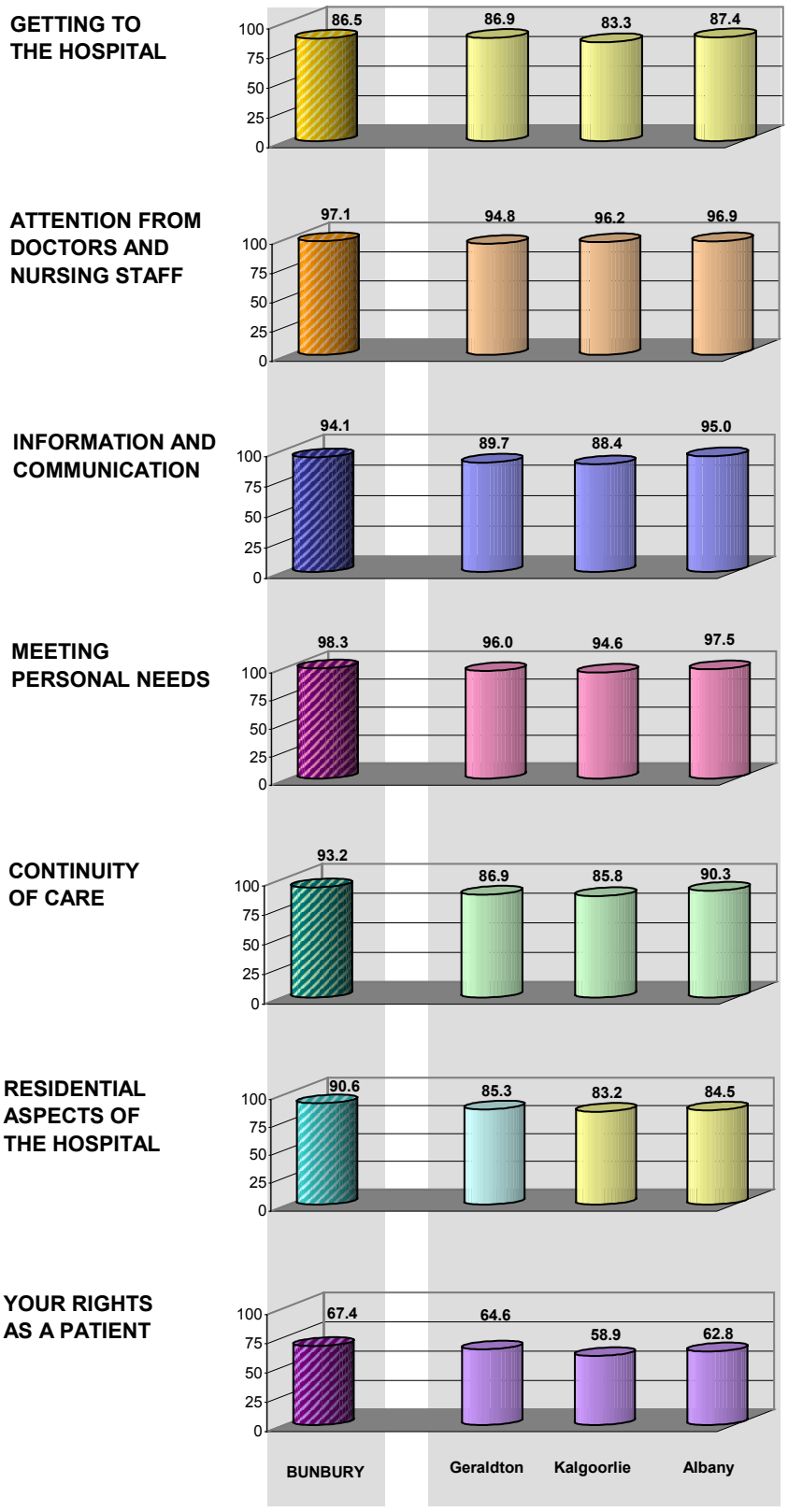
No fees are raised against registered public and private outpatients of the hospital.

Client Satisfaction Surveys

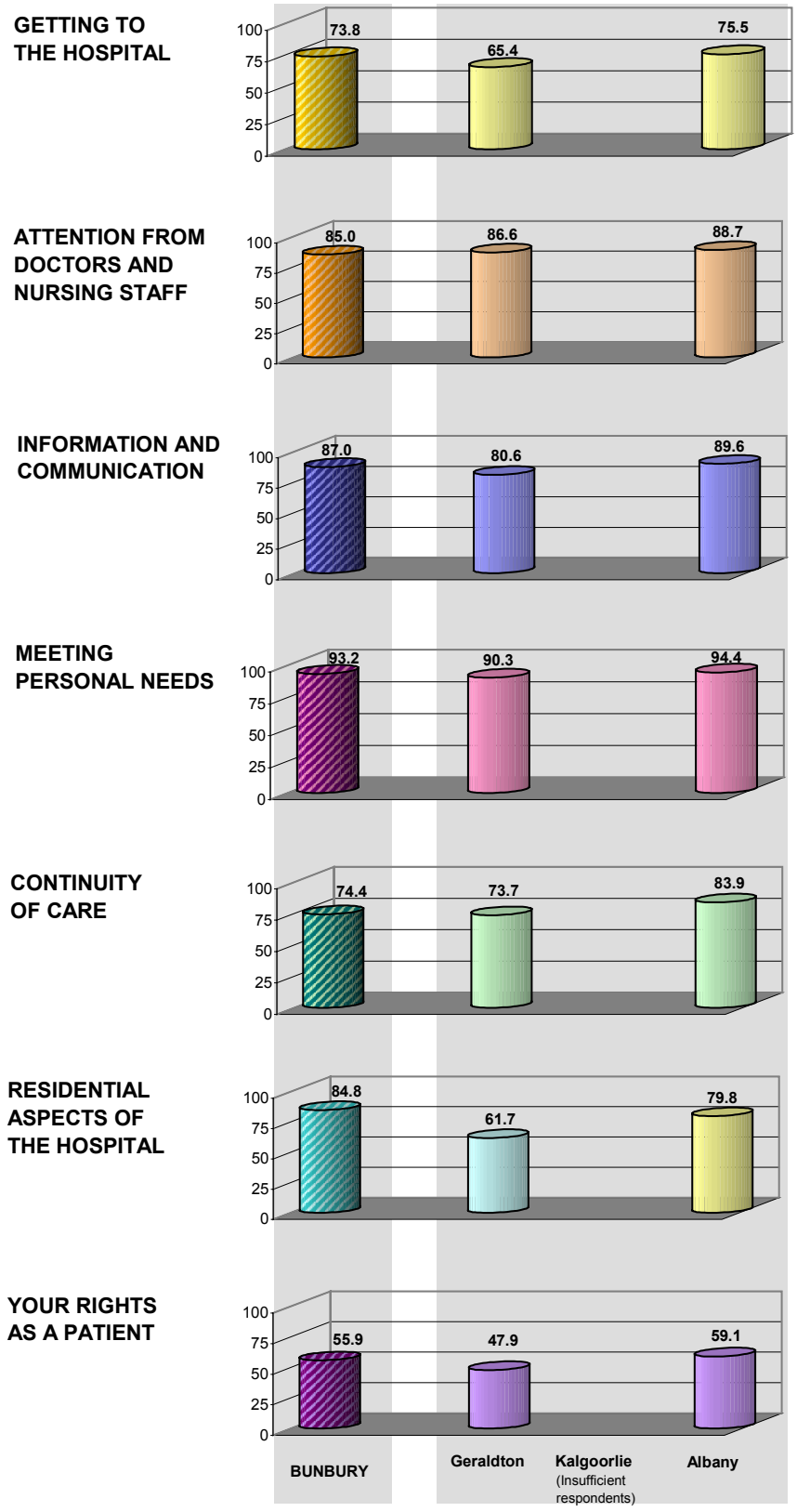
Favourable satisfaction ratings have been associated with favourable health outcomes. In addition, if a patient's perception of health service provision is favourable they will be more likely to seek timely help, assistance or treatment. The Department of Health has produced Client Satisfaction Survey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

Each year a number of client groups are selected to answer questions about their experiences within the health system. The survey process is managed by the Department of Health with questionnaires being posted to patients during a specified survey period. Details of the responses to individual questions are shown below and audited aggregate results of these surveys are shown in the Key Performance Indicator section (page 66) of this report.

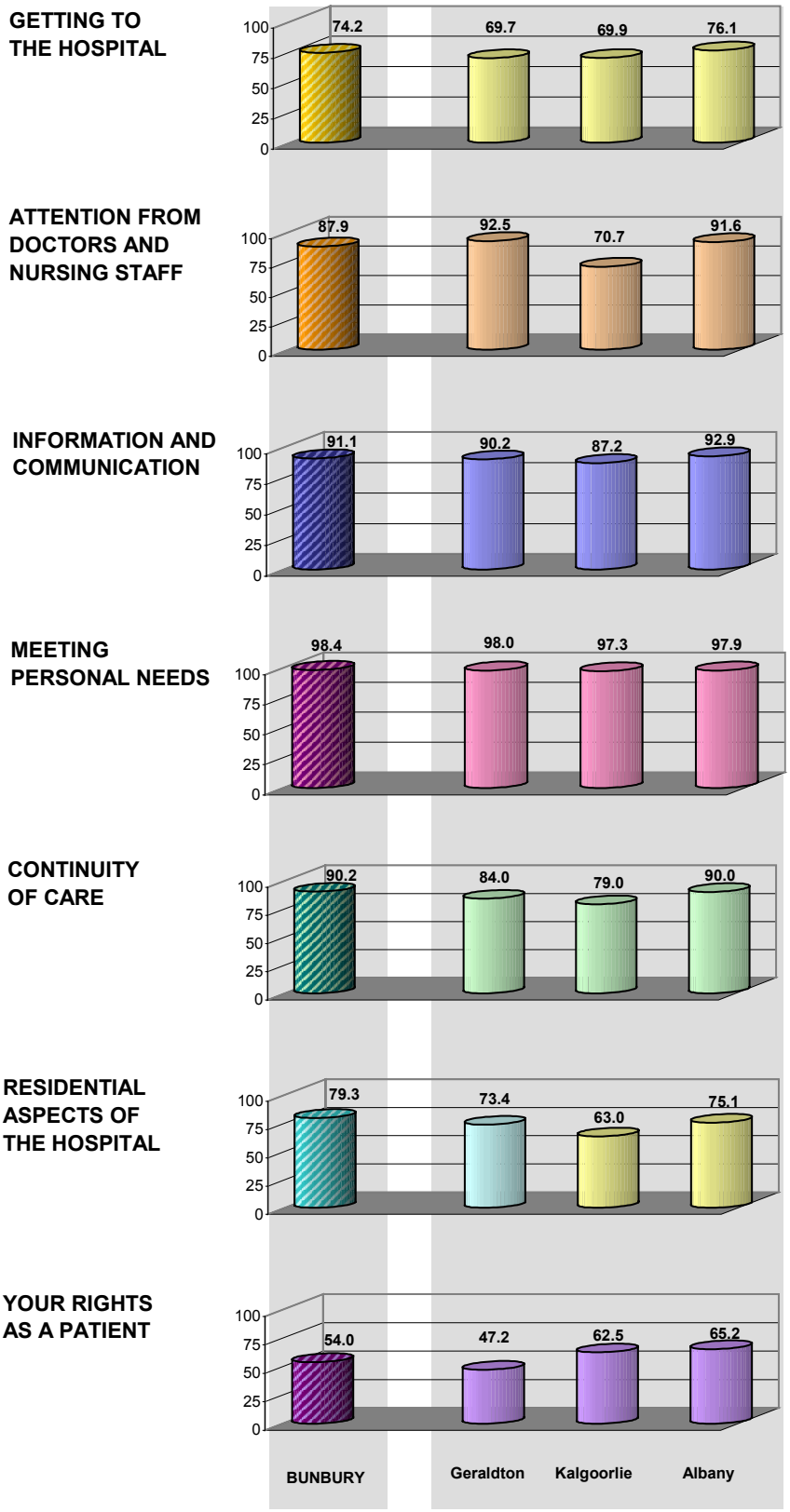
KPI 2.2: SAMEDAY PATIENTS — RURAL



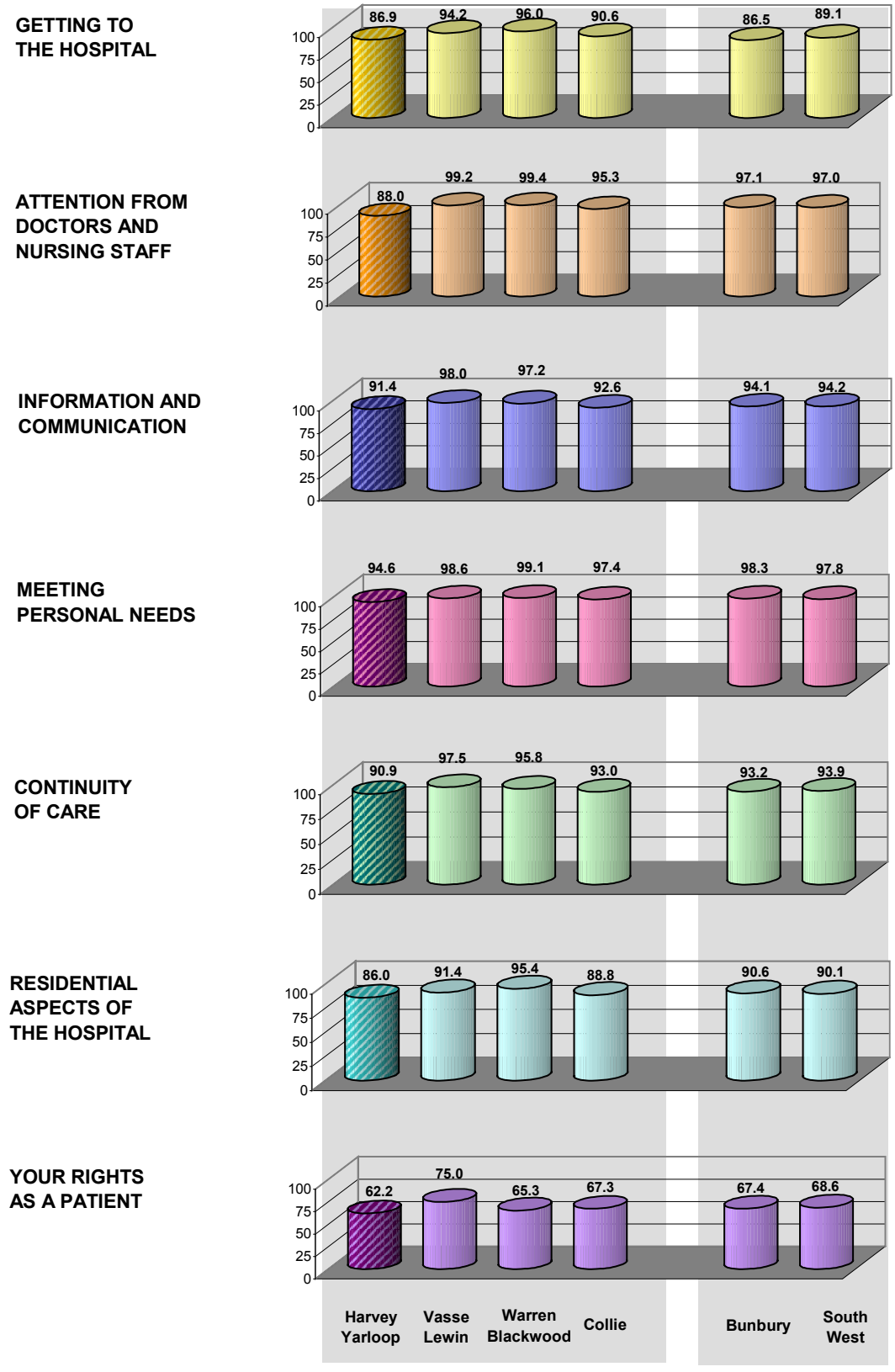
KPI 2.2: EMERGENCY PATIENTS — RURAL



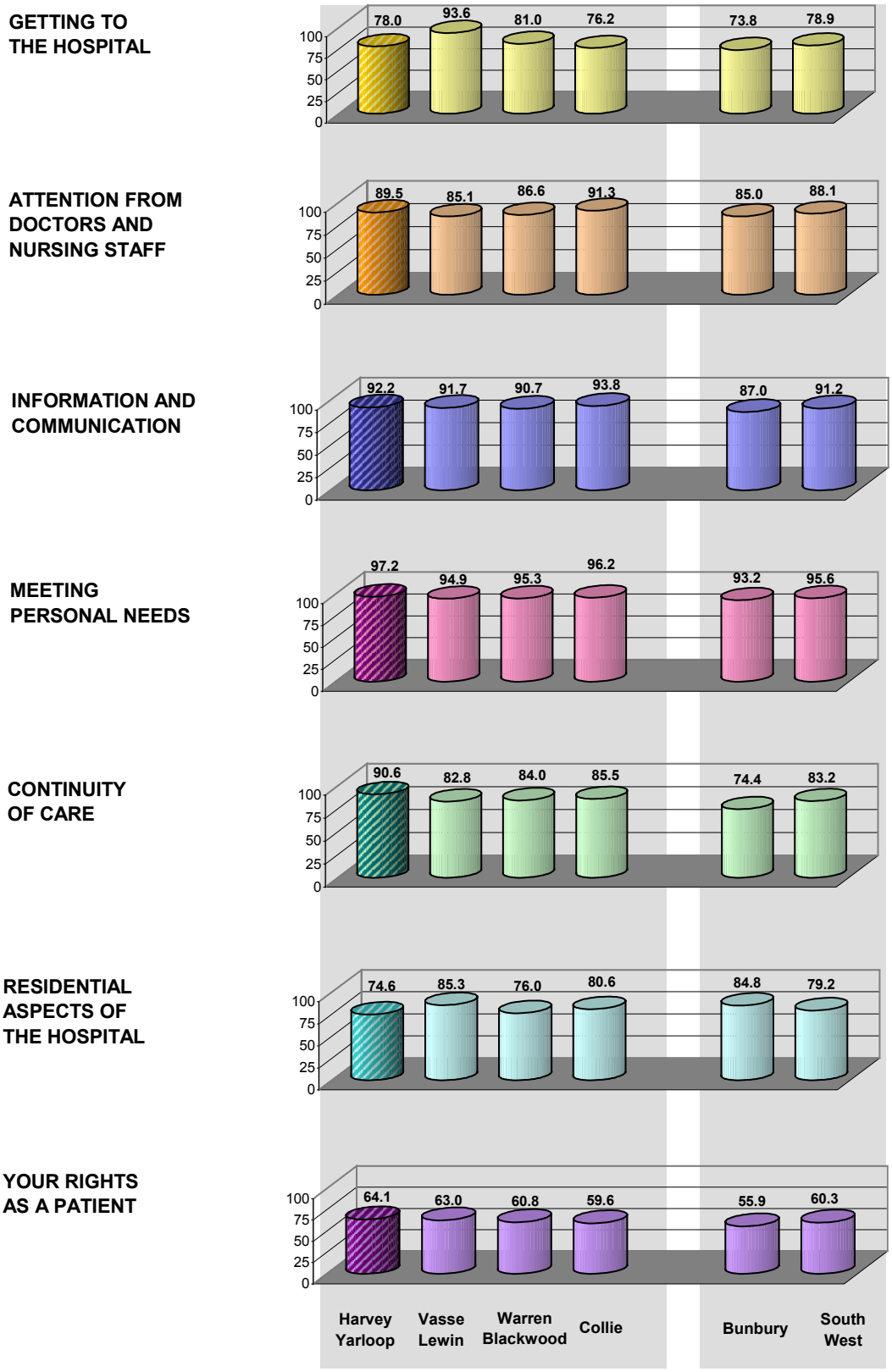
KPI 2.2: OUTPATIENTS — RURAL



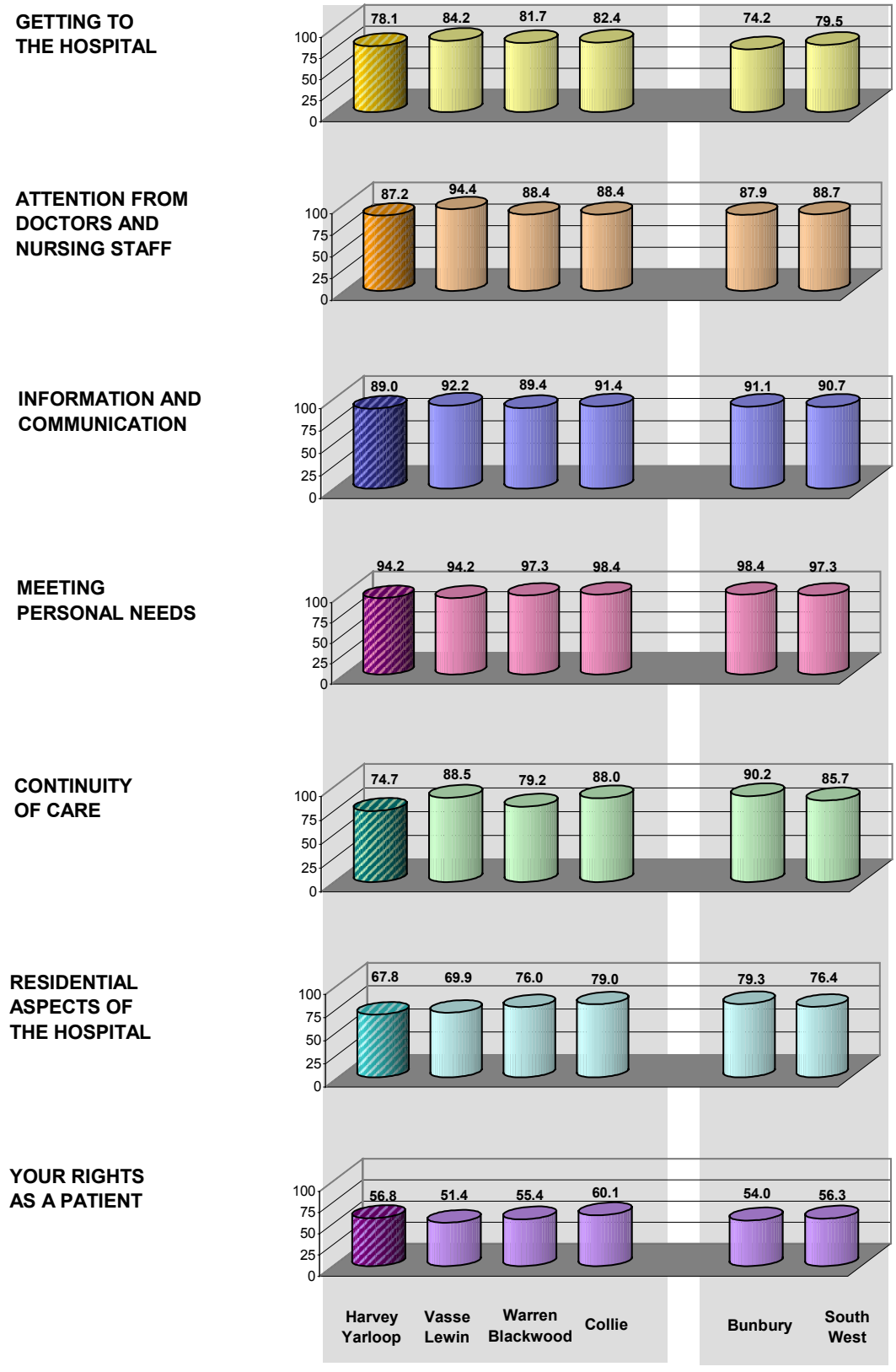
KPI 2.2: SAMEDAY PATIENTS — RURAL



KPI 2.2: EMERGENCY PATIENTS — RURAL



KPI 2.2: OUTPATIENTS — RURAL



AUDITOR GENERAL

To the Parliament of Western Australia

SOUTH WEST HEALTH BOARD
PERFORMANCE INDICATORS FOR THE YEAR ENDED JUNE 30, 2002

Scope

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

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

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

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

Audit Opinion

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

D D R PEARSON
AUDITOR GENERAL
March 28, 2003

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

AUDITOR GENERAL

INTERIM REPORT

To the Parliament of Western Australia

SOUTH WEST HEALTH BOARD

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

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

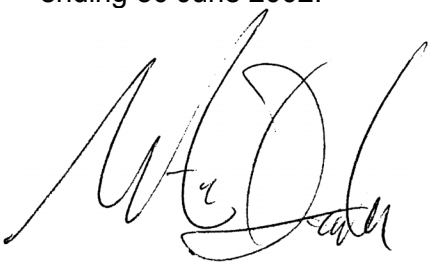
It is anticipated that the opinions will be issued by March 31, 2003.

D D R PEARSON
AUDITOR GENERAL
February 28, 2003

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

SOUTH WEST HEALTH BOARD
CERTIFICATION OF PERFORMANCE INDICATORS
FOR THE YEAR ENDED 30 JUNE 2002

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



Mike Daube
ACCOUNTABLE AUTHORITY
Director General of Health

November 2002

Table of Contents

Background

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

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

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

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

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

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

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

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

Output 1: *Prevention and Promotion*

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

Output 2: *Diagnosis and Treatment*

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

Output 3: *Continuing Care*

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

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

General Approach

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

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

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

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

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

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

Comparative Results

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

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

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

Output Measures

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

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

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

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

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

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

Assessing the Performance of the Health Service

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

Glossary of Terms

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

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

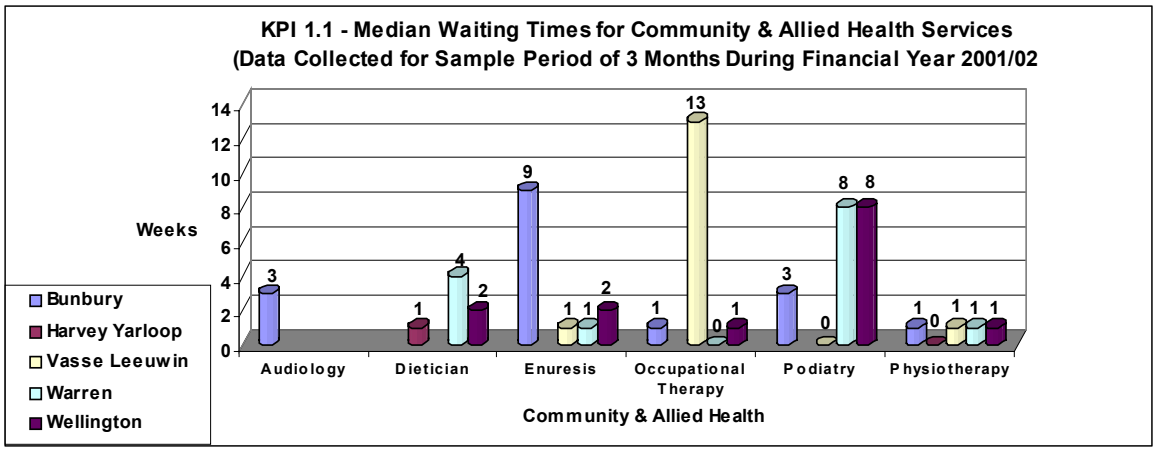
Timely and easy access to health services is effective in reducing the incidence of preventable diseases and premature death by providing clinically appropriate treatment of illness and injury.

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

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

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

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



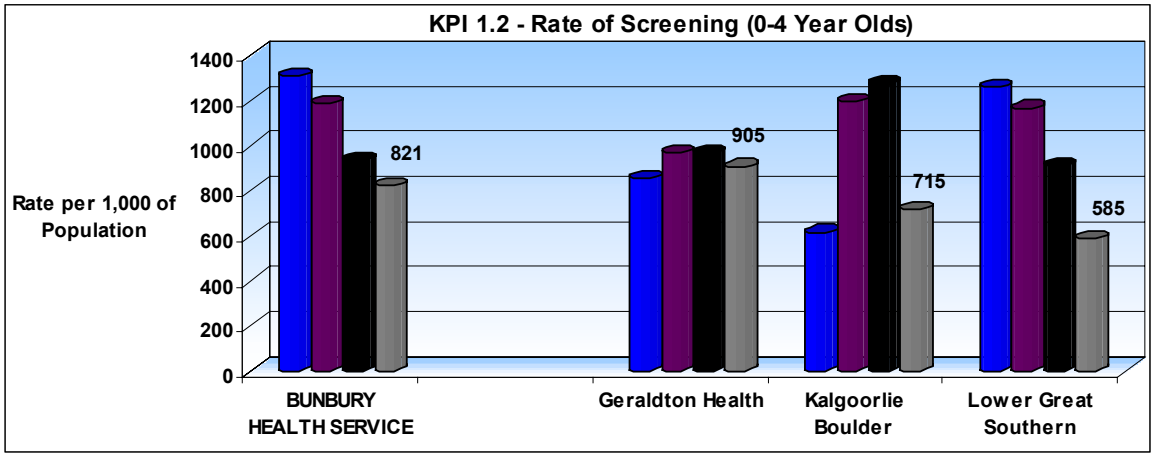
RATE OF SCREENING IN CHILDREN	KPI 1.2

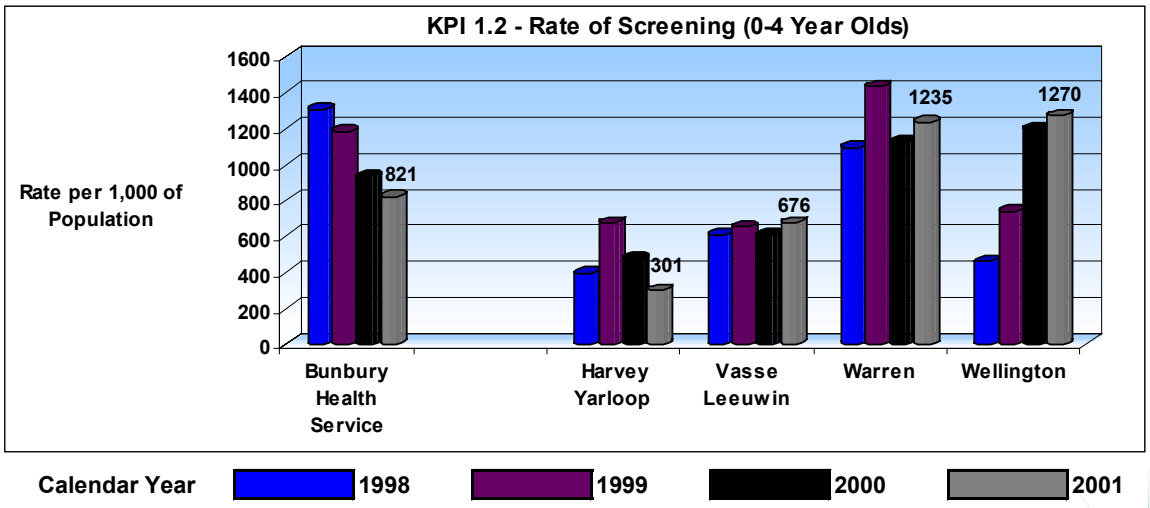
The community sets a very high priority on ensuring that the health and well being of children are safeguarded. Screening programs designed to detect disability and disease in the early stages of childhood development can prevent long-term disability. These programs not only restore children to good health when they become ill, but also help to maintain a state of 'wellness' that allows them to develop to their full potential. The State promotes a program of health monitoring at specific intervals in the period from birth to adolescence in accordance with the National Health and Medical Research Council's (NH&MRC) Minimum Screening Schedule.

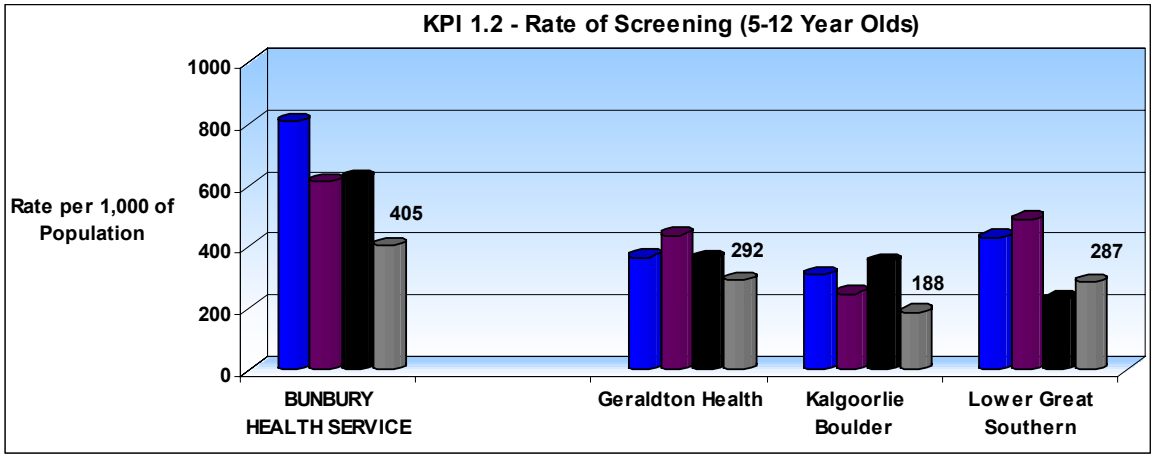
The consequences of any illness or disability not detected by routine screening programs for children are more likely to be permanently disabling or even contribute to their premature death.

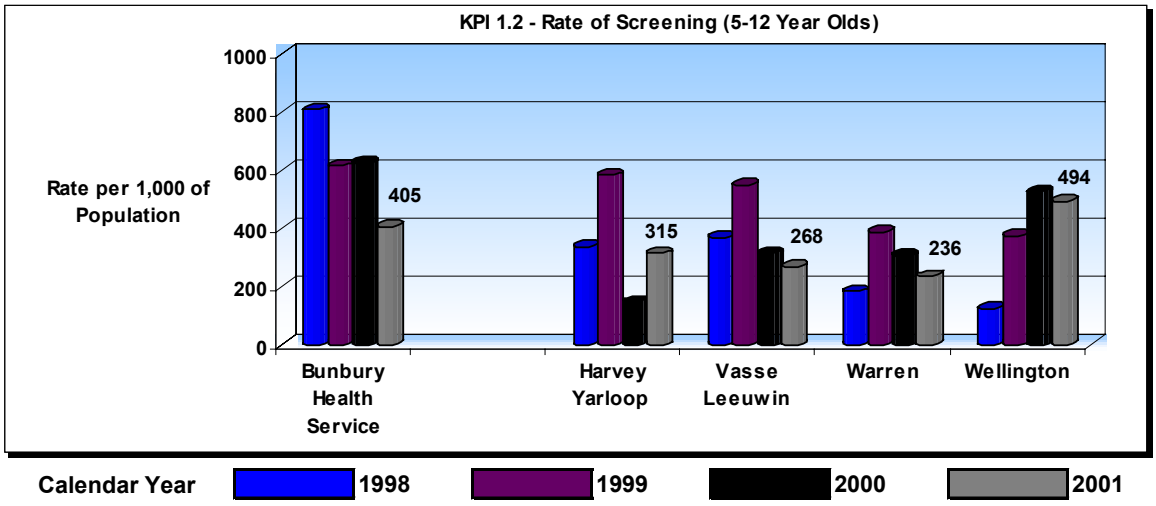
This indicator measures the rate of NH&MRC screening, by 0-4 and 5-12 year age groups of the resident child population in the catchment for the health service.

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






KPI 1.2 - Rate of Screening (5-12 Year Olds)
Rate per 1,000 of Population
1000
800
600
400
200
0
405
292
188
287
BUNBURY HEALTH SERVICE
Geraldton Health
Kalgoorlie Boulder
Lower Great Southern


KPI 1.2 - Rate of Screening (5-12 Year Olds)
Rate per 1,000 of Population
1000
800
600
400
200
0
405
315
268
236
494
Bunbury Health Service
Harvey Yarloop
Vasse Leeuwin
Warren
Wellington
Calendar Year
1998
1999
2000
2001

RATE OF CHILDHOOD IMMUNISATION	KPI 1.5

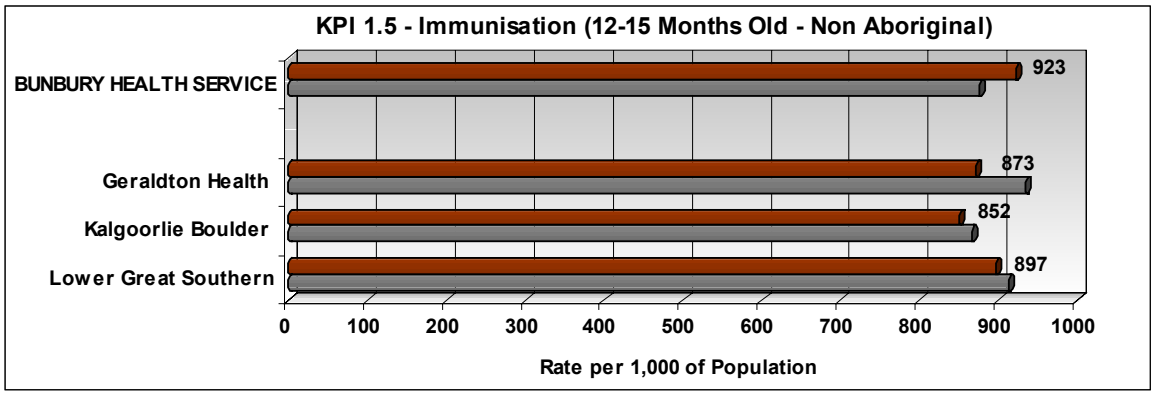
Vaccine preventable diseases are associated with considerable morbidity and mortality, and vaccination is effective in reducing the incidence of these diseases in the community. Through this adoption of the National Immunisation Schedule, health system effectiveness in providing vaccination coverage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

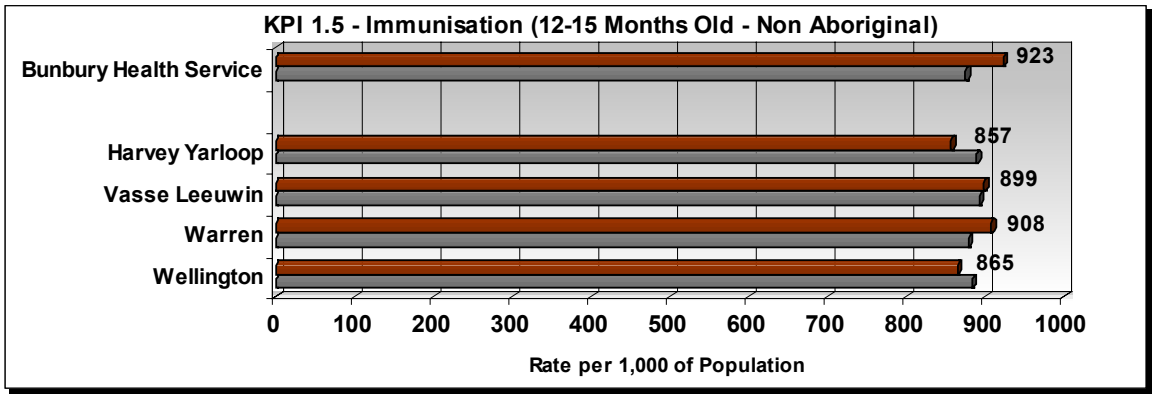
Without access to immunisation for children the consequences of any illness or disability are likely to be more disabling and more likely to contribute to a premature death.

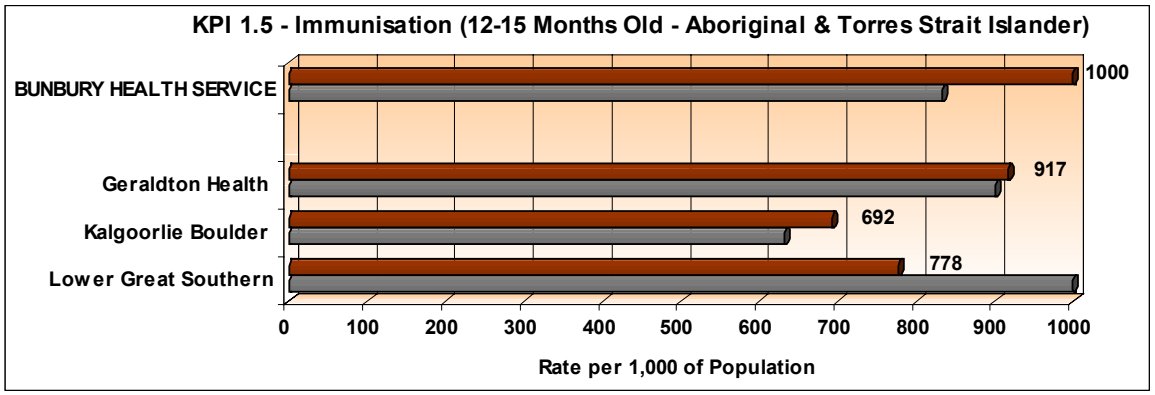
This indicator measures the rate of immunisation against particular diseases, by age group, of the resident child population in the catchment for the Health Service.

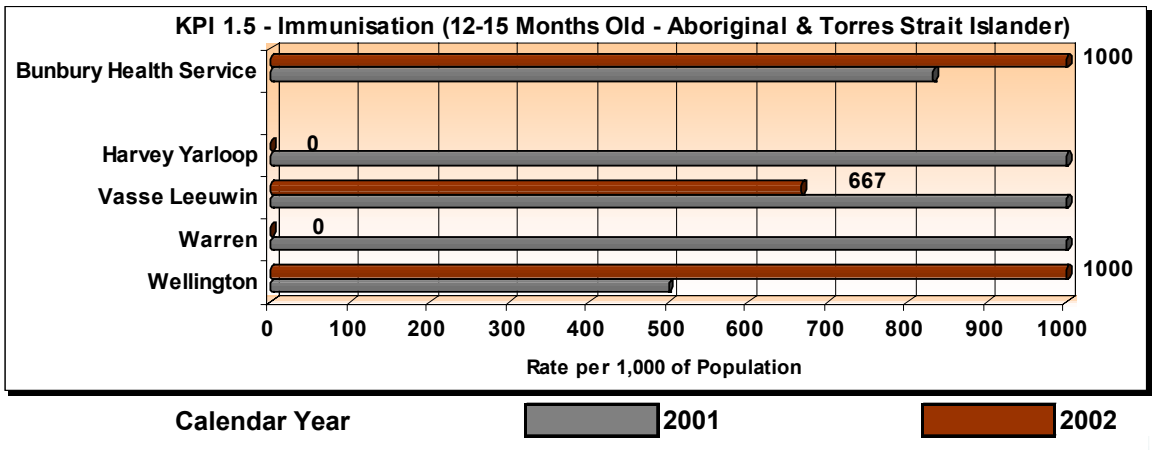
In calculating the rate of Immunisation, the number of Immunisations refer to the number of children who were fully vaccinated in accordance with the National Health and Medical Research Council (NH&MRC) standard vaccination schedule.

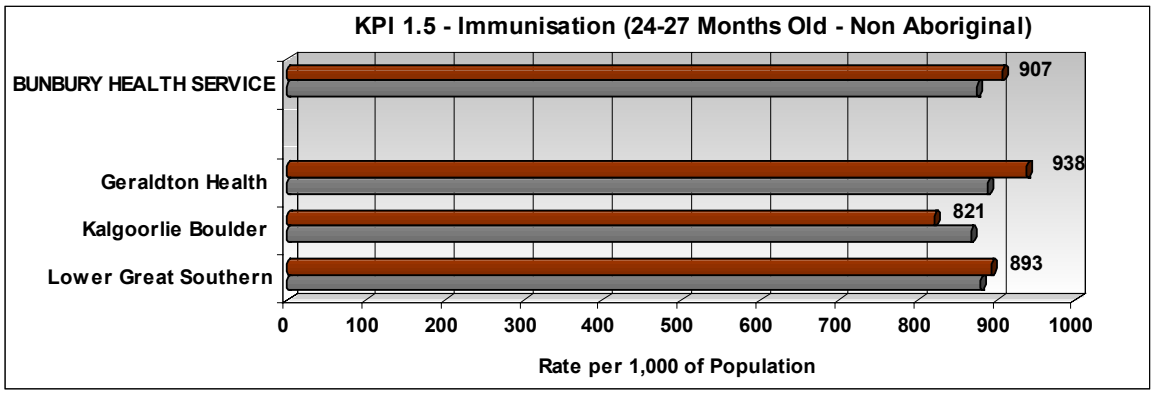
All infants born after May 2000 (but not before) were to be vaccinated against Hepatitis B at birth and again at 12 months. This effectively created 2 classes of immunised infants in that age group (12-15 months). It also means that there will be some discrepancies with the 24-27 month age group of the children shown even up to the calendar year 2002. The data shown for calendar year 2002 is from the first six months of the 2001/02 financial year and is therefore appropriate for this Report.

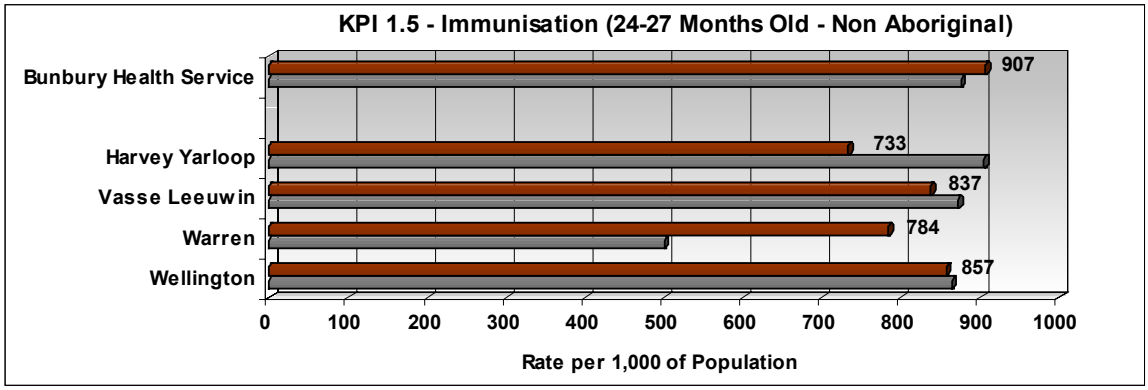

KPI 1.5 - Immunisation (12-15 Months Old - Non Aboriginal)
BUNBURY HEALTH SERVICE
Geraldton Health
Kalgoorlie Boulder
Lower Great Southern
923
873
852
897
0
100
200
300
400
500
600
700
800
900
1000
Rate per 1,000 of Population

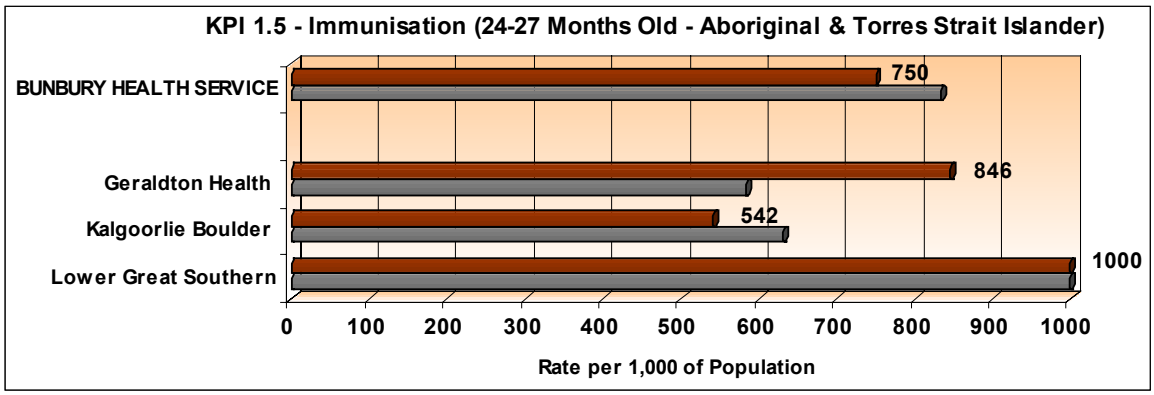

KPI 1.5 - Immunisation (12-15 Months Old - Non Aboriginal)
Bunbury Health Service
Harvey Yarloop
Vasse Leeuwin
Warren
Wellington
923
857
899
908
865
0
100
200
300
400
500
600
700
800
900
1000
Rate per 1,000 of Population

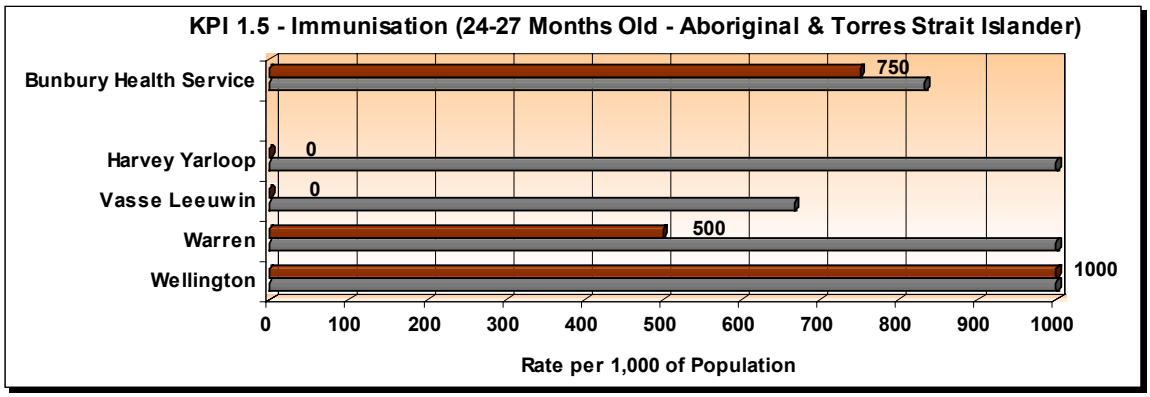

KPI 1.5 - Immunisation (12-15 Months Old - Aboriginal & Torres Strait Islander)
BUNBURY HEALTH SERVICE
Geraldton Health
Kalgoorlie Boulder
Lower Great Southern
1000
917
692
778
0
100
200
300
400
500
600
700
800
900
1000
Rate per 1,000 of Population


KPI 1.5 - Immunisation (12-15 Months Old - Aboriginal & Torres Strait Islander)
Bunbury Health Service
Harvey Yarloop
Vasse Leeuwin
Warren
Wellington
1000
0
667
0
1000
0
100
200
300
400
500
600
700
800
900
1000
Rate per 1,000 of Population
Calendar Year
2001
2002


KPI 1.5 - Immunisation (24-27 Months Old - Non Aboriginal)
BUNBURY HEALTH SERVICE
907
Geraldton Health
938
Kalgoorlie Boulder
821
Lower Great Southern
893
0
100
200
300
400
500
600
700
800
900
1000
Rate per 1,000 of Population


KPI 1.5 - Immunisation (24-27 Months Old - Non Aboriginal)
Bunbury Health Service
907
Harvey Yarloop
733
Vasse Leeuwin
837
Warren
784
Wellington
857
0
100
200
300
400
500
600
700
800
900
1000
Rate per 1,000 of Population


KPI 1.5 - Immunisation (24-27 Months Old - Aboriginal & Torres Strait Islander)
BUNBURY HEALTH SERVICE
750
Geraldton Health
846
Kalgoorlie Boulder
542
Lower Great Southern
1000
0
100
200
300
400
500
600
700
800
900
1000
Rate per 1,000 of Population


KPI 1.5 - Immunisation (24-27 Months Old - Aboriginal & Torres Strait Islander)
Bunbury Health Service
750
Harvey Yarloop
0
Vasse Leeuwin
0
Warren
500
Wellington
1000
0
100
200
300
400
500
600
700
800
900
1000
Rate per 1,000 of Population

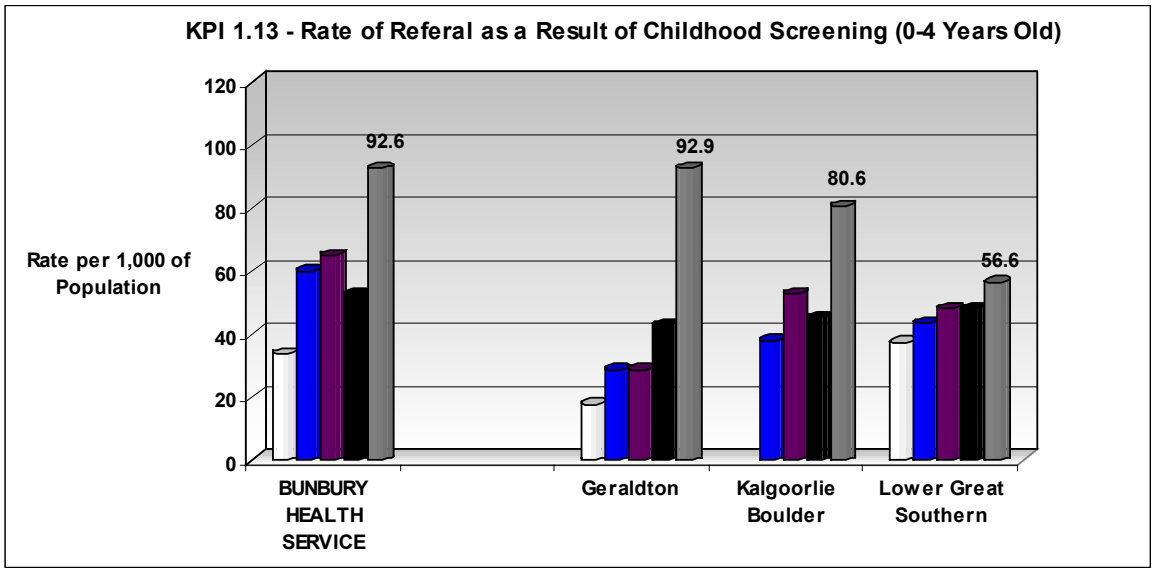

Calendar Year
2001
2002

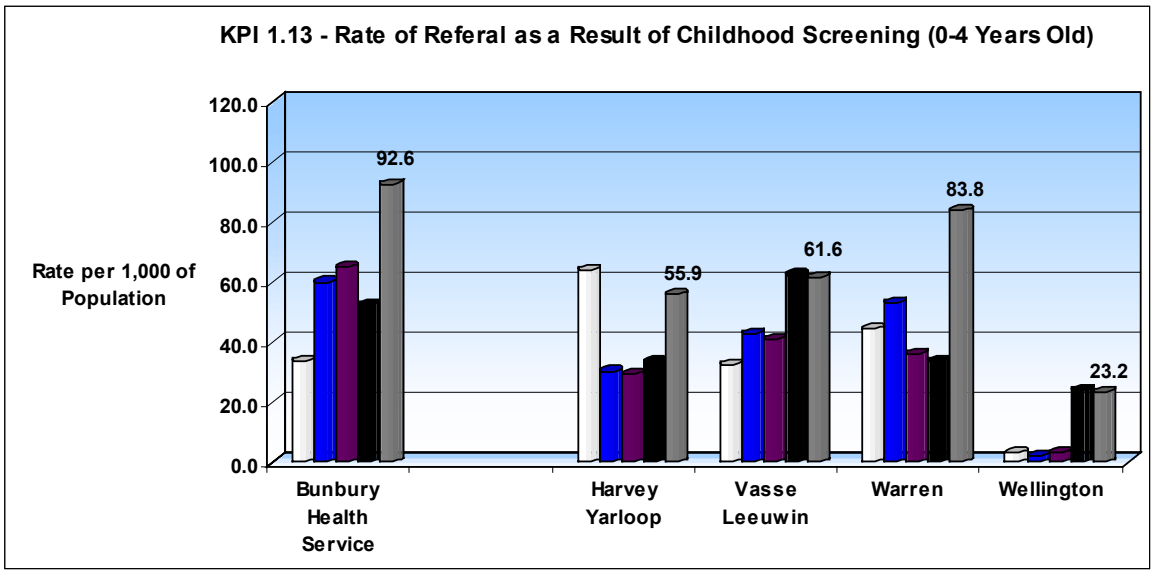
RATE OF REFERRAL AS A RESULT OF CHILDHOOD SCREENING SCHEDULE	KPI 1.13

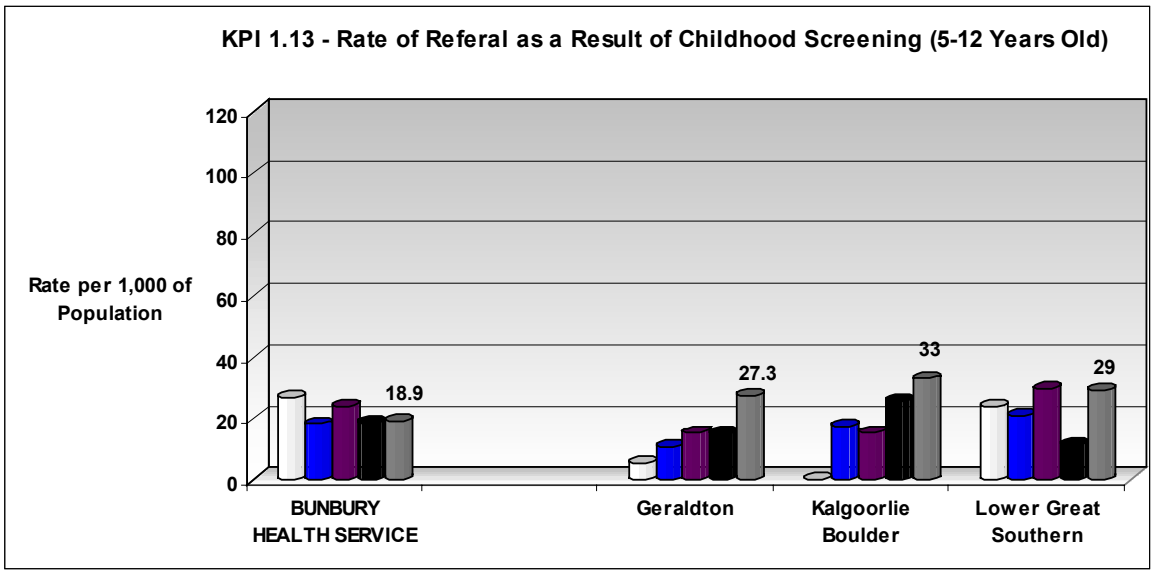
The community sets a very high priority on ensuring that the health and well being of children are safeguarded. Screening programs designed to detect disability and disease in the early stages of childhood development can prevent long-term disability. These programs not only to restore children to good health when they become ill, but also help to maintain a state of 'wellness' that allows them to develop to their full potential.

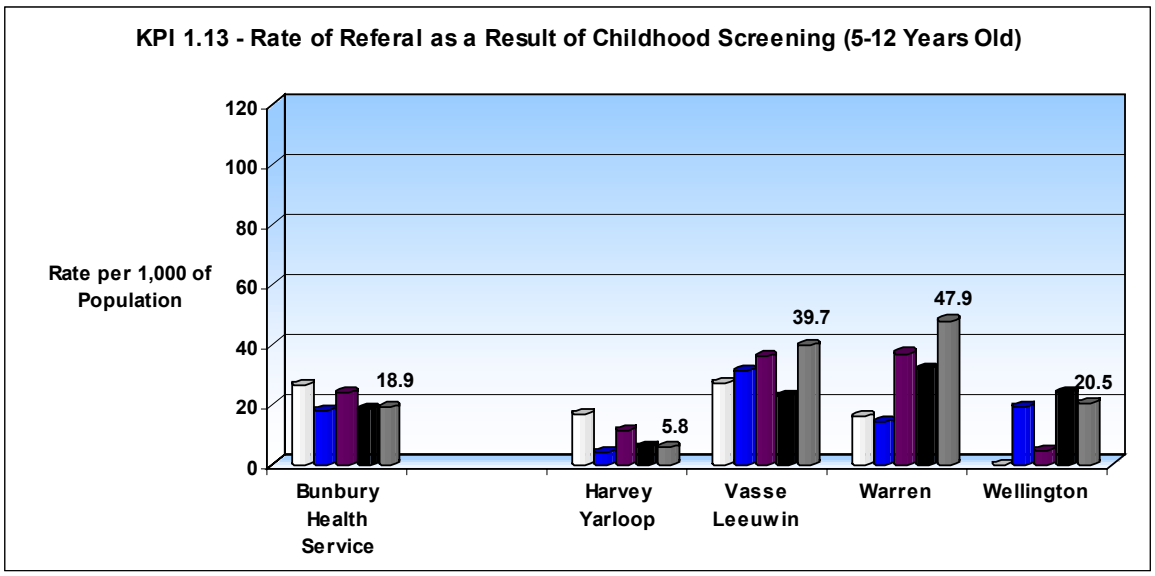
The State promotes a program of health monitoring at specific intervals in the period from birth to adolescence in accordance with the National Health and Medical Research Council's (NH&MRC) Minimum Screening Schedule. This program includes appropriate referral for children needing further assessment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

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


KPI 1.13 - Rate of Referal as a Result of Childhood Screening (0-4 Years Old)
Rate per 1,000 of Population
120
100
80
60
40
20
0
92.6
92.9
80.6
56.6
BUNBURY HEALTH SERVICE
Geraldton
Kalgoorlie Boulder
Lower Great Southern


KPI 1.13 - Rate of Referal as a Result of Childhood Screening (0-4 Years Old)
Rate per 1,000 of Population
120.0
100.0
80.0
60.0
40.0
20.0
0.0
92.6
55.9
61.6
83.8
23.2
Bunbury Health Service
Harvey Yarloop
Vasse Leeuwin
Warren
Wellington
Calendar Year
1997
1998
1999
2000
2001





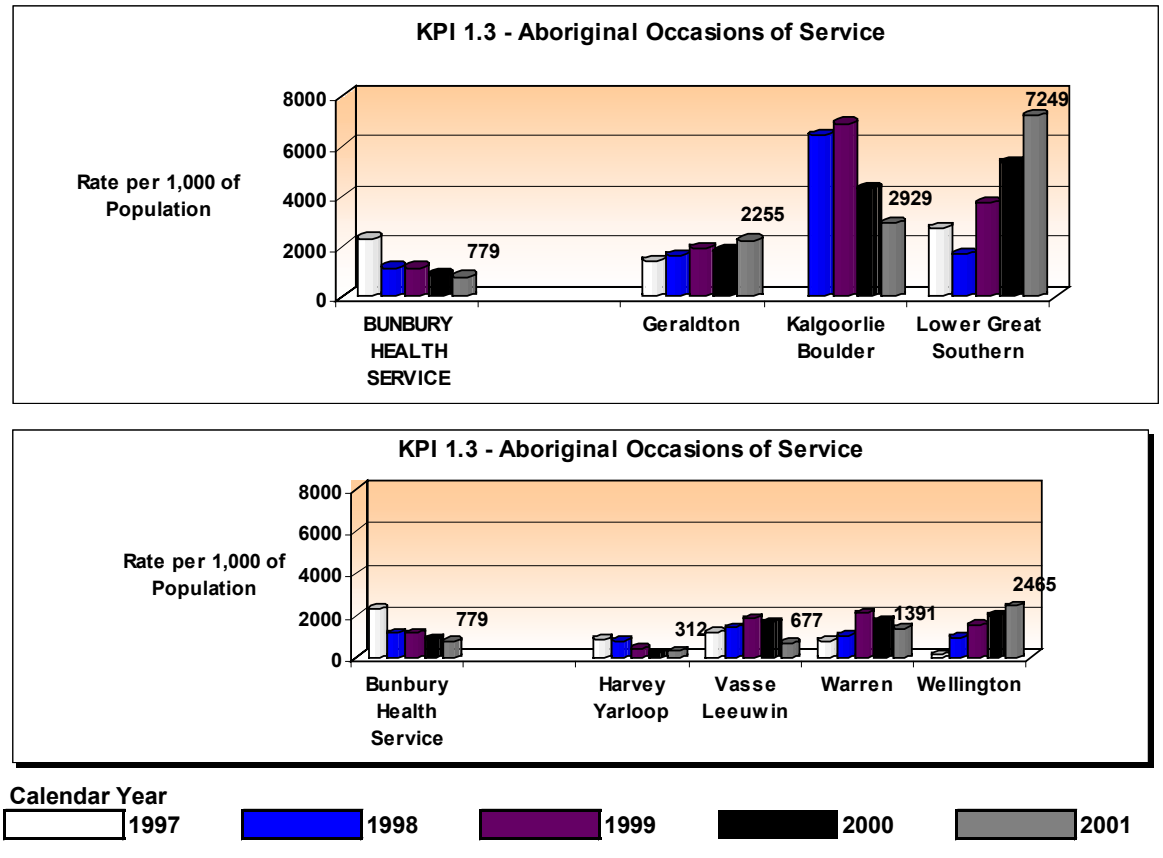
Calendar Year
1997 1998 1999 2000 2001

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

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

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

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



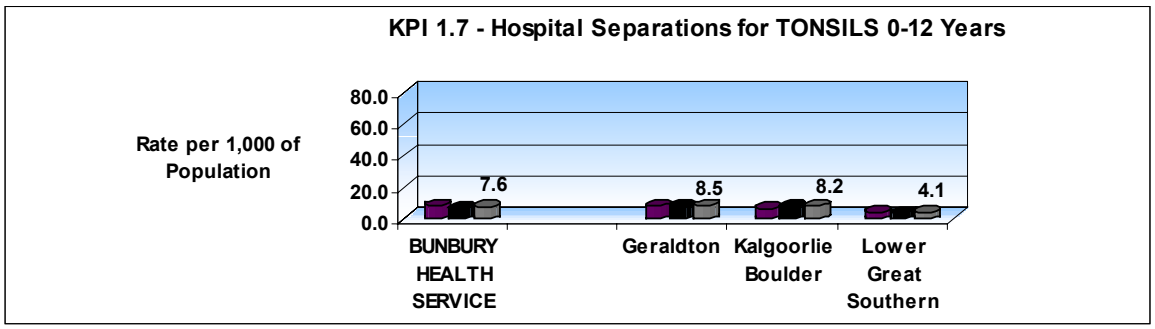
HOSPITAL SEPARATIONS FOR TONSILLECTOMIES & GROMMETS	KPI 1.7

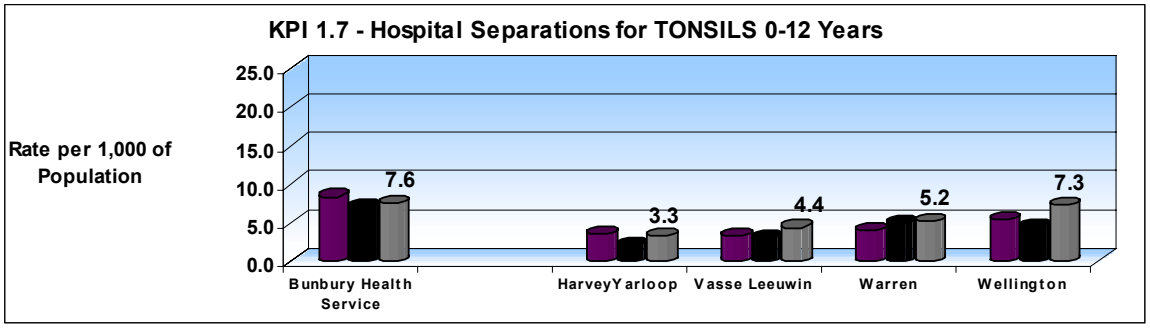
Current evidence suggests many tonsillectomies and grommet insertions are unnecessary and 'watchful waiting' and presurgery testing may be effective in reducing inappropriate surgery.

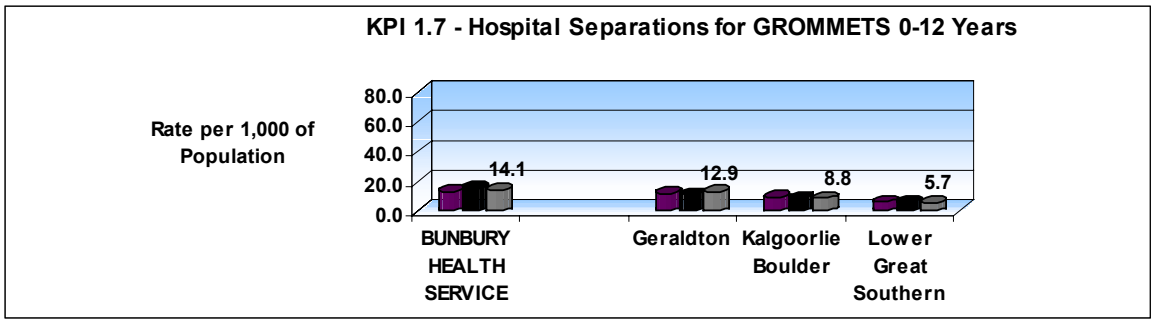
Successful management and treatment of children with chronic infections by community health staff could be anticipated to reduce the level of surgical intervention. As the success of this intervention program cannot be measured directly, an indirect measure of its success can be estimated by determining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

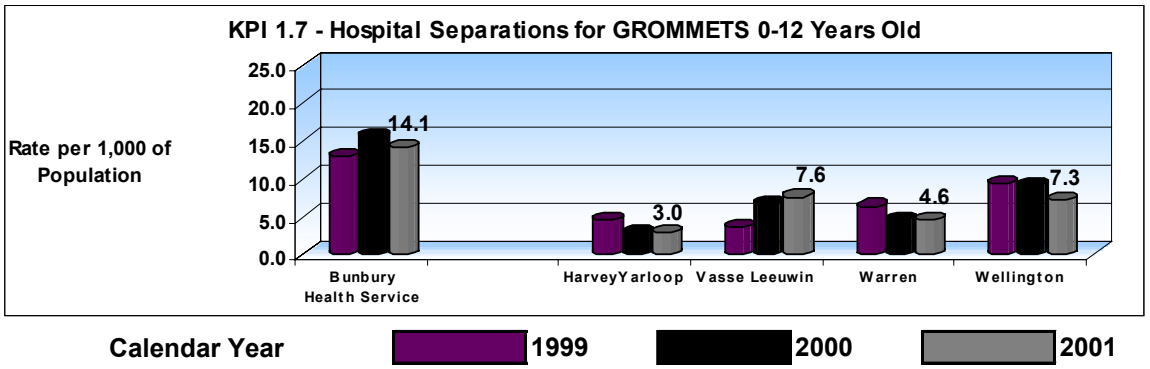
Comparison of the rate of hospitalisation for tonsillectomies and grommet insertions with other comparable areas can help identify those areas where improvements in primary care could be necessary.

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









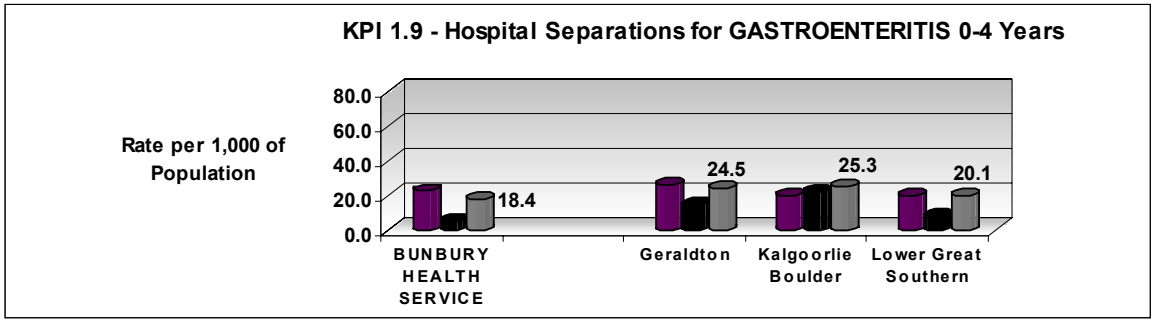
HOSPITAL SEPARATIONS FOR GASTROENTERITIS IN CHILDREN | KPI 1.9

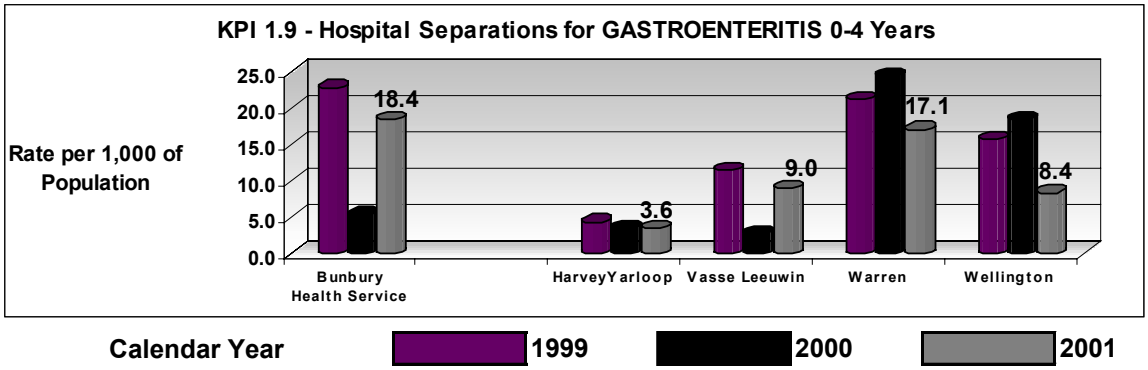
Public health and environmental health programs are aimed at maintaining safe water and sewerage disposal systems, and establishing and enforcing effective food processing and handling practices.

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

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

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





HOSPITAL SEPARATIONS FOR RESPIRATORY CONDITIONS	KPI 1.10

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

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

Bronchiolitis

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

Croup

The graphs show individuals aged 0-4. Of those individuals in Bunbury aged 5-12, 5 were hospitalised this year, a rate of 0.9 per thousand. For those individuals aged 5-12, in Harvey Yarloop, only 2 were hospitalised, a rate of 0.8 per thousand, in Vasse Leeuwin, only 1 was hospitalised this year, a rate of 0.2 per thousand, in Warren, only 2 were hospitalised, a rate of 0.9 per thousand and in Wellington, only 2 were hospitalised, a rate of 1.1 per thousand. Of those individuals aged 13-18 in all areas, none were hospitalised.

Acute Bronchitis

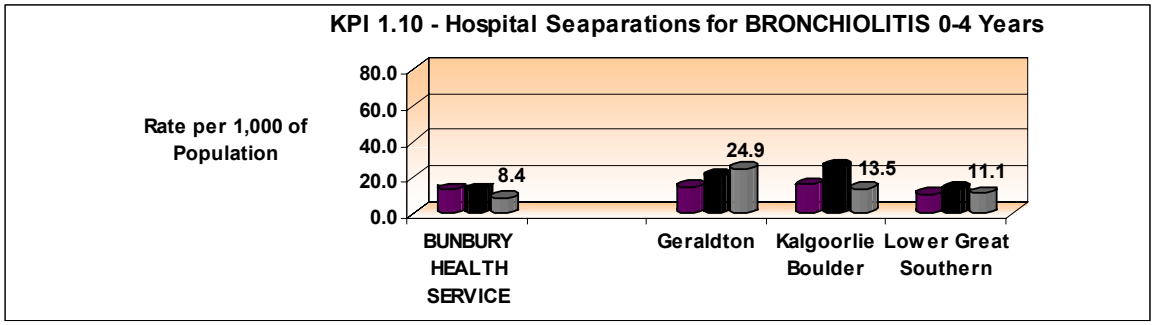
For Bunbury, only 4 individuals aged 0-4 at a rate of 1.3 per thousand were hospitalised this year and no individuals aged 5-12 or 13-18 were admitted.

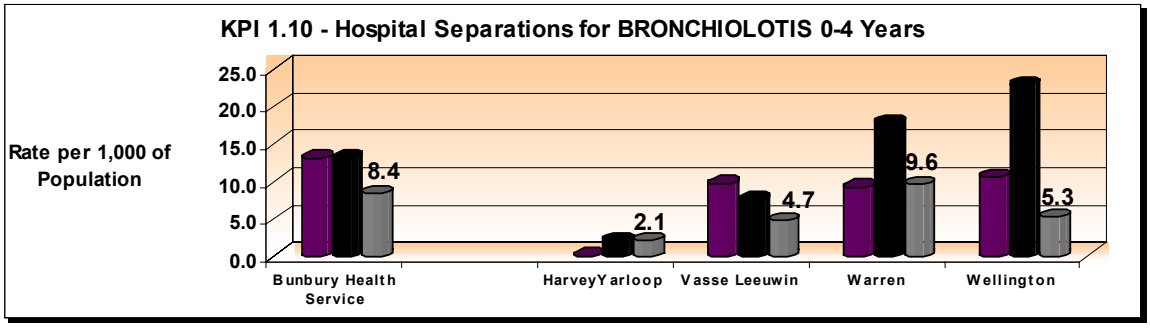
For Harvey Yarloop, only 1 individuals aged 0-4 at a rate of 0.7 per thousand was hospitalised this year and no individuals were admitted aged 5-12 or 13-18.

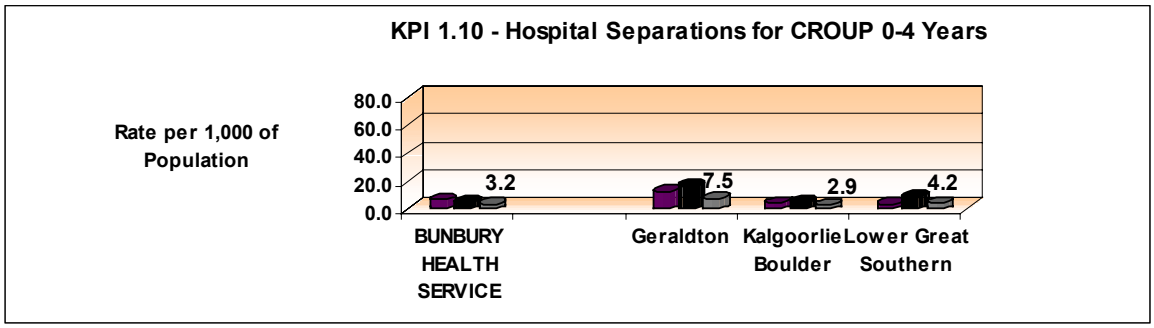
For Vasse Leeuwin, only 1 individual aged 0-4 was admitted this year at a rate of 0.4 per thousand, 1 individual aged 5-12 was admitted at a rate of 0.2 per thousand and no individuals aged 13-18 were admitted.

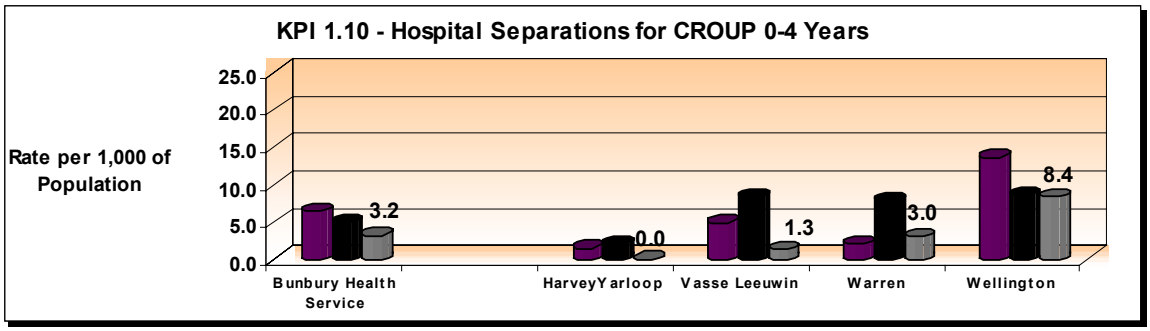
For Warren, only 3 individuals aged 0-4 at a rate of 2.2 per thousand were hospitalised this year, with 1 individual being admitted aged 5-12 at a rate of 0.4 per thousand and no individuals aged 13-18 were admitted.

For Wellington, only 1 individual aged 0-4 at a rate of 1.1 per thousand was hospitalised this year, with 1 individual being admitted aged 5-12 at a rate of 0.6 per thousand and no individuals aged 13-18 were admitted.









Calendar Year 1999 2000 2001

HOSPITAL ADMISSIONS FOR ASTHMA	KPI 3.7

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

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

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

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

For Bunbury, the graphs show individuals aged 0-4 and 5-12. 13 individuals aged 13-18 at a rate of 3 per thousand were hospitalised this year, with 17 individuals being admitted aged 19-34 at a rate of 1.6 per thousand and 33 individuals aged 35 years and over at a rate of 1.4 per thousand.

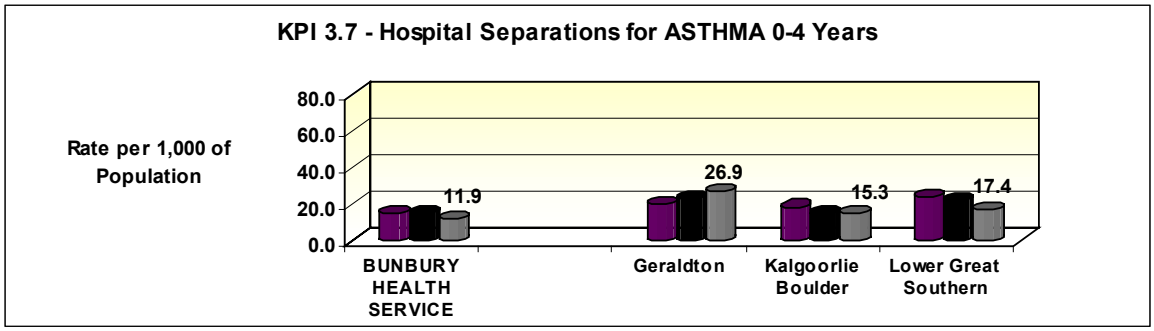
The graphs for Harvey Yarloop, Vasse Leeuwin, Warren and Wellington show individuals aged 0-4 and 5-12.

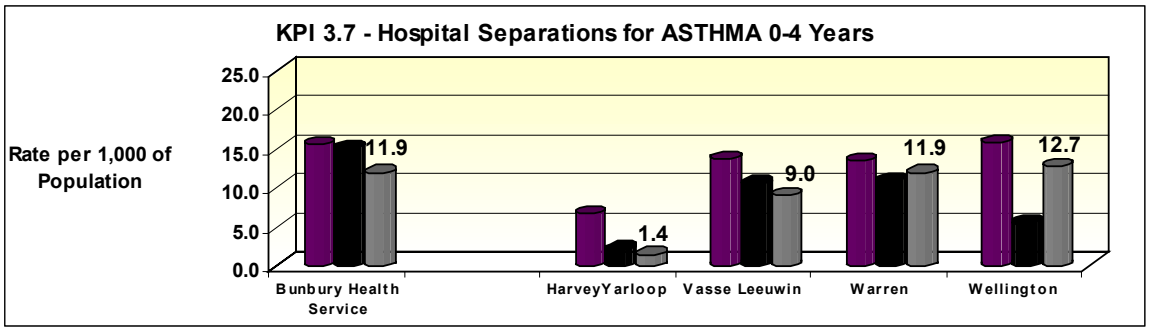
For Harvey Yarloop, 4 individuals aged 13-18 at a rate of 2 per thousand were hospitalised this year, with 1 individual being admitted aged 19-34 at a rate of 0.3 per thousand and 22 individuals aged 35 years and over at a rate of 2.4 per thousand.

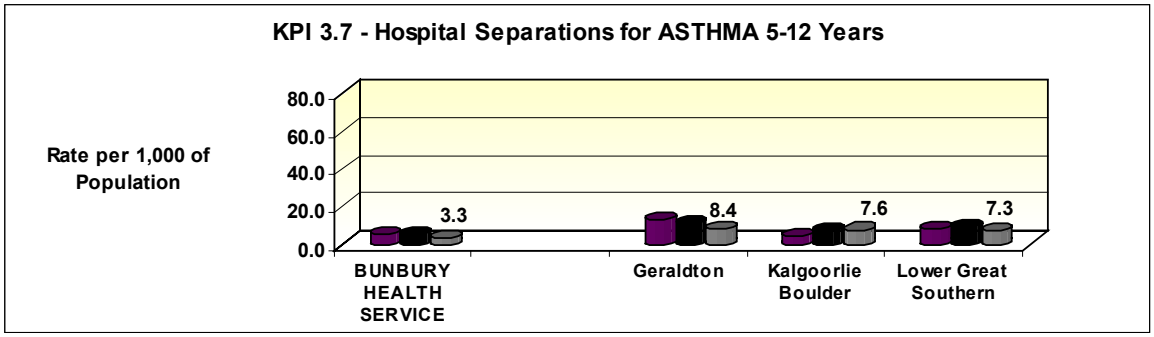
For Vasse Leeuwin, 5 individuals aged 13-18 at a rate of 1.7 per thousand were hospitalised this year, with 5 individuals being admitted aged 19-34 at a rate of 0.7 per thousand and 21 individuals aged 35 years and over at a rate of 1.2 per thousand.

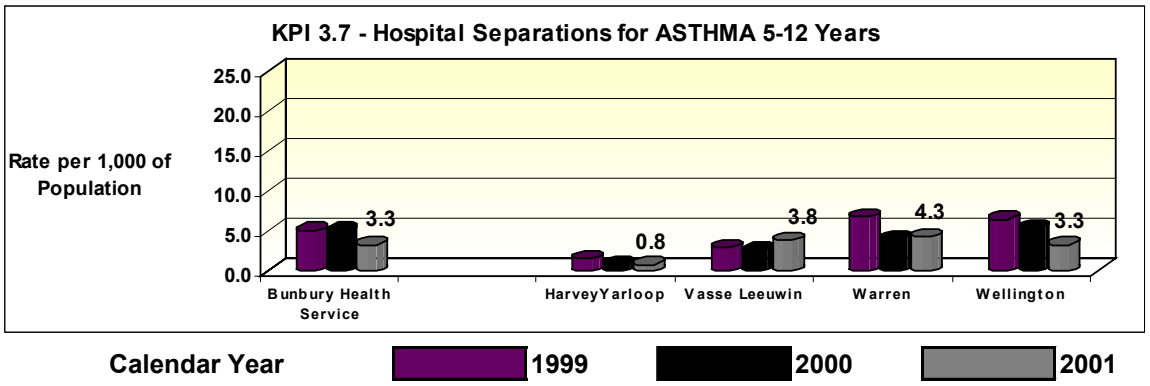
For Warren, 2 individuals aged 13-18 at a rate of 1.5 per thousand were hospitalised this year, with 14 individuals being admitted aged 19-34 at a rate of 4.6 per thousand and 28 individuals aged 35 years and over at a rate of 3 per thousand.

For Wellington, 2 individuals aged 13-18 at a rate of 1.6 per thousand were hospitalised this year, with 2 individuals being admitted aged 19-34 at a rate of 0.8 per thousand and 15 individuals aged 35 years and over at a rate of 2.1 per thousand.









COST PER OCCASION OF SERVICE OF COMMUNITY HEALTH SERVICE	KPI 1.14

Community health occasions of service measure the provision of primary and community health services undertaken by a range of health service professionals in a community setting, with a focus on improving the overall health of the State population. Child health nursing, clinical psychology, occupational and speech therapy are some examples of the types of community-based services provided under this Indicator. It provides a measure of, on average, how cost effective these activities are over time.

A wide range of interventions by practitioners from many specialties are used, singularly and in combination, to effect changes in the health of individuals, their families and their communities. These interventions are quantified as occasions of service but can cover a wide range of services in terms of time and complexity.

This indicator measures the average cost of an occasion of service for the particular use of programs that each health service provides. Given what has been said above, it is only useful for broad comparisons of trends and must be considered in conjunction with an understanding of current program delivery priorities.

HEALTH SERVICE	AVERAGE COST PER OCCASION OF SERVICE OF COMMUNITY HEALTH SERVICE
South West Health Service	$63

NOTE:

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

CLIENT SATISFACTION — KPI 2.2

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

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

The South West Health Board reports an overall satisfaction score of 86 for same-day patients, 74 for emergency patients and 78 for outpatients for this financial year with standard errors of 0.38, 0.68 and 0.67 respectively on a confidence interval of 95%. The estimated populations of individuals surveyed were 5835 Same-Day patients, 37065 Emergency Services patients and 7592 Outpatients.

The table below shows the response rate by patient type.

SURVEY QUESTIONNAIRES			
PATIENT TYPE	**NUMBER SENT**	**NUMBER RETURNED**	**RESPONSE RATE**
South West Health Service			
Same-day Patients	1184	692	58%
Same-day Patients – Mode of Administration Data	51	46	90%
Emergency Patients – Centrally Administered	853	272	32%
Emergency Patients – Hospital Administered	474	150	32%
Outpatients – Centrally Administered	1055	321	30%
Outpatients – Hospital Administered	463	139	30%
Bunbury Regional Hospital			
Same-day Patients	327	191	58%
Same-day Patients – Mode of Administration Data	51	46	90%
Emergency Patients – Centrally Administered	111	39	35%
Emergency Patients – Hospital Administered	215	53	25%
Outpatients – Centrally Administered	107	54	50%
Outpatients – Hospital Administered	262	70	27%
Harvey Yarloop Health Service			
Same-day Patients	40	21	53%
Emergency Patients – Centrally Administered	120	33	28%
Emergency Patients – Hospital Administered	52	21	40%
Outpatients – Centrally Administered	103	35	34%
Outpatients – Hospital Administered	77	28	36%

SURVEY QUESTIONNAIRES			
PATIENT TYPE	**NUMBER SENT**	**NUMBER RETURNED**	**RESPONSE RATE**
Vasse Leewin Health Service			
Same-day Patients	518	317	61%
Emergency Patients – Centrally Administered	186	65	35%
Emergency Patients – Hospital Administered	166	64	39%
Outpatients – Centrally Administered	163	80	49%
Outpatients – Hospital Administered	27	17	63%
Warren Blackwood Health Service			
Same-day Patients	155	93	60%
Emergency Patients – Centrally Administered	297	93	31%
Emergency Patients – Hospital Administered	41	12	29%
Outpatients – Centrally Administered	278	106	38%
Outpatients – Hospital Administered	97	23	24%
Collie District Hospital			
Same-day Patients	142	70	49%
Emergency Patients	84	24	29%
Outpatients	81	30	37%

ELECTIVE SURGERY WAITING TIMES FOR PUBLIC PATIENTS — KPI 2.14

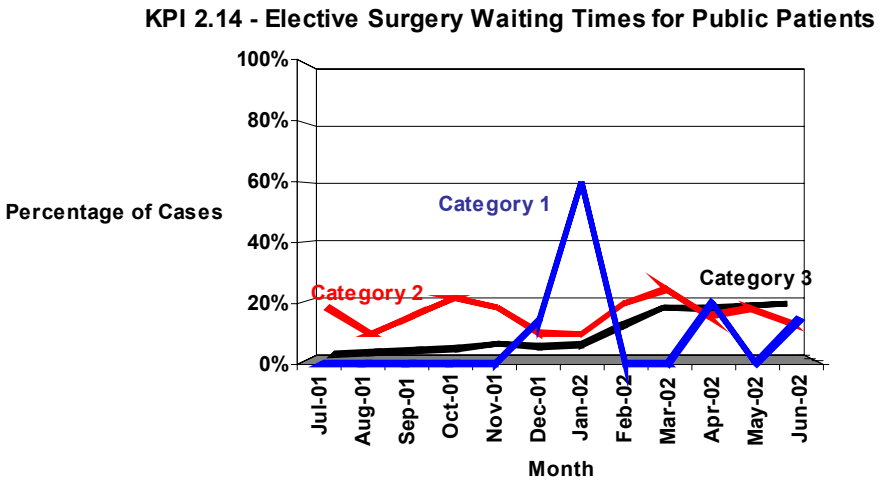
Access to health services must be provided on the basis of clinical need and if an organisation has large numbers of patients waiting for long periods of time for elective surgery, this may reflect sub-optimal practices, the non-availability of specialist staff or a lack of resources.

All patients who are referred for elective surgery must be classified by senior medical staff into one of the three following admission categories:

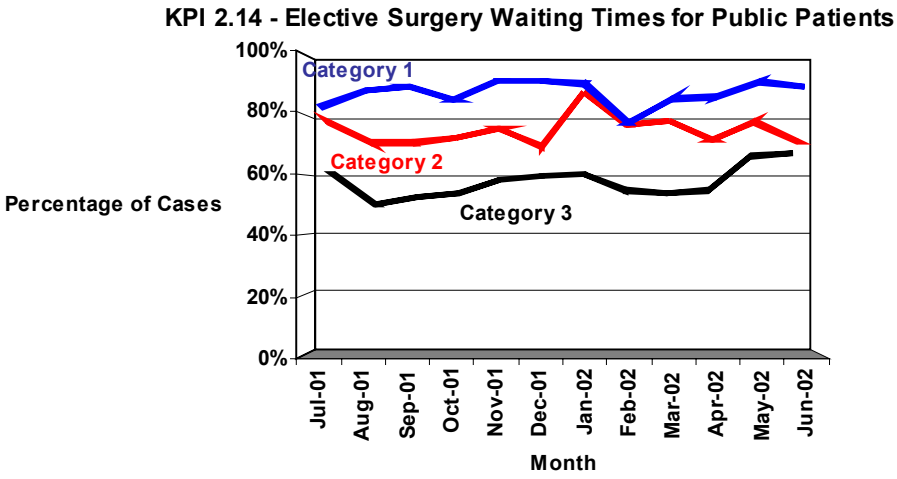
Category 1	Urgent	Admission desired within 30 days
Category 2	Semi-Urgent	Admission desired within 90 days
Category 3	Routine	Admission desirable within 365 days

This indicator measures the percentage of cases on an elective surgery waiting list which were not admitted within the appropriate time frame based on an assessment of their clinical need.

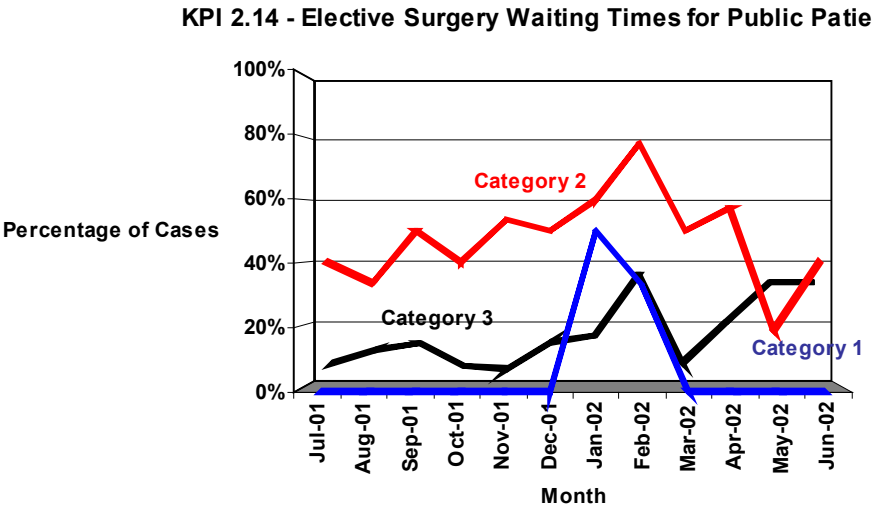
Bunbury District Hospital



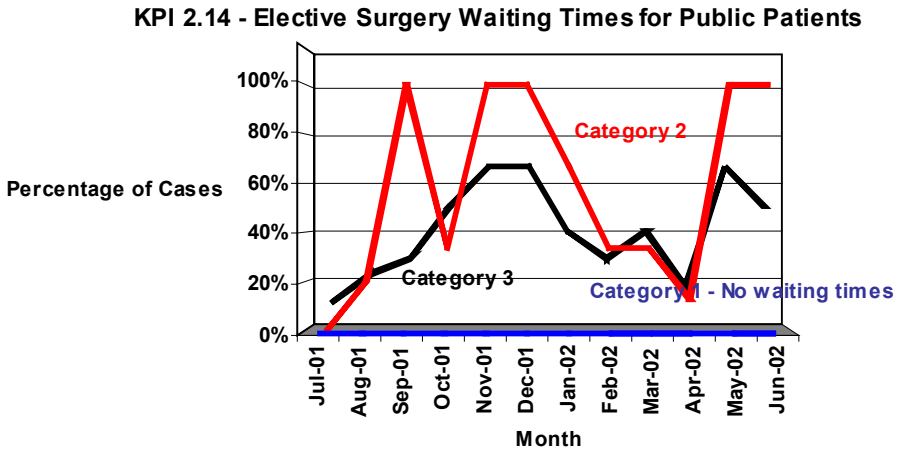
Busselton District Hospital



Bridgetown District Hospital



Warren District Hospital



EMERGENCY DEPARTMENT WAITING TIMES	KPI 2.18

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

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

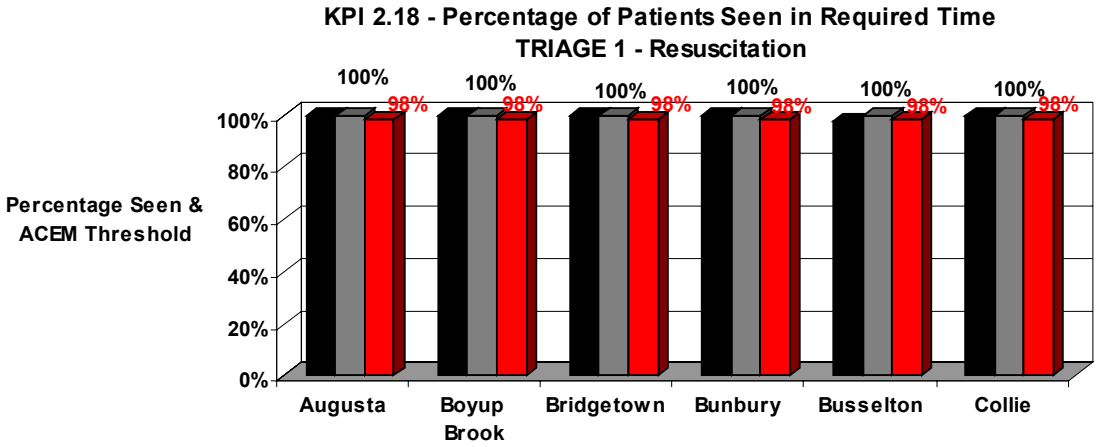
Furthermore, in small health care units, measuring waiting times has either not been regularly performed or the information systems in place collectively pool the data for all health care professionals attending patients in each of the triage categories.

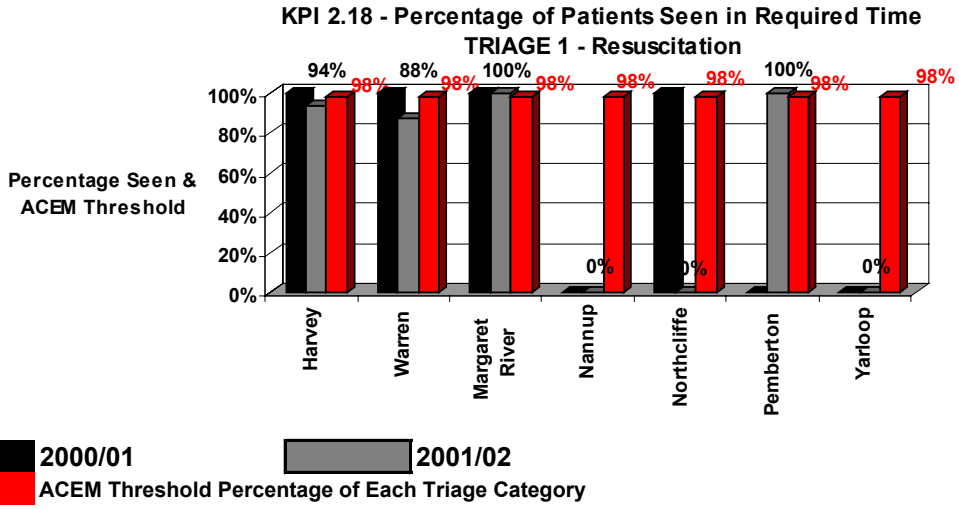
When patients first enter an Emergency Department, they are assessed by nursing staff and allocated a triage code between 1 and 5 that indicates their urgency. This code provides an indication of how quickly patients should be reviewed by medical staff. In rural areas however, where a medical practitioner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

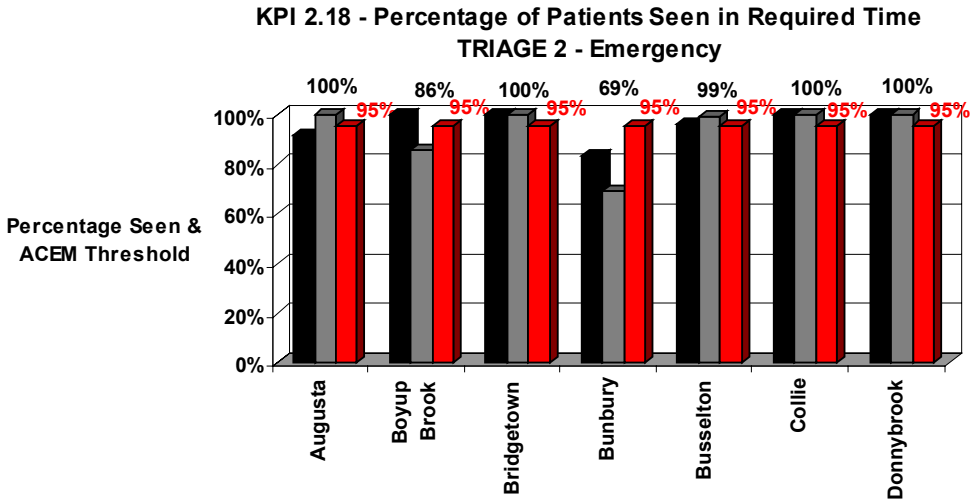
Data relevant to this indicator should be linked to data on the transfer of patients to other health care units, for example, larger hospitals and tertiary metropolitan centres.

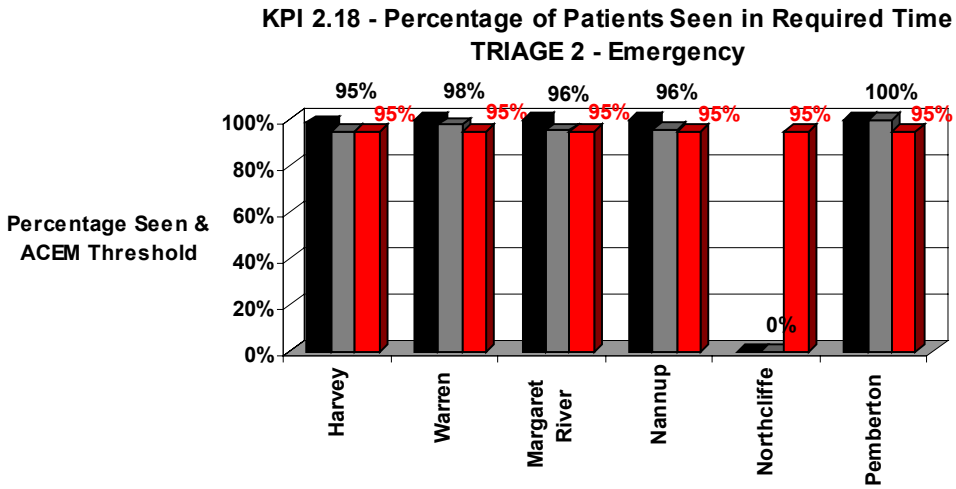
This indicator assesses what percentage of patients in each triage category were seen within the time periods recommended by the Australasian College for Emergency Medicine (ACEM) – in rural areas, this may include for example, telephone advice given by GP.

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

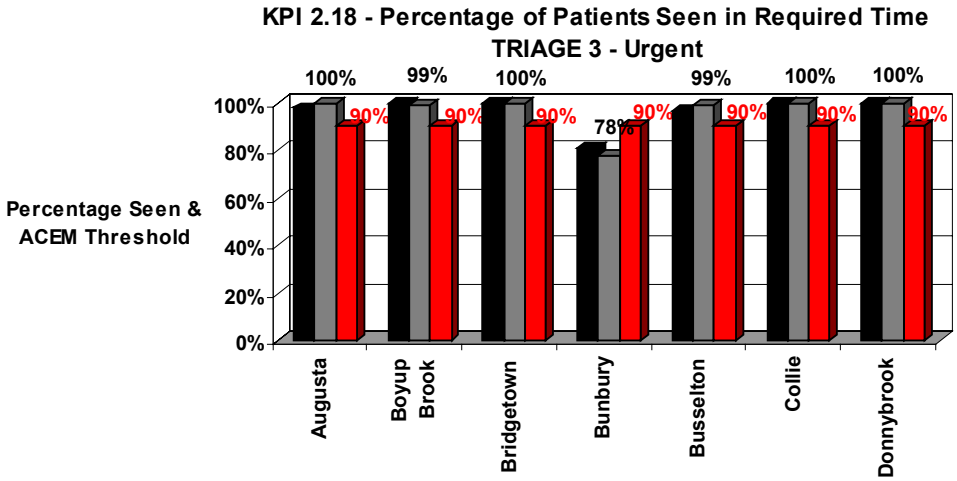

KPI 2.18 - Percentage of Patients Seen in Required Time
TRIAGE 1 - Resuscitation
Percentage Seen & ACEM Threshold
100%
80%
60%
40%
20%
0%
100%
98%
Augusta
Boyup Brook
Bridgetown
Bunbury
Busselton
Collie

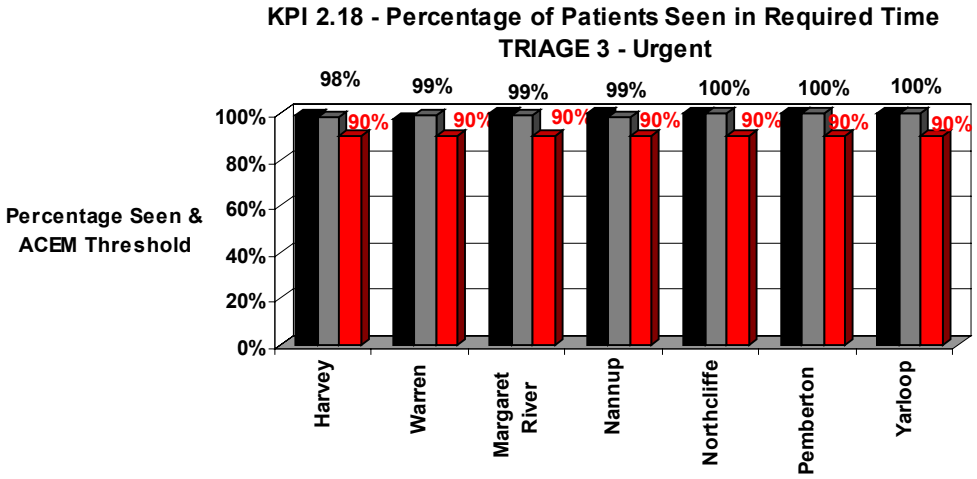

KPI 2.18 - Percentage of Patients Seen in Required Time
TRIAGE 1 - Resuscitation
Percentage Seen & ACEM Threshold
94%
88%
100%
0%
100%
98%
Harvey
Warren
Margaret River
Nannup
Northcliffe
Pemberton
Yarloop
2000/01
2001/02
ACEM Threshold Percentage of Each Triage Category





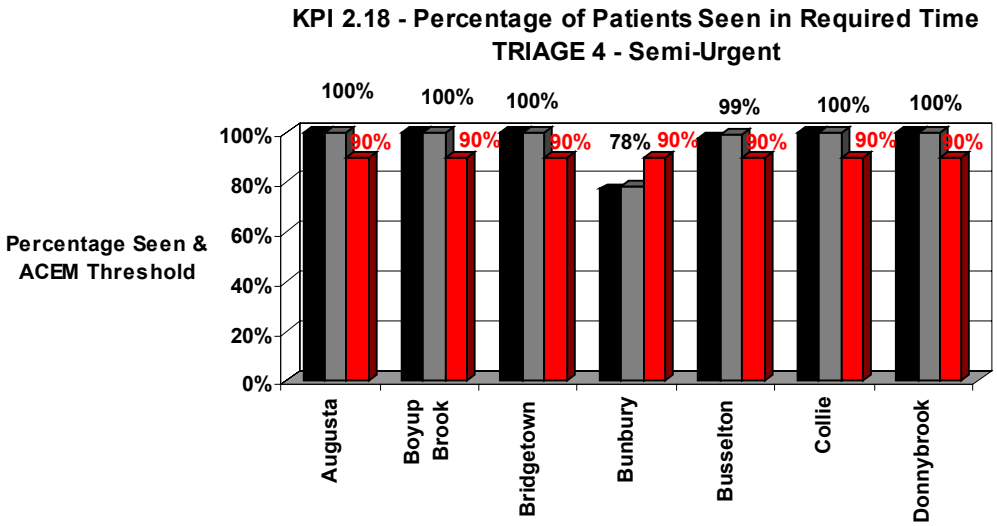
2000/01 2001/02
ACEM Threshold Percentage of Each Triage Category

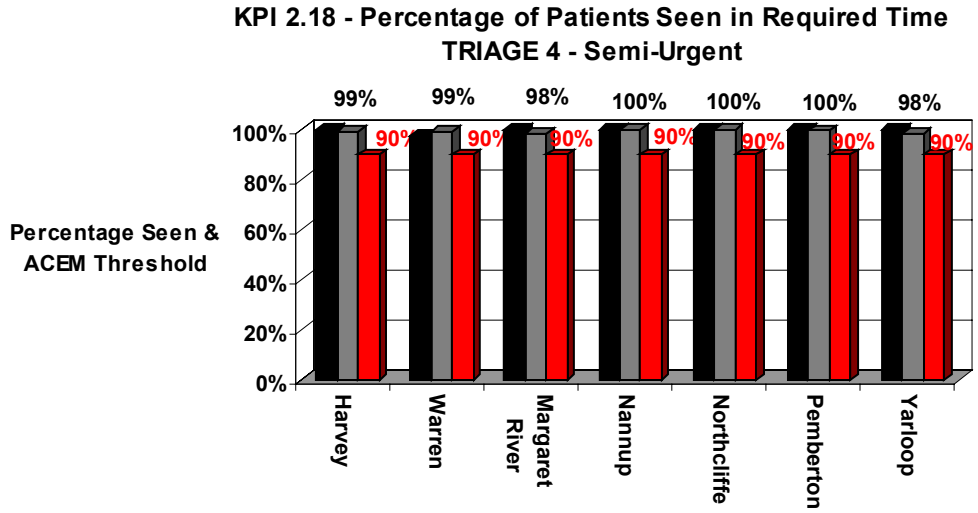




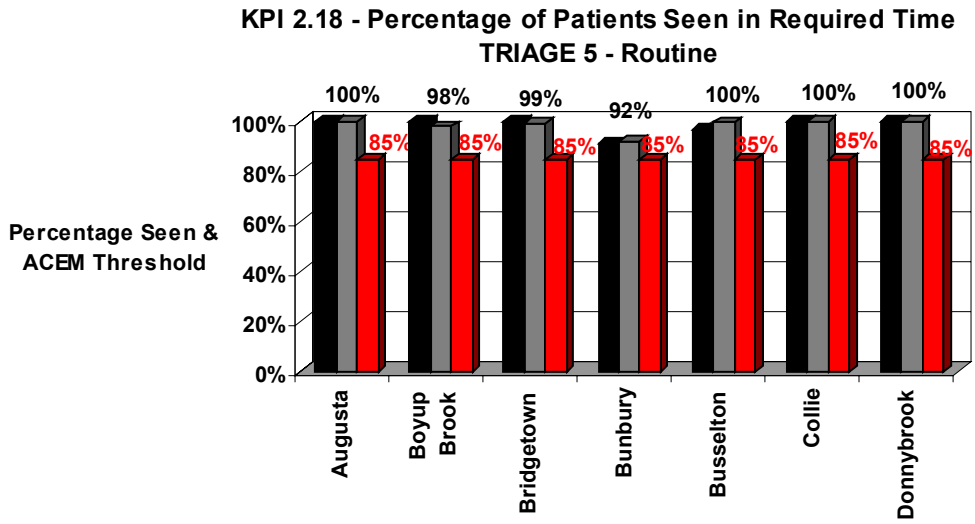
2000/01 2001/02

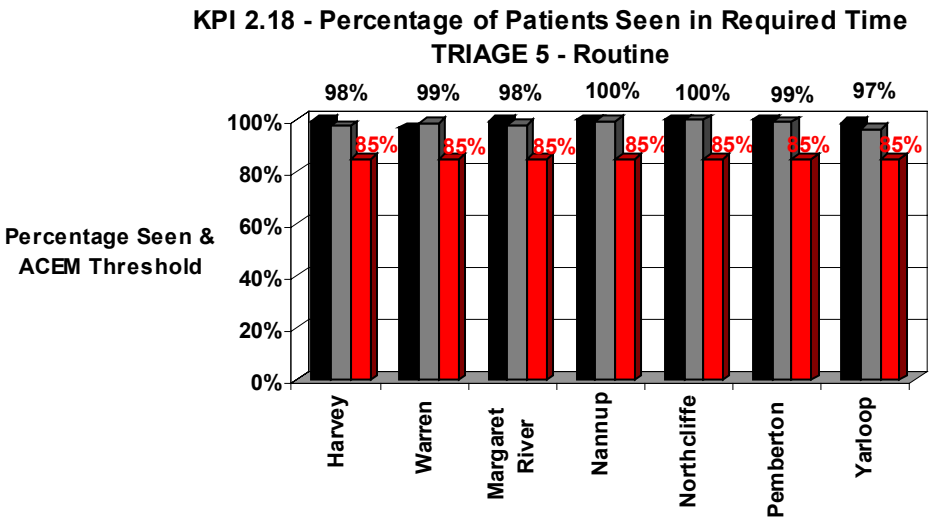
ACEM Threshold Percentage of Each Triage Category


KPI 2.18 - Percentage of Patients Seen in Required Time
TRIAGE 4 - Semi-Urgent
Percentage Seen & ACEM Threshold
100%
80%
60%
40%
20%
0%
100% 100% 100% 78% 99% 100% 100%
90% 90% 90% 90% 90% 90% 90%
Augusta
Boyup Brook
Bridgetown
Bunbury
Busselton
Collie
Donnybrook


KPI 2.18 - Percentage of Patients Seen in Required Time
TRIAGE 4 - Semi-Urgent
Percentage Seen & ACEM Threshold
100%
80%
60%
40%
20%
0%
99% 99% 98% 100% 100% 100% 98%
90% 90% 90% 90% 90% 90% 90%
Harvey
Warren
Margaret River
Nannup
Northcliffe
Pemberton
Yarloop


2000/01
2001/02
ACEM Threshold Percentage of Each Triage Category


KPI 2.18 - Percentage of Patients Seen in Required Time
TRIAGE 5 - Routine
Percentage Seen & ACEM Threshold
100%
80%
60%
40%
20%
0%
100% 98% 99% 92% 100% 100% 100%
85% 85% 85% 85% 85% 85% 85%
Augusta
Boyup Brook
Bridgetown
Bunbury
Busselton
Collie
Donnybrook

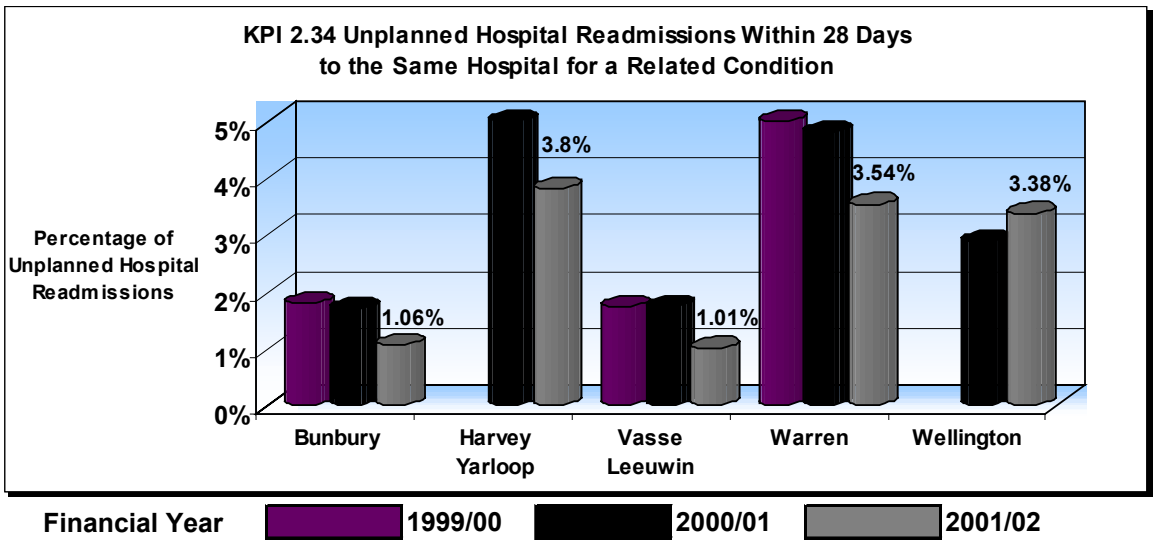

KPI 2.18 - Percentage of Patients Seen in Required Time
TRIAGE 5 - Routine
Percentage Seen & ACEM Threshold
100%
80%
60%
40%
20%
0%
98% 99% 98% 100% 100% 99% 97%
85% 85% 85% 85% 85% 85% 85%
Harvey
Warren
Margaret River
Nannup
Northcliffe
Pemberton
Yarloop


2000/01
2001/02
ACEM Threshold Percentage of Each Triage Category

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

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

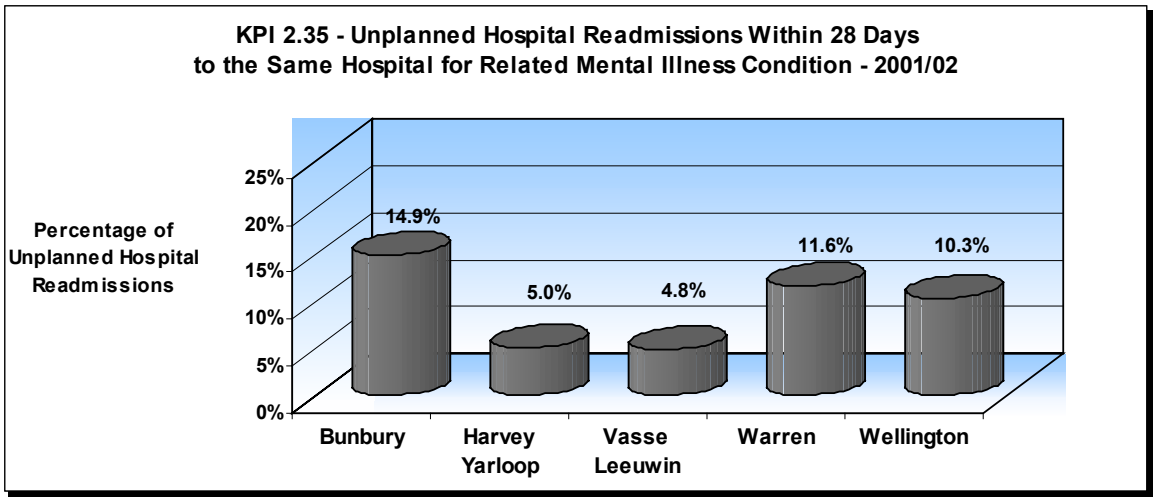
A low unplanned readmission rate suggests that good clinical practice is in operation. Although there are some conditions which may require numerous admissions to enable the best level of care to be given, in most of these cases readmission to hospital would be planned.



UNPLANNED HOSPITAL READMISSIONS WITHIN 28 DAYS TO THE SAME HOSPITAL FOR TREATMENT AND CARE FOR A RELATED MENTAL HEALTH ILLNESS	KPI 2.35

Readmissions to hospital within 28 days is an indicator of the effectiveness of hospital treatment and discharge planning, but may also reflect post-discharge treatment and care. The treatment and care needs of different age groups may be quite different. Readmission rates for these different age groups may provide a measure of the effectiveness of services in addressing these needs.

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



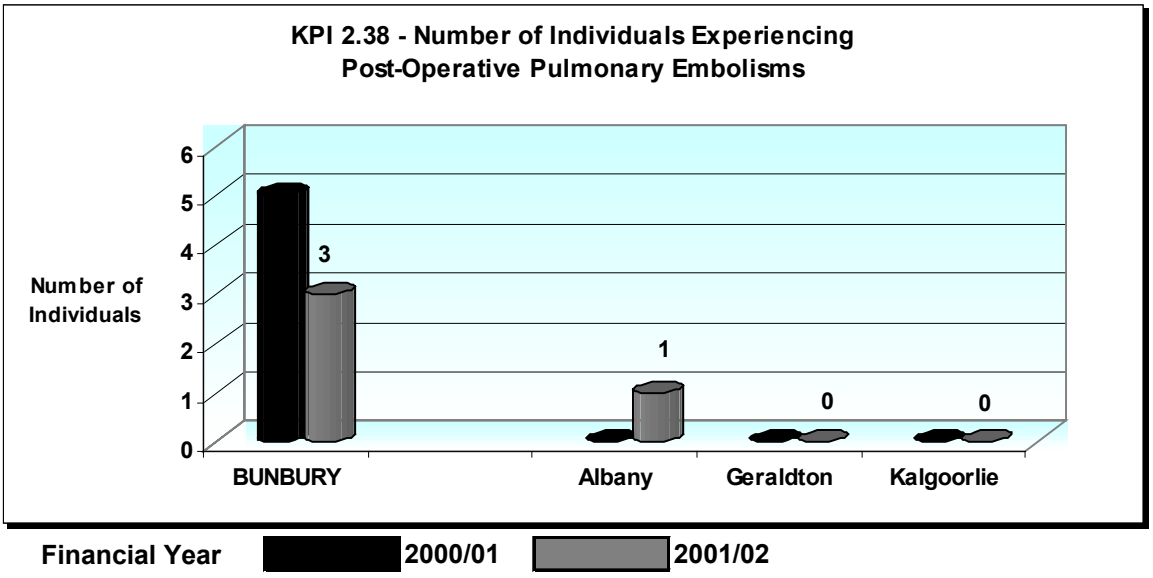
POST-OPERATIVE PULMONARY EMBOLISMS	KPI 2.38

Patients post-operatively can develop a blood clot in the deep veins of the leg. This can travel to the lungs and cause circulatory problems. This is known as a Pulmonary Embolism. This is the main preventable cause of death in fit people undergoing elective surgery.

Hospital staff can take special precautions to decrease the risk of this happening. A low percentage of cases developing Pulmonary Embolism post-operatively suggests that the appropriate precautions have been taken.

This indicator measures the percentage rate of patients who underwent surgery and subsequently developed pulmonary embolism. By monitoring the incidence of post-operative Pulmonary Embolism occurring, a hospital can ensure clinical protocols which minimise such risks are in place and are working.

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



AVERAGE COST PER CASEMIX ADJUSTED SEPARATION FOR RURAL NON-TEACHING HOSPITALS	KPI 2.71

The use of casemix in hospitals is a recognised methodology for adjusting actual activity data to reflect the complexity of service provision and the use of resources. Hence the number of separations in a hospital may be adjusted from an actual number of 50,000 to 60,000 by a casemix index of 1.2 to reflect that very complex services have been provided. In Australia, hospitals utilise the Australian Diagnostic Related Groups (AN-DRGs) Version 4.2 to which cost weights are allocated. In Western Australia, cost weight allocations utilise scaled central episodes.

The use of a casemix index together with expenditure data allows a reasonable comparison between hospitals on the efficient use of resources in providing inpatient services.

This indicator measures the average cost of a casemix-adjusted separation.

HEALTH SERVICE	AVERAGE COST PER CASEMIX ADJUSTED SEPARATION
South West Health Service	$2,469.00

AVERAGE COST PER NON-INPATIENT OCCASION OF SERVICE	KPI 2.86

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

Excessive costs in providing non-inpatient services compared to other hospitals may indicate the inefficient use of resources.

This indicator measures the average cost per non-inpatient occasion of service.

HEALTH SERVICE	AVERAGE COST PER NON-INPATIENT OCCASION OF SERVICE
South West Health Service	$110

AVERAGE COST PER NON-INPATIENT OCCASION OF SERVICE IN NURSING POSTS	KPI 2.87

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

Excessive costs in providing non-inpatient services compared to other nursing posts may indicate the inefficient use of resources.

This indicator measures the average cost per non-inpatient occasion of service.

NURSING POST	AVERAGE COST PER NON-INPATIENT OCCASION OF SERVICE IN NURSING POSTS
Northcliffe Nursing Post	$71

KPI 3.7 : Hospital separations for Asthma

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

NUMBER OF AGED CARE ASSESSMENT TEAM (ACAT) ASSESSMENTS WITHIN TARGETED AGE GROUPS PER 1,000 POPULATION NUMBER OF FIRST ACAT ASSESSMENTS WITHIN TARGETED AGE GROUPS PER 1,000 POPULATION	KPI 3.2 3.3

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

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

This indicator measures the extent to which people within the targeted age groups are assessed by Aged Care Assessment Teams. This is a measure of the extent to which elderly people's support needs are assessed and, where required, Care Plans developed to ensure that they receive the support they require. Care Plans aim to maintain elderly people in their own homes and communities for as long as possible.

Results are reported for the whole population aged 70+ years and for Aboriginal and Torres Strait Islander people aged 50-69 years.

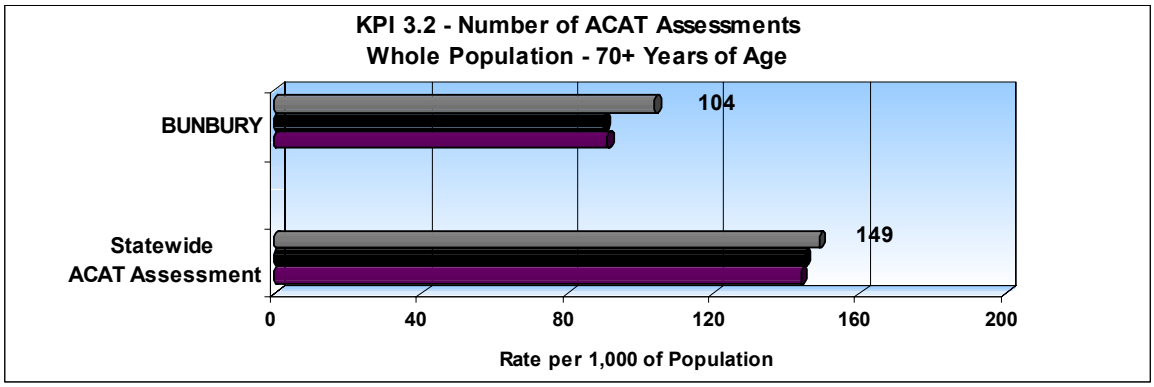
The total number of assessments performed are shown in the first graph, with the number of *first* assessments performed shown in the second graph.*

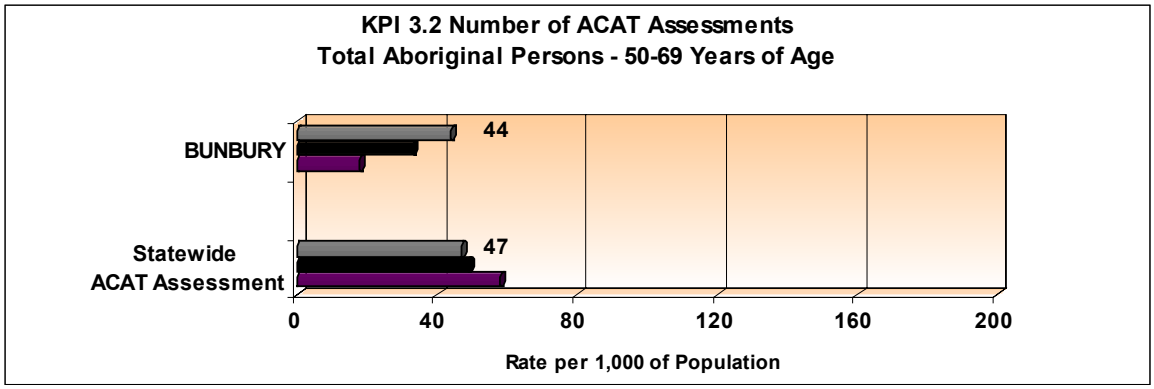
Note: 2001 is the latest year of available data.

*Notes:

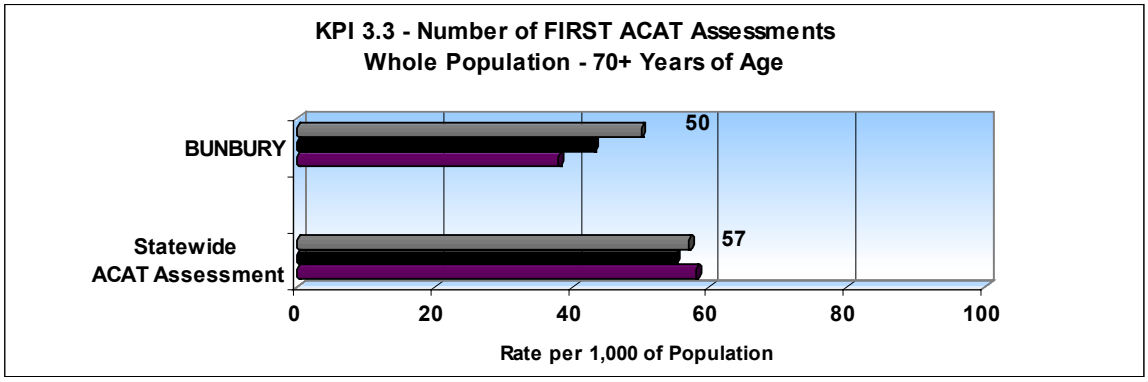
Estimate of the target population (ie, 70+ years) is obtained from the Estimated Resident Population report released by the ABS for the appropriate year (Catalogue No. 3203.5).
Estimate of the number of Aboriginal and Torres Strait Islander people aged 50-69 years is obtained from Epidemiology & Analytical Services, Health Information Centre.

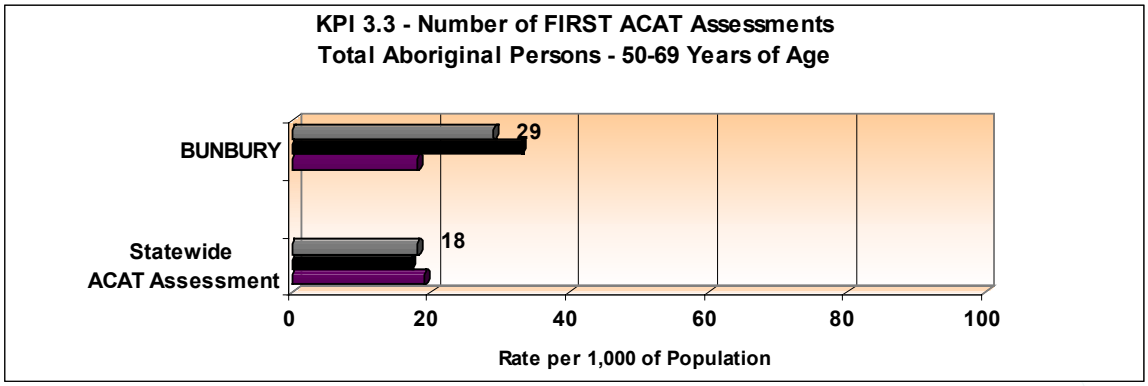
ACAT assessments within targeted age groups





FIRST ACAT assessments within targeted age groups





Calendar Year 1999 2000 2001

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

Number of Individuals Admitted as a Nursing Home Type Patient

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

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

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

Number of admissions to the South West Health Services as Nursing Home Type Patients in persons aged 70+ years

	1999/2000	2000/2001	2001/2002
Number of Admissions	78	110	138
Targeted Population	9,335	9,784	10,489
Admission Rate per 1,000 Population	8.3	11.2	13.15

There were no admissions of Aboriginals aged 50-69 years

Note : there was missing data for Yarloop Hospital in 1999/2000

Average Cost per Nursing Home Type Patient Bed Day

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

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

HEALTH SERVICE	AVERAGE COST PER NHTP
South West Health Service	$349

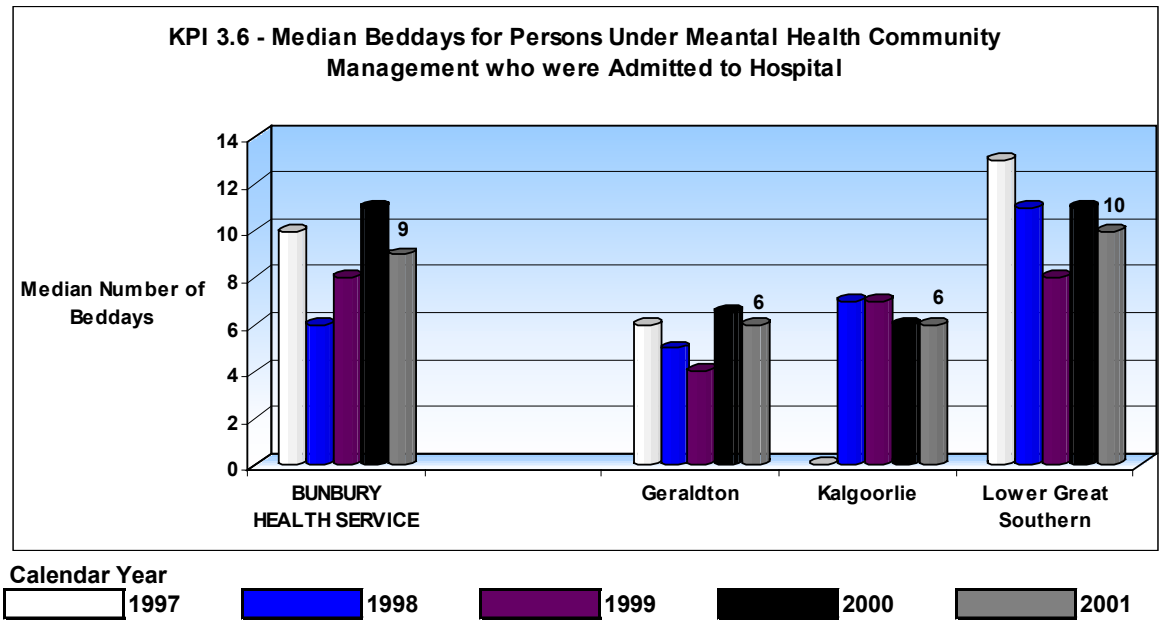
NB: This is the first year this KPI has been reported. Over time, the indicator will be refined so that there is clearer differentiation between the cost of the different care types treated within hospitals.

MEDIAN BED-DAYS FOR PERSONS UNDER MENTAL HEALTH COMMUNITY MANAGEMENT WHO WERE ADMITTED TO HOSPITAL

KPI 3.6

The aim of community management of people with mental illness is to provide the treatment and support required to prevent the recurrence of an acute episode of a severity requiring hospitalisation. This indicator shows the extent to which community mental health services have achieved this aim, by measuring the number of bed-days of people under Mental Health community management. This indicator consists of all overnight admissions to public psychiatric inpatient facilities.

Inpatient admissions include those from acute public hospitals, approved psychiatric hospitals and Elderly Mental Health Services. Day cases at all hospitals are excluded.



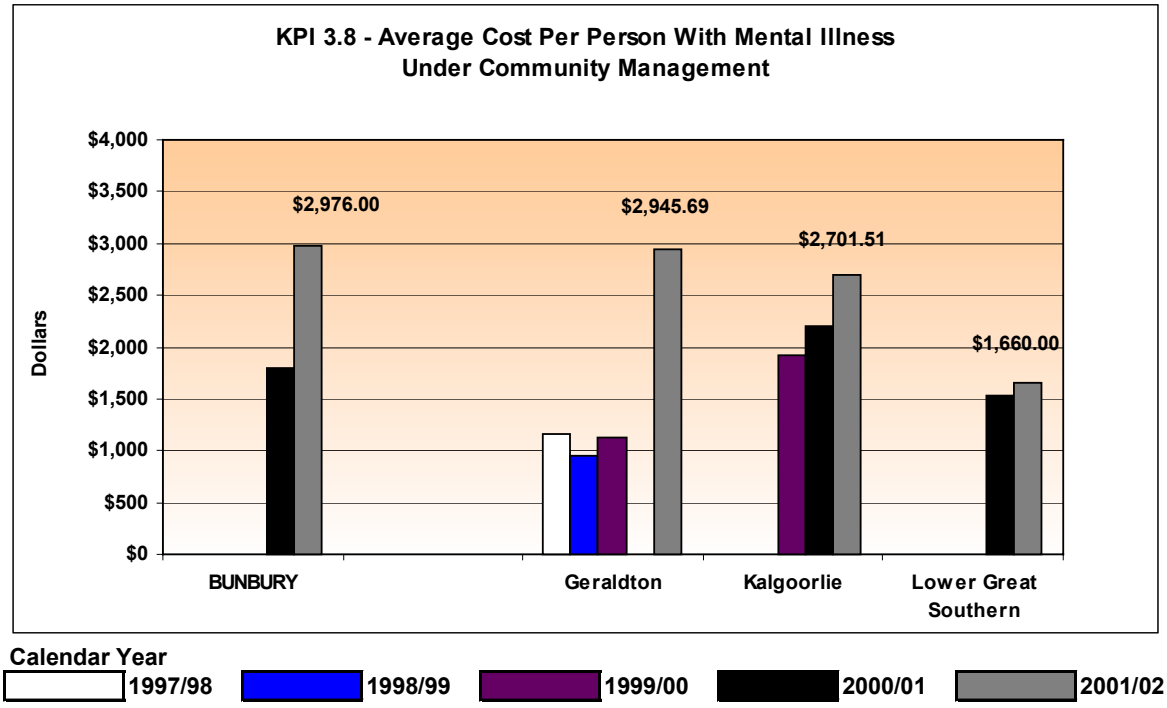
AVERAGE COST PER PERSON WITH MENTAL ILLNESS UNDER COMMUNITY MANAGEMENT	KPI 3.8

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

The figures for this indicator are obtained by dividing the combined gross accrued cost of community based services by the total number of persons who received at least one occasion of service during the period.

Comparative data has not been provided as this is the first reporting year for the South West Health Board, and is a result of amalgamation of five former individual health services (Bunbury, Vasse Leeuwin, Warren Blackwood, Wellington and Harvey Yarloop) that operated within the wider south west area.

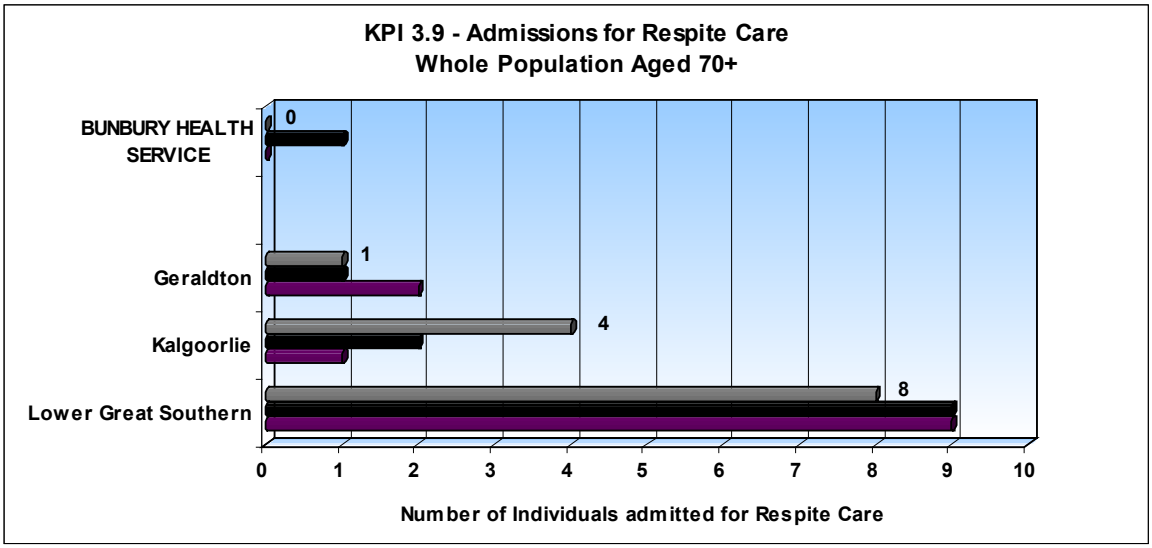
The average cost per person is considered higher than normal. This is as a result of a temporary down turn in available beds at Bunbury and a corresponding re-allocation of fixed expenses to the community based project.

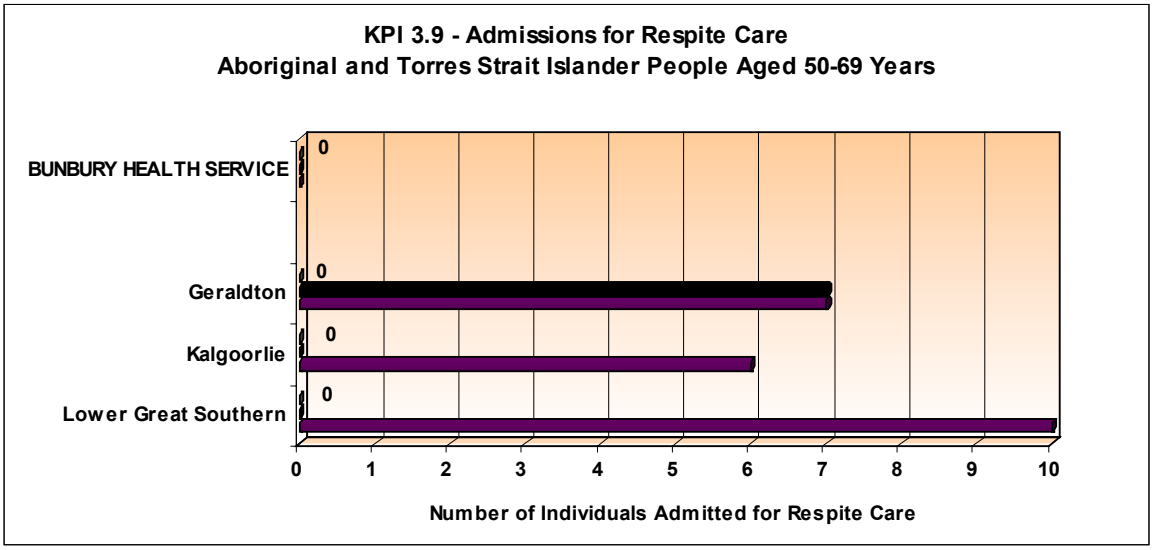


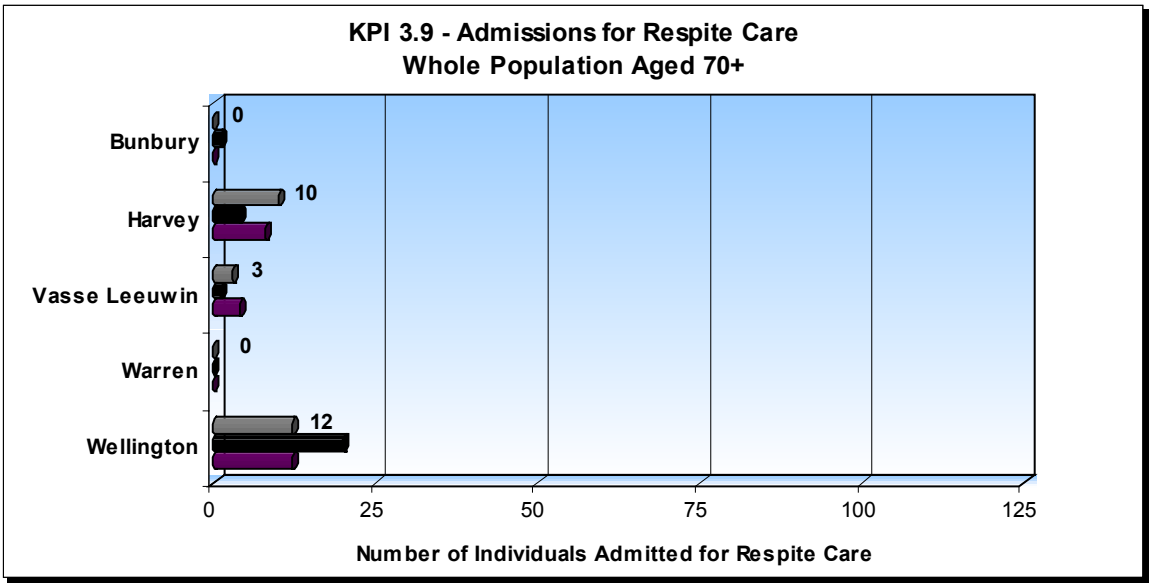
NUMBER OF INDIVIDUALS WITHIN TARGETED AGE GROUP ADMITTED FOR RESPITE CARE	KPI 3.9

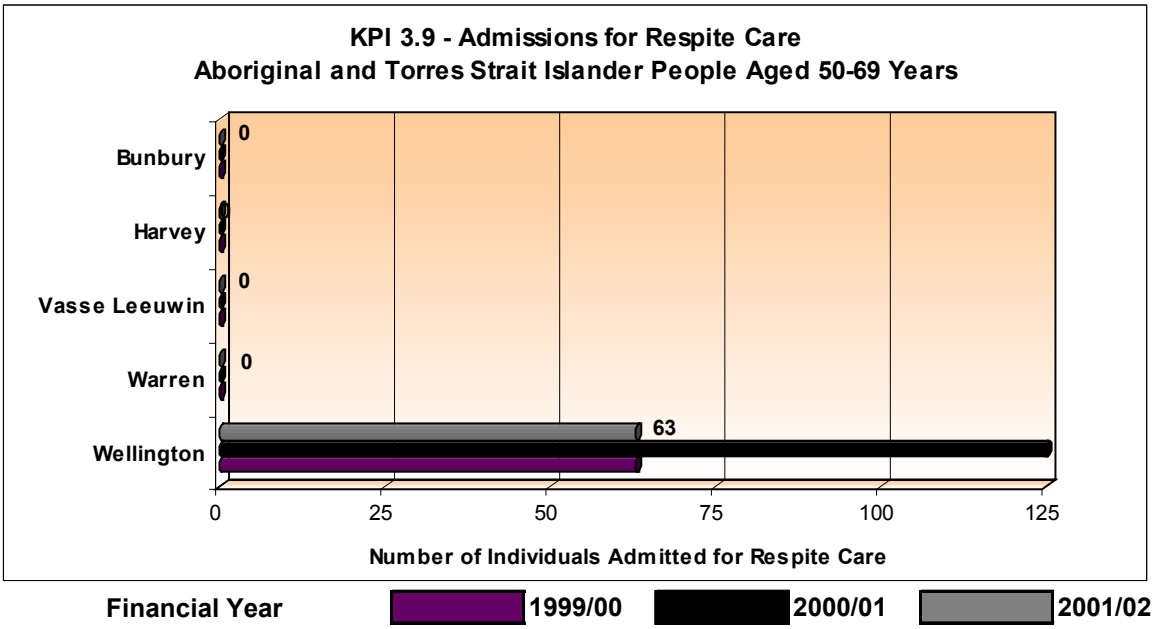
Some people with chronic illness and disability are cared for at home or in a family member's home with the support of local community services including Home & Community Care (HACC). To enable the carer to have a break from the continual carer role, short-term care may be provided in country facilities.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

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






KPI 3.9 - Admissions for Respite Care
Whole Population Aged 70+
Bunbury
Harvey
Vasse Leeuwin
Warren
Wellington
0
10
3
0
12
0
25
50
75
100
125
Number of Individuals Admitted for Respite Care


KPI 3.9 - Admissions for Respite Care
Aboriginal and Torres Strait Islander People Aged 50-69 Years
Bunbury
Harvey
Vasse Leeuwin
Warren
Wellington
0
0
0
63
0
25
50
75
100
125
Number of Individuals Admitted for Respite Care
Financial Year
1999/00
2000/01
2001/02

AUDITOR GENERAL

To the Parliament of Western Australia

SOUTH WEST HEALTH BOARD
FINANCIAL STATEMENTS FOR THE YEAR ENDED JUNE 30, 2002

Scope

I have audited the accounts and financial statements of the South West Health Board for the year ended June 30, 2002 under the provisions of the Financial Administration and Audit Act 1985.

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

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

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

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

South West Health Board
Financial Statements for the year ended June 30, 2002

Audit Opinion
In my opinion,

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

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

D D R PEARSON
AUDITOR GENERAL
March 28, 2003

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

CERTIFICATION OF FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2002

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

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

Michael Daube
Director General of Health
Accountable Authority for
South West Health Board

26 September 2002

Hugh Thomson
Principal Accounting Officer
South West Health Board

26 September 2002

Statement of Financial Performance
For the year ended 30 June 2002

	Note	2001/02 $
COST OF SERVICES		
Expenses from Ordinary Activities		
Employee expenses		57,163,743
Fees for visiting medical practitioners		10,278,166
Superannuation expense		4,622,642
Patient support costs	3	11,832,268
Patient transport costs		1,186,230
Borrowing costs expense		276,271
Repairs, maintenance and consumable equipment expense		3,549,698
Depreciation expense	4	4,378,081
Capital user charge	6	8,067,396
Other expenses from ordinary activities	7	5,841,002
Total cost of services		107,195,497
Revenues from Ordinary Activities		
Patient charges	8	3,157,035
Commonwealth grants and contributions	9	979,641
Donations revenue	10	89,334
Net profit on disposal of non-current assets	5	98,378
Interest revenue		38,537
Other revenues from ordinary activities	11	3,406,523
Total revenues from ordinary activities		7,769,448
NET COST OF SERVICES		**99,426,049**
Revenues from Government		
Output appropriations	12	99,788,356
Liabilities assumed by the Treasurer	13	109,382
Resources received free of charge	14	107,000
Total revenues from government		100,004,738
Change in net assets before restructuring		578,689
Net revenues from restructuring	35	94,116,981
Change in net assets		**94,695,670**
Total changes in equity other than those resulting from transactions with WA State Government as owners		**94,695,670**

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

Statement of Financial Position
As at 30th June 2002

	Note	2001/02 $
CURRENT ASSETS		
Cash assets	15	2,973,688
Restricted cash assets	18	213,815
Receivables	17	2,327,429
Inventories	19	525,857
Prepayments		64,727
Total current assets		6,105,516
NON-CURRENT ASSETS		
Amounts receivable for outputs	18	4,447,725
Property, plant and equipment	20	110,587,662
Construction works in progress		48,980
Total non-current assets		115,084,367
Total assets		**121,189,883**
CURRENT LIABILITIES		
Payables		3,478,273
Interest-bearing liabilities	21	120,579
Accrued salaries	22	3,882,418
Provisions	23	8,271,864
Total current liabilities		15,753,134
NON-CURRENT LIABILITIES		
Interest-bearing liabilities	21	3,239,072
Provisions	23	5,494,658
Total non-current liabilities		8,733,730
Total liabilities		**24,486,864**
Net Assets		**96,703,019**
EQUITY		
Contributed equity	24	2,007,349
Accumulated surplus	25	94,695,670
Total Equity		**96,703,019**

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

Statement of Cash Flows
For the year ended 30 June 2002

	Note	2001/02 $ Inflows (Outflows)
CASH FLOWS FROM GOVERNMENT		
Output appropriations	26(c)	87,613,103
Net cash provided by Government		87,613,103
Utilised as follows:		
CASH FLOWS FROM OPERATING ACTIVITIES		
Payments		
Supplies and services		(36,629,581)
Employee costs		(54,342,095)
GST payments on purchases		(3,191,203)
Receipts		
Receipts from customers		3,174,299
Commonwealth grants and contributions		958,998
Donations		89,334
Interest received		39,656
GST receipts on sales		389,922
GST receipts from taxation authority		2,399,081
Other receipts		2,757,272
Net cash used in operating activities	26(b)	(84,354,317)
CASH FLOWS FROM INVESTING ACTIVITIES		
Payments for purchase of non-current assets	20	(1,134,857)
Proceeds from sale of non-current assets	5	222,006
Net cash used in investing activities		(912,851)
Net increase in cash held		2,345,935
Cash assets at the beginning of the reporting period		841,568
Cash assets at the end of the reporting period	26(a)	3,187,503

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

Note 1 Significant accounting policies

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

(a) General Statement

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

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

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

(b) Output Appropriations

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

(c) Contributed Equity

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

(d) Acquisition of Assets

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

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

(e) Depreciation of Non-current Assets

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

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

Buildings	50 years
Computer equipment	5 to 15 years
Furniture and fittings	5 to 50 years
Motor vehicles	4 to 10 years
Other mobile plant	10 to 20 years
Other plant and equipment	4 to 50 years

(f) Leases

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

The Health Service has no contractual obligations under finance leases.

(g) Cash

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

(h) Receivables

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

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

(i) Inventories

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

(j) Payables

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

(k) Accrued Salaries

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

(l) Interest-bearing liabilities

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

(m) Provisions

Employee Entitlements

i) Annual and Long Service Leave

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

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

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

ii) Superannuation

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

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

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

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

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

iii) Deferred Salary Scheme

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

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

(n) Revenue Recognition

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

(o) Grants and Other Contributions Revenue

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

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

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

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

(q) Comparative Figures

The South West Health Board is a new legal entity, being gazetted by the Executive Council on 28 December 2001. As such no comparative figures are required to be reported this financial year.

(r) Integration of Health Services

The financial statements incorporate the assets and liabilities of the following health services controlled by the South West Health Board as at 30 June 2002 and their results for the year then ended. The South West Health Board and it's hospitals and health services together are referred to in this financial report as the Board.

Bunbury Health Service
Harvey Yarloop Health Service Board
Vasse Leeuwin Health Board
Warren Blackwood Health Service Board
Wellington Health Service Board

Where control of a health service or parts thereto is obtained during a reporting period, its results are included in the consolidated operating statement from the date that control commences. Where control of a health service or parts thereto ceases during a reporting period, its results are included for that part of the reporting period during which control exists.

Comparitive figures are not provided for the first reporting period of the Board.

Note 2 Administered trust accounts

	2001/02 $

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

a) The Board 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	140,383
Add Receipts	
- Patient Deposits	301,568
- Interest	1,024
	442,975
Less Payments	
- Patient Withdrawals	290,016
- Interest / Charges	70
Closing Balance	152,889

Note 3 Patient support costs	2001/02 $
Medical supplies and services	4,962,724
Domestic charges	910,480
Fuel, light and power	1,651,100
Food supplies	1,679,476
Purchase of external services	2,628,487
	11,832,268

Note 4 Depreciation expense	
Buildings	2,961,960
Computer equipment and software	404,978
Furniture and fittings	211,975
Motor vehicles	71,577
Other mobile plant	3,740
Other plant and equipment	723,851
	4,378,081

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

a) **Proceeds from sale of non-current assets**

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

Received as cash by the Health Service	222,006
Gross proceeds from sale of non-current assets	222,006

b) **Profit / (Loss) on disposal of non-current assets:**

Computer equipment and software	(4,354)
Furniture and fittings	68,460
Motor vehicles	54,393
Other mobile plant	(671)
Other plant and equipment	(19,450)
	98,378

Note 6 Capital user charge

	8,067,396

A capital user charge rate of 8% has been set by the Government for 2001/02 and represents the opportunity cost of capital invested in the net assets of the Health Service used in the provision of outputs. The charge is calculated on the net assets adjusted to take account of exempt assets. Payments are made to the Department of Treasury and Finance on a quarterly basis by the Department of Health on behalf of the Health Service.

Note 7 Other expenses from ordinary activities	
Workers compensation insurance	1,335,009
Other employee expenses	572,794
Motor vehicle expenses	604,652
Insurance	588,223
Communications	700,358
Printing and stationery	446,568
Rental of property	260,861
Audit fees - external	158,042
Bad and doubtful debts expense	9,098
Other	1,165,398
	5,841,002

Note 8 Patient charges	
Inpatient charges	3,041,642
Outpatient charges	115,393
	3,157,035

	2001/02 $
Note 9 Commonwealth grants and contributions	
Grant for nursing homes	428,154
Commonwealth Specific Grants	
PTAC Funding (Interns)	13,000
Primary Health Care	29,127
CAEP Funding	281,686
Additional Counselling Support	57,500
Safety Innovations In Practice (SIIP)	9,000
Epidural Practice Improvement Program	9,000
Nursing Clinical Placement Program	19,250
Stay On Your Feet Program	263
Diabetes Program	33,327
HACC Funding	3,320
DH & AC Administered Carer Funding	15,277
Warren Blackwood Mental Health Project	63,636
Speech Therapy Funding	2,500
Dieticians Program	12,600
Play To Grow Program	2,000
	979,641
Note 10 Donations revenue	
General public contributions	89,334
Note 11 Other revenues from ordinary activities	
Rent from properties	140,255
Boarders' accommodation	2,359
Recoveries	2,535,805
Use of hospital facilities	543,748
Other	184,356
	3,406,523
Note 12 Government appropriations	
Output appropriations (I)	99,788,356

(I) Output appropriations are accrual amounts as from 1 July 2001, reflecting the full price paid for outputs purchased by the Government. The appropriation revenue comprises a cash component and a receivable (asset). The receivable (holding account) comprises the estimated depreciation expense for the year and any agreed increase in leave liability during the year.

(II) Capital appropriations were revenue in 2000/01 (year ended 30 June 2001). From 1 July 2001, capital appropriations, termed Capital Contributions, have been designated as contributions by owners and are credited directly to equity in the Statement of Financial Position.

Note 13 Liabilities assumed by the Treasurer	
Superannuation	109,382
Note 14 Resources received free of charge	

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

Office of the Auditor General	
- Audit services	107,000

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

Note 15 Cash assets	
Cash on hand	23,340
Cash at bank - general	2,109,729
Cash at bank - donations	840,620
	2,973,688

	2001/02 $
Note 16 Restricted cash assets	
Cash assets held for specific purposes	
Cash at bank (Percy Dewe Account)	213,815
- Percy Dewe Account to be used specifically for permanent care accommodation at Harvey District Hospital.	213,815
Note 17 Receivables	
Patient fee debtors	417,553
GST receivable	638,968
Other receivables	1,404,256
	2,460,778
Less: Provision for doubtful debts	(133,349)
	2,327,429
Note 18 Amounts receivable for outputs	
Non-current	4,447,725
This asset represents the non-cash component of output appropriations. It is restricted in that it can only be used for asset replacement or payment of leave liability.	
Note 19 Inventories	
Supply stores - at cost	416,759
Pharmaceutical stores - at cost	100,865
Engineering stores - at cost	8,233
	525,857
Note 20 Property, plant and equipment	
Land	
At cost	6,651,000
Buildings	
Clinical:	
At cost	98,231,889
Accumulated depreciation	(2,936,347)
	95,295,542
Non-Clinical:	
At cost	974,022
Accumulated depreciation	(25,613)
	948,409
Computer equipment and software	
At cost	1,649,171
Accumulated depreciation	(404,978)
	1,244,193
Furniture and fittings	
At cost	2,520,971
Accumulated depreciation	(211,927)
	2,309,044
Motor vehicles	
At cost	187,748
Accumulated depreciation	(65,240)
	122,508
Other mobile plant	
At cost	25,220
Accumulated depreciation	(3,740)
	21,480
Other plant and equipment	
At cost	4,719,337
Accumulated depreciation	(723,851)
	3,995,486
Total of property, plant and equipment	110,587,662

Note 20 Property, plant and equipment - continued	2001/02 $
Payments for non-current assets	
Payments were made for purchases of non-current assets during the reporting period as follows:	
Paid as cash by the Health Service from output appropriations	1,029,763
Paid as cash by the Health Service from capital contributions	105,094
Paid by the Department of Health	6,813,759
Gross payments for purchases of non-current assets	7,948,616
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	
Land	
Carrying amount at start of year	6,651,000
Carrying amount at end of year	6,651,000
Buildings	
Carrying amount at start of year	92,757,987
Additions	6,447,924
Depreciation	(2,961,960)
Carrying amount at end of year	96,243,951
Computer equipment and software	
Carrying amount at start of year	1,316,555
Additions	359,510
Disposals	(32,756)
Depreciation	(404,978)
Write-off of accumulated depreciation on disposal of assets	19,734
Other asset adjustments	(13,872)
Carrying amount at end of year	1,244,193
Furniture and fittings	
Carrying amount at start of year	1,922,631
Additions	612,877
Disposals	(139,452)
Depreciation	(211,975)
Write-off of accumulated depreciation on disposal of assets	89,519
Other asset adjustments	35,444
Carrying amount at end of year	2,309,044
Motor vehicles	
Carrying amount at start of year	125,421
Additions	100,566
Disposals	(163,912)
Depreciation	(71,577)
Write-off of accumulated depreciation on disposal of assets	132,010
Carrying amount at end of year	122,508
Other mobile plant	
Carrying amount at start of year	24,481
Additions	1,410
Disposals	(1,100)
Depreciation	(3,740)
Write-off of accumulated depreciation on disposal of assets	429
Carrying amount at end of year	21,480
Other plant and equipment	
Carrying amount at start of year	4,279,250
Additions	445,366
Disposals	(68,522)
Depreciation	(723,851)
Write-off of accumulated depreciation on disposal of assets	40,422
Other asset adjustments	22,821
Carrying amount at end of year	3,995,486

	2001/02 $
Note 21 Interest-bearing liabilities	
a) **Western Australian Treasury Corporation (WATC) loans**	
Balance at beginning of year	589,946
Less repayments this year	(21,997)
Balance at end of year	567,949
Amount repayable within the next 12 months	21,752
Amount repayable after 12 months	546,196
Balance at end of year	567,949

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) **Department of Treasury and Finance loans**	
Balance at beginning of year	2,886,178
Less repayments this year	(94,476)
Balance at end of year	2,791,703
Amount repayable within the next 12 months	98,826
Amount repayable after 12 months	2,692,876
Balance at end of year	2,791,703

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

Total interest-bearing liabilities:	
Balance at beginning of year	3,476,124
New loans this year	0
Less repayments this year	(116,473)
Balance at end of year	3,359,651
Amount repayable within the next 12 months	120,579
Amount repayable after 12 months	3,239,072
Balance at end of year	3,359,651

Note 22 Accrued salaries

Amounts owing for:	3,882,418
Nursing staff	
14 days from 17 June to 30 June 2002	
Non-nursing staff	
10 days from 17 June to 30 June 2002	

Note 23 Provisions

Current liabilities:	
Annual leave	6,004,075
Long service leave	2,015,104
Superannuation	252,685
	8,271,864
Non-current liabilities:	
Long service leave	2,542,837
Superannuation	2,951,821
	5,494,658
Total employee entitlements	13,766,522

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

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

Note 24 Contributed equity

Balance at beginning of the year	0
Capital contributions (i)	2,007,349
Balance at end of the year	2,007,349

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

Note 25 Accumulated surplus	2001/02 $
Balance at beginning of the year	0
Change in net assets	94,695,670
Balance at end of the year	94,695,670

Note 26 Notes to the statement of cash flows

a) **Reconciliation of cash**

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

Cash assets (Refer note 15)	2,973,688
Restricted cash assets (Refer note16)	213,815
	3,187,503

b) **Reconciliation of net cash flows used in operating activities to net cost of services**

Net cash used in operating activities (Statement of Cash Flows)	(84,354,317)
Increase / (decrease) in assets:	
GST receivable	346,187
Other receivables	285,890
Inventories	16,964
Prepayments	13,631
Decrease / (increase) in liabilities:	
Doubtful debts provision	6,315
Payables	539,068
Accrued salaries	(1,935,151)
Provisions	(1,063,116)
Non-cash items:	
Depreciation expense	(4,378,081)
Profit / (loss) from disposal of non-current assets	98,378
Interest paid by Department of Health	(276,271)
Capital user charge paid by Department of Health	(8,067,396)
Superannuation liabilities assumed by the Treasurer	(109,382)
Resources received free of charge	(107,000)
Other	(441,768)
Net cost of services (Statement of Financial Performance)	(99,426,049)

c) **Notional cash flows**

Output appropriations as per Statement of Financial Performance	99,788,356
Capital appropriations credited directly to Contributed Equity	2,007,349
	101,795,705
Less notional cash flows:	
Items paid directly by the Department of Health for the Health Service and are therefore not included in the Statement of Cash Flows:	
Interest paid to WA Treasury Corporation	(31,921)
Repayment of interest-bearing liabilities to WA Treasury Corporation	(21,997)
Interest paid to Department of Treasury & Finance	(244,350)
Repayment of interest-bearing liabilities to Department of Treasury & Finance	(94,476)
Capital user charge	(8,067,396)
Capital subsidy not paid as cash	(1,218,621)
Output Appropriations Accrual	(4,447,725)
Other non cash adjustments to output appropriations	(56,115)
	(14,182,602)
Output appropriations as per Statement of Cash Flows	87,613,103

Note 27 Revenue, public and other property written off or presented as gifts

a) Revenue and debts written off.	15,188

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

Note 28 Losses of public moneys and public or other property

	2001/02 $
Losses of public moneys and public or other property through theft or default	7,136
Less recovery of losses	8,468
Net recovery of losses	(1,332)

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

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

	2001/02
$70,001 - $80,000	7
$80,001 - $90,000	7
$90,001 - $100,000	5
$100,001 - $110,000	1
Total	20

	$
The total remuneration of senior officers is:	1,800,000

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

Numbers of Senior Officers presently employed who are members of the Pension Scheme:	0

Note 30 Commitments for Expenditure

	2001/02 $
Operating lease commitments:	
Commitments in relation to non-cancellable operating leases are payable as follows:	
Not later than one year	384,880
Later than one year, and not later than five years	104,027
	488,907

These commitments are all exclusive of GST.

Note 31 Contingent liabilities

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

Note 32 Events occurring after reporting date

The South West Health Board had no significant events occurring after balance date.

Note 33 Related bodies

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

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

Note 34 Affiliated bodies

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

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

Note 35 Net revenues from restructuring

A new statutory authority was formed under section 16 of the Hospitals and Health Services Act 1927 on 1st July 2001 (Refer note 1(r)). Net assets transferred to the Board by the amalgamation are :

	Total Assets $	Total Liabilities $	Total 2001/02 $
- Bunbury Health Service	51,183,869	8,833,588	42,350,281
- Harvey Yarloop Health Service Board	4,072,782	1,004,078	3,068,704
- Vasse Leeuwin Health Board	20,324,625	6,445,910	13,878,715
- Warren Blackwood Health Service Board	27,349,363	4,189,323	23,160,040
- Wellington Health Service Board	13,330,482	1,671,241	11,659,241
			94,116,981

Note 36 Financial instruments

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

	Weighted average effective interest rate %	Variable interest rate $000	Fixed interest rate maturities Less than 1 year $000	1 to 5 years $000	Over 5 years $000	Non interest bearing $000	Total $000
As at 30th June 2002							
Financial Assets							
Cash assets	0.0%	2,950.4	0.0	0.0	0.0	23.3	2,973.7
Restricted cash assets	0.0%	213.8	0.0	0.0	0.0	0.0	213.8
Receivables		0.0	0.0	0.0	0.0	2,327.4	2,327.4
		3,164.2	0.0	0.0	0.0	2,350.7	5,514.9
Financial Liabilities							
Payables		0.0	0.0	0.0	0.0	3,478.3	3,478.3
Interest-bearing liabilities							
- W A Treasury Corporation	5.7%	0.0	21.8	91.9	454.3	0.0	568.0
- Department of Treasury & Finance	8.6%	0.0	98.8	443.3	2,249.6	0.0	2,791.7
		0.0	120.6	535.2	2,703.9	3,478.3	6,838.0
Net financial assets / (liabilities)		3,164.2	(120.6)	(535.2)	(2,703.9)	(1,127.6)	(1,323.1)

Note 37 Output information

	Prevention & Promotion 2001/02 $000	Diagnosis & Treatment 2001/02 $000	Continuing Care 2001/02 $000	Total 2001/02 $000
COST OF SERVICES				
Expenses from Ordinary Activities				
Employee expenses	5,242.6	47,228.2	4,693.0	57,163.7
Fees for visiting medical practitioners	557.5	9,316.2	404.5	10,278.2
Superannuation expense	384.8	3,906.7	331.1	4,622.6
Patient support costs	552.1	10,524.9	755.2	11,832.3
Patient transport costs	92.3	798.3	295.7	1,186.2
Borrowing costs expense	39.7	216.2	20.4	276.3
Repairs, maintenance and consumable equipment expense	284.9	2,968.6	296.2	3,549.7
Depreciation expense	306.4	3,786.3	285.3	4,378.1
Net loss on disposal of non-current assets	0.6	0.4	0.0	1.1
Capital user charge	441.2	7,157.8	468.4	8,067.4
Other expenses from ordinary activities	714.6	4,636.1	490.4	5,841.0
Total cost of services	8,616.8	90,539.6	8,040.2	107,196.6
Revenues from Ordinary Activities				
Patient charges	240.1	2,428.0	488.9	3,157.0
Commonwealth grants and contributions	50.9	335.0	593.7	979.6
Donations revenue	10.3	71.9	7.1	89.3
Net profit on disposal of non-current assets	0.0	73.4	26.0	99.4
Interest revenue	2.4	29.1	7.0	38.5
Other revenues from ordinary activities	246.0	2,890.4	270.1	3,406.5
Total revenues from ordinary activities	549.6	5,827.9	1,393.0	7,770.5
NET COST OF SERVICES	**8,067.2**	**84,711.7**	**6,647.2**	**99,426.0**
Revenues from Government				
Output appropriations	7,762.0	85,870.6	6,155.7	99,788.4
Liabilities assumed by the Treasurer	10.7	94.4	4.3	109.4
Resources received free of charge	7.4	88.7	10.9	107.0
Total revenues from government	7,780.0	86,053.7	6,171.0	100,004.7
Change in net assets before restructuring	**(287.2)**	**1,342.1**	**(476.2)**	**578.7**
Net revenues from restructuring	5,108.1	83,353.3	5,655.6	94,117.0
Extraordinary revenue / (expense)	0.3	(0.3)	0.0	0.0
Change in net assets	**4,821.3**	**84,695.0**	**5,179.3**	**94,695.7**

Note 37 Output information (continued)

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

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

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

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

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

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

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

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

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

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

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

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

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

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