South West Area Health Service

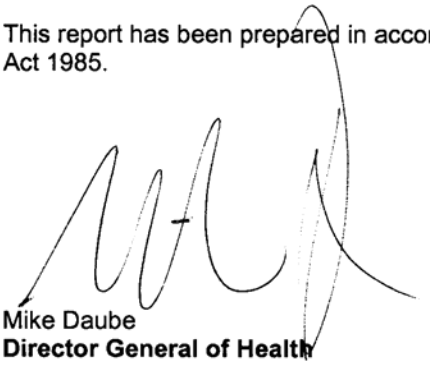
Annual Report 2003-04

Department of Health
Government of Western Australia

To the Hon Jim McGinty MLA
MINISTER FOR HEALTH

In accordance with Section 62 of the Financial Administration and Audit Act 1985, I hereby submit for your information and presentation to Parliament, the Report of the South West Area Health Service for the year ended 30 June 2004.

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



Mike Daube
Director General of Health
Accountable Authority for South West Area Health Board

31 August 2004

Contents

Contents

Contents

ILLUSTRATIONS

Director General's Overview

During the financial year 2003-04, the West Australian health system has continued to deliver outstanding services to the community through a strong and committed workforce.

Despite the inevitable pressures placed on health systems everywhere, our hospitals and health services have coped exceptionally well. The community continues to enjoy some of the best health and health care in the world, by both national and international standards.

There have been several major achievements for the health system during this year.

We achieved a budget surplus of $500,000 in a budget of $3.1 billion, a major turnaround from budget deficits of previous years. A number of strategies have been implemented over the year to bring this about and simultaneously improve health care services throughout the State.

The use of technology continues to expand and rural regions in particular have benefited this year. The Department played a key role in determining spending priorities for the $8 million National Communications Fund grant to WA. Fifty-seven health sites in 53 regional towns are now in line for service improvements through enhanced telecommunications. The highly successful and jointly funded (State/Commonwealth) WA Telehealth Project was concluded in June 2004, after installing over 130 service projects across regional WA. More community-based services and strategies have also been developed to facilitate and meet specific care needs in the community, with increased focus on health promotion and illness prevention.

Population health campaigns in the South West region have included information packages on the management of meningococcal meningitis to assist Emergency Departments in hospitals and clinics, and regional public health warnings about Ross River virus to reduce the incidence and impact of infection and spread.

This year *Healthy Communities* was established as a joint project between the South West Area Health Service and the Peel South West Division of General Practice. Community consultation and participation played a major role in the development of this new model of service delivery and future strategic direction for the region. A number of consultative committees were also established to ensure the Service received input from employees, unions and key stakeholders.

In addition, *South West 24* was launched as a freecall mental health telephone support line in the south west region. This service has proved very successful in its first 12 months, receiving in the vicinity of 2000 calls a month. The program provides around-the-clock mental health telephone advice to south west residents and complements existing mental health and primary health care services in the region.

This year also saw the presentation to and acceptance by Government of the report of the Health Reform Committee. Government accepted 85 out of 86 recommendations by the Committee to bring about a major and fundamental reconfiguration of our health system over the next 10 to 15 years.

Major advantages of the reform process will be improved accountability mechanisms and revenue generation, bringing the WA public health system up to the national average for per capita own source revenue, as well as increased safety, quality and workforce sustainability within the system, and long-term financial sustainability. Prior to the end of the financial year an action plan had been developed and implementation had commenced.
While health reform issues have clearly dominated public interest, it is important to note that excellent progress has continued in many other crucial areas of country health services in the last year, including:

- Expanded dental health services to schoolchildren, the aged and rural communities, with 240,000 school children receiving preventative/restorative care and 80,000 eligible patients receiving subsidised general dental care through the Country Patients' Dental Subsidy Scheme and Metropolitan Patients' Dental Subsidy Scheme; and

- Reduced dentist wait lists and dentist shortages in rural areas, which are being addressed through a new Public Sector Dental Workforce Scheme.

WA has a first class health system, which provides world-class health services to the community. I take this opportunity to personally thank all staff in the South West and surrounding regions for their ongoing professionalism, dedication and commitment to delivering the highest quality of care to their fellow Western Australians.

Mike Daube
Director General of Health

31 August 2004

ADDRESS AND LOCATION

Department of Health
(South West Area Health Service)
South West Area Health Service
18 West Street
BUSSELTON WA 6280

☎ (08) 9754 0555
(08) 9754 0544

SERVICES PROVIDED AND CORE ACTIVITIES

The following is a list of services and facilities available to the community, please note that these services are not available in all health services.

Direct patient services:
Anaesthetics
Cardiology
Emergency Medicine
Endocrinology
ENT
Gastroenterology
General Medicine
General Practice
General Surgery
Gynaecology
Haematology
Neurology
Obstetrics
Ophthalmology
Orthopaedics
Paediatrics
Palliative Care
Plastics
Psychiatry
Radiology
Respite Care
Urology

Medical support services (Allied Health):
Audiology
Continence advice
Dietetics
Medical Imaging
Occupational Therapy
Pathology
Pharmacy
Physiotherapy
Podiatry
Social Work
Speech Pathology

Community and Population Health Services
Aged Care Assessment Team
Child and Adolescent Mental Health
Community Adult Mental Health
Community and Child Health
Continence Adviser
Integrated Diabetes program
Parenting program
School Health

Home and Community Care:
Home Care Domestic
Home Care Nursing
Home Maintenance
Day Care
Meals on Wheels
Personal Care
Respite & Transport
Social Support

Health protection services:
Environmental Health
Human Epidemic Emergency Management
Communicable Disease Surveillance and Control
Immunisation
Sexual Health
HIV/AIDS and Blood Borne Virus Program
Alcohol and Drugs
Injury prevention
Physical Activity
Nutrition
Tobacco Control

Other support services
Hotel Services
Medical Records

VISION STATEMENT

To ensure that the health status of the Western Australian population leads the world and the standard of health care is acknowledged as international best practice.

MISSION STATEMENT

The State health system is dedicated to ensuring the best achievable health status for all of the Western Australian community.

In particular, the system will deliver:

- Strong public health and preventive measures to protect the community and promote health.
- First class acute and chronic health care to those in need.
- Appropriate health, rehabilitation and domiciliary care for all stages of life.
- A continuing and co-operative emphasis on improving the health status of our indigenous, rural and remote and disadvantaged populations.

VALUES

- Evidence-based practices leading to high quality and effective health care at all levels.
- Ethical behaviour, equity and justice.
- Collaboration and co-operation between all parts of the health portfolio and with other agencies.
- Excellence in communication within the system and externally.
- Transparency of operations.
- Commitment to engaging the community.
- A workforce that is valued.
- Supporting and recognising those individuals and groups demonstrating effective leadership in the achievement of the Vision and Mission of the Western Australian health system.

GOALS

The State health system strives for excellence in:

- The delivery of health services and care to the WA population.
- Preventive measures and activities to maintain and improve the health status of the WA community.
- Indigenous health.
- Evaluation and research aimed at improving the health of people and the services they need.

BROAD OBJECTIVES

The broad objectives of the Western Australian Department of Health are as follows:

Promoting and Protecting Health
To give priority to promoting and protecting the health of the people of Western Australia.

Reducing Inequities
To reduce inequities in health status and inequities in access to health care with particular focus on Aboriginal people, people with mental illness and the poor.

Provision of Safe, High Quality, Evidence-based Health Care
To provide safe, high quality health care, underpinned by good evidence.
To pursue a culture of continuous improvement.
To ensure appropriate care is provided in appropriate settings.

A Patient Centred Continuum of Care
To ensure a patient focused, patient friendly system.
To enable a patient to move between the different levels of health care in a seamless and easy manner.

Value for Money
To ensure the use of health care resources is based on best value for money and allocated fairly.

Transparent and Accountable
To promote transparency and accountability to the community and government.
To promote a culture of 'budgetary integrity' as the defining objective in resource use.
To put in place clear and robust accountability mechanisms, and ensure that these accountability mechanisms are adhered to.

Optimal Public/Private Mix
To ensure complementarity between the public sector and the non-government and private sectors.

Sustainability
To ensure that funding and workforce requirements for the Western Australian health system are sustainable into the future.

ENABLING LEGISLATION

The DOH is established by the Governor under section 35 of the *Public Sector Management Act 1994.* The Director General of Health is responsible to the Minister for Health for the efficient and effective management of the organisation. The Department of Health supports the Minister in the administration of 43 Acts and 105 sets of subsidiary legislation.

Acts administered
Acts Amendment (Abortion) Act 1998
Alcohol and Drug Authority Act 1974
Anatomy Act 1930
Animal Resources Authority Act 1981
Blood Donation (Limitation of Liability) Act 1985
Cannabis Control Act 2003
Chiropractors Act 1964
Co-opted Medical and Dental Services for the Northern Portion of the State Act 1951
Cremation Act 1929
Dental Act 1939
Dental Prosthetists Act 1985
Fluoridation of Public Water Supplies Act 1966
Health Act 1911
Health Legislation Administration Act 1984
Health Professionals (Special Events Exemption) Act 2000
Health Services (Conciliation and Review) Act 1995
Health Services (Quality Improvement) Act 1994
Hospital Fund Act 1930
Hospitals and Health Services Act 1927
Human Reproductive Technology Act 1991
Human Tissue and Transplant Act 1982
Medical Act 1894
Mental Health Act 1996
Mental Health (Consequential Provisions) Act 1996
Nuclear Waste Storage (Prohibition) Act 1999
Nurses Act 1992
Occupational Therapists Registration Act 1980
Optical Dispensers Act 1966
Optometrists Act 1940
Osteopaths Act 1997
Perth Dental Hospital Land Act 1942
Pharmacy Act 1964
Physiotherapists Act 1950
Podiatrists Registration Act 1984
Poisons Act 1964
Psychologists Registration Act 1976
Public Dental Hospital Land Act 1934
Queen Elizabeth II Medical Centre Act 1966
Radiation Safety Act 1975
Tobacco Control Act 1990
University Medical School Act 1955
University Medical School Teaching Hospitals Act 1955
Western Australian Bush Nursing Trust Act 1936

Acts Passed During 2003-04
Cannabis Control Act 2003
Nurses Amendment Act 2003

Acts in Parliament at 30 June 2004
Human Reproductive Technology Amendment Bill 2003
Human Reproductive Technology Amendment Bill (Prohibition of Human Cloning) 2003
Health Amendment Bill 2004
Health Legislation Amendment Bill 2004

Amalgamation and Establishment of Boards
There were no Boards amalgamated or established during 2003-04.

MINISTERIAL DIRECTIVES

The Minister for Health did not issue any directives on Department of Health operations during 2003-04.

STATEMENT OF COMPLIANCE WITH PUBLIC SECTOR STANDARDS

In the administration of the South West Area Health Service, I have complied with the *Public Sector Standards in Human Resource Management*. 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.

Human Resource Management
An audit has been conducted of compliance with Public Sector Standards by the Internal Audit Branch, Department of Health in April 2004. Ongoing internal reviews are monitored and assessed for EQuIP accreditation requirements due in November 2004. A database is maintained internally for monitoring of Public Sector Standards Compliance.

Internal HR practitioners conduct ongoing monitoring through appropriate policy and procedures being followed. Any documentation is evidenced and kept in accordance with Records Management Act.

Summary of extent of compliance with public sector standards
South West Area Health Service has had no reported breaches of any Public Sector Standards in Human Resource Management 2003-04.

Summary of Breach of Standards Claims
SWAHS had five applications made to report a breach in standards in 2003-04, three in relation to recruitment selection and appointment and two claims lodged in relation to redeployment.

The three claims lodged in relation to recruitment selection and appointment were resolved in the agency and the two claims reported in relation to redeployment are still pending.

Code of Ethics and Code of Conduct
Compliance with the Public Sector Code of Ethics and SWAHS Code of Conduct are monitored by internal human resource practitioners, who ensure that appropriate policy and procedures are being followed.

An audit has been conducted of compliance with Public Sector Standards by the Internal Audit Branch, Department of Health in April 2004. Ongoing internal reviews are monitored and assessed for EQuIP accreditation requirements due in November 2004.

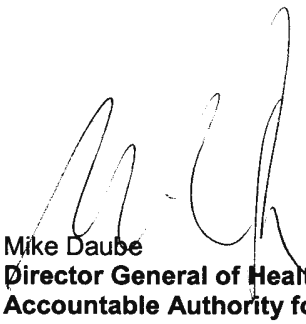
A database is maintained internally for monitoring Public Sector Standards compliance. Any documentation is evidenced and kept in accordance with Records Management Act.

Summary of extent of compliance with ethical codes
There have been eight material breaches of Code of Ethics by employees in South West Area Health Service 2003-04. Five of these breaches resulted in formal written warnings being issued to the employees involved. Three breaches resulted in immediate dismissal.

Agency Code of Conduct
SWAHS has a formal code of conduct. This is a new policy and is provided to new staff. This policy must be signed off before staff commence employment. In addition, the policy has been provided in the form of handouts.

Complaints alleging non-compliance with the Code of Ethics or the Code of Conduct
There have been 23 complaints lodged relating to non-compliance with the Public Sector Standards. These were investigated and resolved internally within the SWAHS.

The SWAHS has not been investigated or audited by the Office of the Public Sector Standards Commissioner for the period to 30 June 2004.



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

31 August 2004

ACCOUNTABLE AUTHORITY

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

PECUNIARY INTERESTS

Senior officers of the South West Area Health Service have declared the following pecuniary interests:

Dr Jon Mulligan is the President of the Australian Council of HealthCare Standards, which has a contract with SWAHS to provide and conduct EQuIP surveys. He does not benefit financially from his association with ACHS.

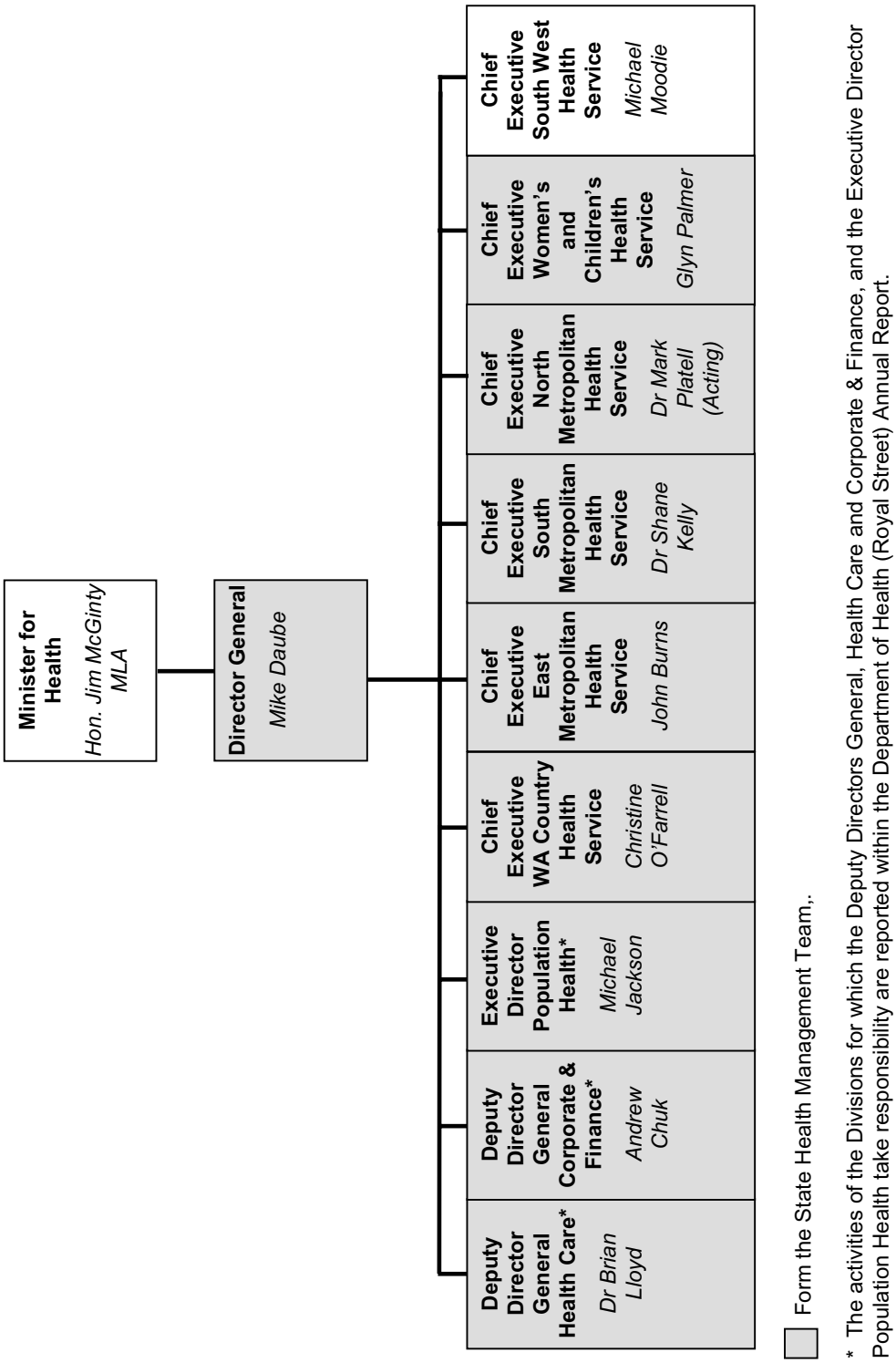
SENIOR OFFICERS

The senior officers of the South West Area Health Service and their areas of responsibility are listed below:

Table 1: Senior Officers

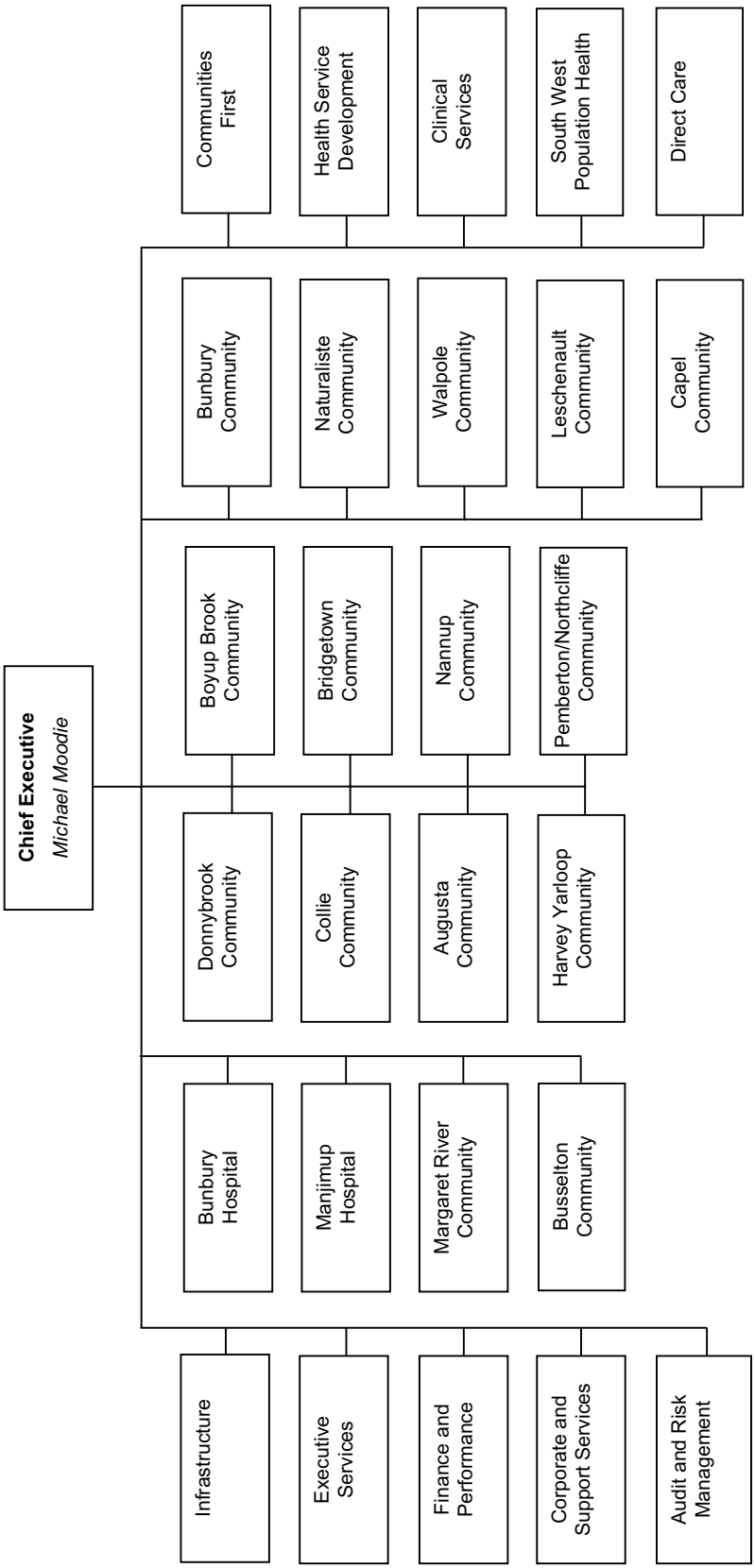
Area of Responsibility	Title	Name	Basis of Appointment
Overall Responsibility	Chief Executive Officer	Michael Moodie	Contract
Finance and Infrastructure	Director, Finance and Infrastructure	Vacant	Vacant
Corporate and Support Services	Director, Corporate and Support Services	John McCredden	Acting
Community Development	Director, Communities First	Anne Donaldson	Permanent
Service Development	Director, Health Service Development	Noel Carlin	Acting
Population Health	Director, Population Health	David Naughton	Permanent
Clinical Services	Director Clinical Services	Dr Jon Mulligan	Permanent
Direct Care Services	Director, Direct care Services	Susan Jones	Acting

DEPARTMENT OF HEALTH (AS AT 30 JUNE 2004) SENIOR MANAGEMENT INCLUDING STATE HEALTH MANAGEMENT TEAM



* The activities of the Divisions for which the Deputy Directors General, Health Care and Corporate & Finance, and the Executive Director Population Health take responsibility are reported within the Department of Health (Royal Street) Annual Report.

SOUTH WEST AREA HEALTH SERVICE STRUCTURE AS AT 30 JUNE 2004



South West 24
SW 24 was introduced in April 2003 as a free call telephone service for people in the South West who required immediate support with mental health issues. The service offered the community a single point of contact for advice, assessment, referral and information about services. In addition it offered the health professionals community and other service providers 24 hours telephone support information and advice.

During 2003-04 SW 24 has developed to a point where it is now handling approximately 2000 calls per month in relation to mental health matters in the South West. It has become a single point of entry for all community adult mental health contacts with SWAHS and is developing the case management capabilities to ensure co-ordinated care for consumers. During 2003-04 planning has progressed for the SW 24 to support a number of key SWAHS functions including management of the Patient Assisted Travel Scheme and application of the technology to a number of other condition based programs being developed by SWAHS.

Services Planning
During 2003-04 SWAHS has significantly progressed services planning. The objective of service planning is to focus on the health needs of the SW population and identify the appropriate response by SWAHS. This will guide the development of service at various settings including the requirement for development of facilities.

It is anticipated that detailed services planning will be completed by SWAHS early in 2004-05 financial year.

Partnerships
In 2003-04 substantial progress has been made by SWAHS in the development of a key partnership with Disability Services Commission (DSC). The purpose of this partnership is to develop an integrated service delivery system for people with a disability who live in the South West.

This partnership with DSC is part of wider agenda for SWAHS in the provision of health and human services across the South West region.

Particular progress has been made between the two organisations in relation to the transfer of the responsibility for the provision of allied health services to children and adults with disabilities living in the South West.

A key dimension of the partnership between SWAHS and DSC will be the implementation of the Functional Development Model, which will include the policies, protocols, procedures and documentation in relation to agreed practice and care of people with disabilities. The Model will also use SW 24 as the entry and exit point for the system as well as facilitating case management and care co-ordination for consumers.

CORPORATE AND SUPPORT SERVICES
Shared Services
Corporate & Support Services has implemented the Shared Services area model of service delivery for the following areas;

- Human Resources and Industrial Relations.
- Hotel Services.
- Medical Imaging Services.
- Transport Services (including PATS, St John Ambulance and RFDS).
- Pharmacy Services.
- Materials Management (Supply and Purchasing).

A regional service delivery model for sterilising services is currently being examined.

Service Reforms
Reforms have been progressed in many Corporate Service areas. This has included the reconfiguration of services, exploration of alternative service delivery modes, job redesign, the implementation of new management structures and the introduction of agreed industry benchmarks in accordance with respective budget allocations. Consultative committees have been implemented to ensure the SWAHS receives input from employees, Unions and key stakeholders as service reforms are progressed.

Reduction of Corporate & Support Service Costs
The introduction of reforms has led to a reduction in the organisation's Corporate Service overhead costs thereby maximising available funding for clinical and community service areas. The primary focus in managing Corporate Service expenditures has been on the control of staffing costs, contract costs for services and supplies, and expenditure for consumables.

Quality/EQuIP
Corporate and Support Services are actively engaged in progressing the introduction of a number of policies, programs and processes which will ensure quality systems are in place to monitor service delivery for Corporate Service functions.

Corporate Services has developed a number of Key Performance Indicators to monitor the effectiveness of service delivery and to demonstrate that industry standards are being met. Corporate Services is also committed to achieving external independent recognition of these quality systems by accreditation under the EQuIP program.

Health Service Restructure Plan/Human Resource Plans
Corporate and Support Services developed and distributed the Health Services Restructure/Human Resource Plan in October 2003. The Restructure Plan was disseminated widely to staff, politicians, Shires and interested community groups within the South West in an endeavour to articulate the strategic direction of the organisation.

The Restructure Plan describes the reasons behind the establishment of the SWAHS and informs on the new *Healthy Communities* model of service delivery and the future strategic direction of the organisation. It explains the Health Service's focus on the consumer at the local community level and details the consultative processes that will occur to ensure community input into the development of health care services.

The Human Resources Plan provides specific detail regarding the processes to be followed to assist employees through the change management process occurring in SWAHS. This document details the rights and obligations of both the employee and employer and also documents the protections afforded to employees to ensure job security in a changing environment.

CLINICAL SERVICES

Safety & Quality
Following training of key personnel, the technique of root cause analysis was introduced during the year and has already demonstrated its power in the investigation of a number of incidents. Important lessons have been shared both within the Area Health Service and with other providers through the Office of Safety and Quality. It is expected that increasing numbers of staff will be trained in this technique because of its proven value in other health settings.

A commendable commitment to staff reporting of incidents has been demonstrated and falls prevention, medication safety and safety culture enhancement projects have been initiated.

The priority accorded these projects was determined in consultation with staff that attended the second South West Safety & Quality Forum at which a number of staff showcased their safety and quality improvement activities. The forums have been highly successful and will be held regularly in future.

The medical practitioner Credentialing and Clinical Privileging Committee has continued to evolve and formal policies and procedures aligned with the draft National Standards for this important work have been adopted by SWAHS.

We were pleased to recruit an Area Infection Control Coordinator and Ms Mary-Rose Godsell took up her appointment in April 2004.

An important quality assurance strategy for SWAHS is Third Party Accreditation through the ACHS EQuIP Program and the Health Service has been involved in a review of activities across a wide spectrum of functions and services in preparation for organisation-wide survey in November 2004.

Risk Management
As part of the risk management strategy of SWAHS a standardised risk assessment tool has been developed covering the key domains of clinical risk, staff risk and business risk. Wide application of this tool has greatly assisted the heightened risk awareness, which is evident throughout the Organisation, and is facilitating the development of integrated risk management and reporting systems. It is hoped that an integrated risk database will be introduced in the near future.

RECORDS MANAGEMENT

Record Keeping Plan
The South West Area Health Service Record Keeping Plan was approved in March 2003 subject to interim milestones, which will meet compliance with the State Records Act 2000. The introduction of the State Records Act requires all government agencies to provide a record keeping plan, which documents evidence of compliance with the principles and standards for records management. South West Area Health Service is currently working towards a March 2005 deadline to submit a revised record keeping plan.

External Audit
An external audit on controls and compliance of records management was completed by the Auditor General's Office in March 2004. The South West Area Health Service Record Keeping Plan was one of the first to be approved in Western Australia. As a result of this South West Area Health Service was selected as one of four government agencies to participate in this audit. The report *"Records Management in Government – A Preliminary Study"* was tabled in Parliament on 30 June 2004.

TRIM
TRIM, an electronic document management system was chosen as the tool to facilitate the management of the administrative records for the South West Area Health Service. TRIM is being utilised from the Department of Health as this will increase the information sharing across the health system. The implementation of TRIM has occurred at SWAHS Head Office based in Busselton. Initial stages of training have commenced.

Archiving
The South West Area Health Service implemented the archiving project in March 2004. A building on the Manjimup hospital site has been upgraded to meet the International Standards ISO 15489 for a central archival repository.

Since March, approximately 500 archive boxes have been created and over 6000 individual files have been created, registered and sentenced within TRIM. Two employees have been comprehensively trained in applying the retention and disposal schedules to each of the records. General Disposal Authorities approved by the State Records Commission will be used to provide the legal disposition or retention of records. As at the 30 June 2004, seven health sites have transferred inactive records to Manjimup for sentencing.

POPULATION HEALTH UNIT
As an integrated part of the South West Area Health Service, the Population Health Unit provides three key functions:
- Health protection.
- Research and evaluation.
- Monitoring and reporting emerging health issues.

At an Area level, this involves strategic alerts, information and advice on emerging health issues as well as supporting Area planning, monitoring and evaluation of health programs and initiatives.

Resources developed
The Population Health Unit has developed the following resources for the SWAHS:
- An epidemiological profile for 16 sites in the South West.
- A South West Human Epidemic Emergency Management Plan.
- A 'best practice' nutrition paper.
- Established an in principle MOU between the SWAHS and Divisions of GPs.
- An epidemiological profile of disability in the South West.
- An information file on management of meningococcal meningitis – distributed to all emergency departments in the SWAHS.
- A planning and evaluation toolkit for health promotion programs.
- Developed a South West and Peel Regional road safety evaluation plan.
- A preliminary SWAHS communication plan.
- A generic MOU template for health and community agencies.

Specific alerts
The Population Health Unit was responsible raising specific health alerts for the region. In particular the unit issued Ross River Virus epidemic proportion notifications, which required high level media activity, education and management support by the Unit.

Other alerts and information disseminations were provided for:
- SARS.
- Avian Flu.
- Pertussis.
- Meningococcal meningitis.

Health Protection
The Unit undertook a range of surveillance activities throughout the year including a significant investigation into an outbreak of sporotrichosis in the Margaret River region.

As part of its role in keeping the community informed of health issues, the Unit produced fortnightly and extraordinary reports to GPs and the Department of Education.

The Unit continued a number of prevention programs.

To assist in the coordination of the programs a Needle and Syringe Program Coordinator was appointed. The Unit also provided the regional coordination of the meningococcal vaccination program through South West schools and communities

Publications, presentations and awards
The Population Health Unit was responsible for disseminating health information through a range of mediums. The following presentations were presented over the reporting period:

- Journals and Publications:
  - Clinical and Infectious Diseases Journal (International): *Outbreak of Aeromonas Hydrophila Wound Infections Associated with Mud Football.*
  - World Transport Policy and Practice Journal.
  - Medical Journal of Australia: *Aetiology of Ross River Virus in Children* (pending acceptance).
- Presentations:
  - National Physical Activity Conference presentation.
  - Injury Control Council of WA, Community Injury Prevention Award 2003.
  - Joint Injury Prevention and Dept of Community Development - LINKX Conference WA presentation.
  - Rural and Remote Mental Health Conference presentation: (A Population Health Approach to Suicide Prevention).
  - State Falls Interest Group presentation.
  - Falls in Older People Workshop presentation.

State level coordination and support
The Population Health Unit also participated in a number of statewide projects and working groups. These activities included:

- Mental health promotion.
- Hepatitis C support.
- Needle and syringe exchange.
- Sexual health training for teachers and school health nurses.
- School and community immunisation.
- Child injury prevention.
- Falls prevention.
- Regional road safety.
- Healthy eating.
- Physical activity.

Grant applications waiting approval
As part of our ongoing pursuit for establishing partnerships in health, the following grants have been submitted for approval:

- National Suicide Prevention Strategy (Department of Health and Aged Care): *South West Suicide Prevention – Understanding and Building Resilience.*
- Adolescent Aboriginal Sexual Health – *Youth Blood Borne Virus Prevention* (joint application with Department of Education and Training).

COMMUNITIES FIRST
Healthy Communities
Funding was successfully sourced via the Commonwealth to establish the Healthy Communities project in the South West. To implement this program a partnership was established with the Peel South West Division of General Practice who are now the fund holders and employer.

A MOU has been signed between the Commonwealth, SWAHS and the Peel South West Division of GPs (PSWDGP) to establish the guidelines for the partnership. An advisory structure has been established to oversee the project and a project manager has now been appointed to the position.

The project will focus primarily on the communities that have a multi purpose service structure and by the end of the project the following outcomes will have been achieved.

The project aims to bring people together in participating communities and asks them to consider important questions about their community's health such as:

- How healthy is our community?
- What are important lifestyle and environmental factors that influence our community's health?
- How can we harness our community assets and resources to improve and sustain health?

At completion of the projects these resources will have been developed:

- Learning opportunities in a supportive environment.
- Funded networking events and workshops.
- A Healthy Communities tool kit.
- A Healthy Communities website.
- The provision of assistance to develop community action plans.

The project involves:

- The formation of a project advisory group to provide advice and guidance to the Project, membership to include representatives of PSWDGP, SWAHS, the DOH, Healthway, and other organisations as determined by the group.
- The completion of a detailed literature review incorporating a collation and analysis of current material on safe and health communities and community development theory.
- The conduct of community consultations in Augusta, Nannup, Pemberton and Boyup Brook on the current state of the communities in relation to safety and health, and their desired state of health and safety.
- The development of resources to facilitate the implementation of safe and healthy communities such as an information kit, a community profile and gap analysis pro forma, examples of effective strategies, worksheets and case studies to consolidate key concepts for service managers and community leaders, benchmarks and goals for communities, and evaluation materials.
- The development and pilot testing of a short training course for community leaders and other community members, health and other service managers, GPs and other primary health providers, on the implementation of the safe and healthy communities model.

Regional Managers Group

In December 2003, the Human Service Regional Managers endorsed the formation of a regional structure to be known as South West Community Services Planning Committee with the following purpose and objectives:

Purpose

To establish a South West Community Services Planning Committee with the aim of working in partnership to progress regional strategic agendas to benefit the communities of the South West.

Objectives

- To support human services agencies to build strategic alliances to review and support sustainable programs.
- To establish a South West Community Services Plan to benefit the communities of the South West.
- To ensure that all appropriate regional information is used to develop a Community Services Strategic Plan.
- Through contact and action to value add to the operational outcomes of the agencies within the forum.

Immediate actions

- In collaboration with South West Development Commission contribute to the development of a triple bottom line strategic plan with identified options for action.
- Promote an understanding of the role of each Human Service agency and how effective collaboration and communication can be established.

This is in line with the Social Policy Unit of Premier and Cabinets document “Harmonising Western Australians”.

Community Participation

In April 2004 a community consultation planning day was held with local representation from the South West to discuss a process to establish an effective community participation in health.

The participants at the planning day recommended establishing a Community Steering Group to plan a South West Health Forum to be held in September 2004. It was recommended that the forum would be run over two days with the following information about SWAHS:

- who we are;
- what we have done; and
- what we propose for the future.

The forum will also provide the participants with the opportunity to have input into:

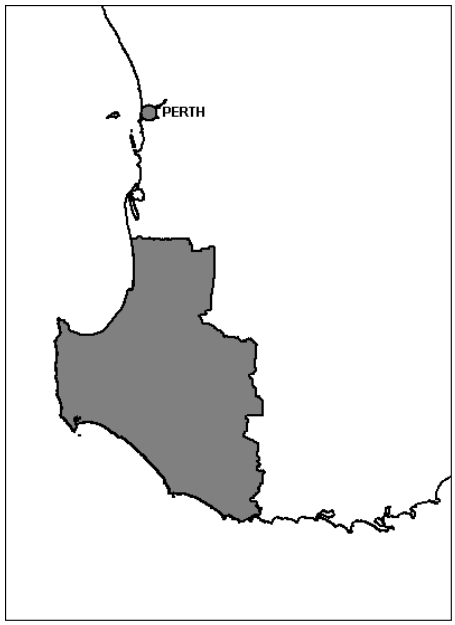
- the future directions for SWAHS,
- the principles that will guide the development of the health service, and
- the process for community participation.

The Health Forum will provide an opportunity to showcase the work currently being undertaken within the SWAHS including and will include a presentation of the health profile of the area including the health status and demographics of the communities and will also explain the ‘Healthy Communities’ concept. The Program Statements currently under development for the ten health conditions will be described and information will be provided on the future structure, budget and resources of SWAHS.

Participation in the Health Forum is currently being finalised in consultation with the Steering Committee and on advice from Dr Christina Gillgren, Director Citizens and Civic Unit within the Department of Premier and Cabinet. Considerable progress has now been made towards the running of a South West Health Forum in September 2004.

DEMOGRAPHY

Map 1: SWAHS region demography



The SWAHS covers an area of 23,978 square kilometres in the beautiful South West corner of Western Australia. SWAHS has the largest regional population in Western Australia with a population in 2003 of 135,450 (Australian Bureau of Statistics (ABS), 2004).

This represents 6.9% of the State's population and shows an average increase of 2,533 people per year since 1981.

The population density of the area is 5.6 people per sq km, which is greater than State average (0.8 per sq km; Country: 0.18 per sq km). The age-structure is similar to that of the State.

The indigenous population in 2002 was 2,894 who represent 2.1% of the SWAHS regional population.

There were 18,833 people born overseas in 2001. They represented 15.4% of the SWAHS region. In 2001, 3.9% of the regional population did not speak English at home.

Table 2: Communities and local authorities in the SWAHS

Local Authority	Population as at 2001	Projected Growth to 2006	Change (%)
Augusta–Margaret River	10,266	11,901	13.7
Boyup Brook	1,655	1,702	2.8
Bridgetown–Greenbushes	4,217	4,399	4.1
Bunbury	30,493	29,998	-1.7
Busselton	23,337	27,002	13.6
Capel	7,112	7,801	8.8
Collie	9,056	9,101	0.5
Dardanup	9,001	12,600	28.6
Donnybrook–Balingup	4,673	4,801	2.7
Harvey	18,611	20,698	10.1
Manjimup	10,246	10,800	5.1
Nannup	1,211	1,400	13.5

Data Sources
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
South West Development Commission (2001), Population Growth Projections.

Rugged coastline, world-class surfing and caves and wineries are some of the attractions for visitors. The major industries employing residents of the South West region are retail (15.0%), manufacturing (12.5%) and agriculture (including horticulture), forestry or fishing (10.6%). In total, there are 58,701 people in the labour force in this area, with 4,309 (7.3%) seeking work.

There are a high number of people, (63.6%) in labour and other manual occupations in the South West region compared to the State rate of 60.6%. A lower percentage of the population have a tertiary education qualification compared to the State (8.3% compared to 12.0%). The number of people in professional/managerial occupations was less than the State (34.4% compared to 38.1%).

There is significant variation in the occupational structures between all of the sites in the South West. Collie had the largest percentage of unemployed people (11.1%). Nannup had the largest proportion of people in professional or managerial occupations (38.3%). Small business and farming enterprises are included in this data classification for Nannup. There is increased growth and demands within the South West and the challenge will be to meet this demand with infrastructure and support services.

In 2002, the South West had a higher percentage of children aged 0-14 years of age and a greater proportion of people aged 65 years and over. The dependency ratio (i.e. the proportion of people aged less than 20 and more than 64 years of age) in the region was higher at 0.70 than the State dependency ratio of 0.65. This is higher than the State ratio of 0.65, indicating the workforce is supporting a higher ratio of young children and older people than the average for the State.

By 2010, the dependency ratio will have decreased to 0.65. Most of this change in the dependency ratio will be due to a decrease in the proportion of young children in the population. By 2011, the population of the South West area is anticipated to increase to 157,300; this is an increase of 16% from the estimated population in 2003.

In 2002 the life expectancy for males and females in this area was 80.6 years and 85.9 years. This compares favourably with the 1993 figures of 77.3 years and 83.2 years. (Note: These estimates are experimental.) While there is little variation between the rates of disease and death in the SWAHS catchment area compared to the State, there are some differences. Some of this variation may be attributed to socio-economic factors.

The socio-demographics within the South West area can be quite diverse. Rural communities differ in size from regional centres to small towns. Similarly there is a diverse range of occupations but often with fewer opportunities for teenagers and young adults than for those who live in the metropolitan area. Many rural centres have a high Aboriginal population but may also have sizeable ethnic community.

Factors influencing health

People living in the South West area experience similar health problems to those seen across the State with circulatory diseases, cancer, respiratory diseases, digestive diseases and injury and poisoning being major causes of hospitalisation and death.

Local variations do occur. It is widely accepted that health risk factors such as smoking, cholesterol, diet and exercise impact on health. For males and females, no risk behaviours for smoking, consumption vegetables and fruit and exercise rates had a higher prevalence compared to people in other parts the State.

The State weighted prevalence for males and females respectively who live in the South West area were diabetes (4.7%, 4.5%), heart disease (6.1%, 5.1%), arthritis (16.6%, 19.3%), cancer (4.5%, 5.8%), asthma (6.6%, 9.9%), other respiratory diseases (0.8%, 1.6%), stroke (0.8%, 1.2%), osteoporosis (0.0%, 4.0%) and mental health problems (6.2%, 13.5%). For both males and females, the prevalence of none of the chronic conditions mentioned above was higher compared to the State.

Based on the *Health and Well Being Survey*, the proportion of residents who accessed different types of health care were primary care services (81.9%), mental health services (4.6%), allied health services (38.5%) and hospital services (30.0%). These figures are similar to those for the State as a whole.

In the South West area, the prevalence of feeling a medium to very high level of psychological distress in males and females was 5.0% and 9.1% respectively. The proportion having no sense of control over their lives most of the time was 3.5% and 1.6%. These findings are similar to those of the State.

Mortality
The major causes of death in SWAHS are Circulatory diseases, Cancer, Injury and Poisoning, Respiratory diseases and Nervous System diseases for the years between 1998 and 2002 (DOH, 2004). Compared to the State rate, the number of male deaths due to transport related accidents and prostate cancer were greater than expected.

Compared to the State rate, the number of female deaths due to transport related accidents and diseases of arteries, arterioles & capillaries were greater than expected.

Morbidity
A total of 178,750 hospitalisations were registered in SWAHS 1998 –2002 inclusive. The five major reasons for hospitalisation from 1998 – 2002 were digestive diseases (14% of hospitalisations), musculoskeletal diseases (8% of hospitalisations), injury and poisoning (7.5% of hospitalisations), Complications due to pregnancy (7% of hospitalisations) and cancer (6.8% of hospitalisations).

Compared to the State rate, the number of male hospitalisations due to blood diseases, nervous system diseases, respiratory diseases, digestive diseases, musculoskeletal diseases, ill-defined conditions and injury and poisoning conditions were greater than expected. Of these related to injury the specific conditions were due to transport accidents, accidents caused by fire, accidents due to natural/environmental factors and other accidents.

Compared to the State rate, the number of female hospitalisations due to nervous system diseases, circulatory diseases, respiratory diseases, digestive diseases, genitourinary diseases, complication due to pregnancy, musculoskeletal diseases and ill-defined conditions were greater than expected. Some female hospitalisations due to specific injury conditions were also greater than expected compared to the State. These were due to transport accidents, accidents caused by fire, accidents due to natural/environmental factors and other accidents.

References
Codde, J (2003/2004) *Profile Of Health and Wellbeing*, Epidemiology Branch, Health Information Centre, DOH.
Codde, J (2003/2004) *Mortality in South West Public Health Region*, Epidemiology Branch, Health Information Centre, DOH.
Codde, J (2003/2004) *Hospitalisations in South West Public Health Region,* Epidemiology Branch, Health Information Centre, DOH.

http://intranet.health.wa.gov.au/corpdocs/hic/Epidemiology//
http://intranet.health.wa.gov.au/hic/epidemiology/New_ElectronicReports//
http://www.health.wa.gov.au/Publications/CWHS/index/html
http://www.swdc.gov.au

SWAHS –Population Health (2004). Epidemiological Profile Data, SWAHS

DISABILITY SERVICE PLAN OUTCOMES

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

Programs and initiatives
The SWAHS has aimed to improve its disability services plan during 2003-04, according to objectives outlined in the *Disability Service Act 1993*. This goal has been achieved through programs and initiatives run on behalf of the following key outcome areas:

Outcome 1
Existing services are adapted to ensure they meet the needs of people with disabilities
- Disability service issues are considered when new polices are developed and endorsed.
- Representatives participate in the reference group for the facility.
- Redevelopment to ensure adequate provision for disabled clients.
- All public events are now conducted in accessible venues.
- Appropriate patient transport can be organised for patients with disabilities.

Outcome 2
Access to buildings and facilities is improved
- Appropriate changes to existing facilities are made as funds become available.
- Regular reviews undertaken to ensure access to buildings and facilities.
- Hand rails/railings have been added to facilities.
- Toilets and bathrooms upgraded to allow wheelchair access.
- Access ramps added to entrances.

Outcome 3
Information about services is provided in formats, which meet the communication requirements of people with disabilities
- Availability of published materials in alternative formats such as Braille, IBM compatible disk, large print or audio cassette.

Outcome 4
Advice and services are delivered by staff that are aware of and understand the needs of people with disabilities
- New staff are provided with disability awareness training as part of the SWAHS orientation program.
- Programs are implemented to train health workers how to meet the needs of people with disabilities in particular settings as the need arises.

Outcome 5
Opportunities are provided for people with disabilities to participate in public consultations, grievance mechanisms and decision making processes
- Community consultation programs are undertaken as part of planning processes.
- Complaint procedures have been redesigned to meet the needs of clients who are unable to make written complaints.
- Grievance mechanisms are in place that allow people with disabilities to participate without impediment.

CULTURAL DIVERSITY AND LANGUAGE SERVICES OUTCOMES

The SWAHS seeks to ensure that language is not a barrier in the delivery of health services to all its clients. In recognising cultural diversity and the needs of those whose first language is not English, the SWAHS has undertaken the following:

- Allocated funding in the budget for Language Services Policy requirements.
- Translated important information about our services into the languages relevant to our client base.
- Trained staff to know what to do when they are presented with a Western Australian Interpreter Card.
- Implemented procedures to record feedback from clients.
- Installed conference/dual handset telephones/TTYs in public contact areas and interview rooms.
- Trained staff to work with interpreters.
- Consulted with appropriate groups before producing multilingual information for clients.
- Trained staff throughout the SWAHS in cross-cultural communication.
- Procedures to monitor and evaluate the Language Services Policy have been implemented.
- Guidelines are provided to staff on when to use telephone or on-site Interpreting services.

Programs and initiatives
During 2003-04 a program aimed at cross-cultural communication was undertaken. Guidelines for use of interpreters were included in orientation packages and relevant staff received on going training.

A language and cultural skills audit was also undertaken of consenting staff.

YOUTH OUTCOMES

Policy
The SWAHS acknowledges the rights and special needs of youth and endeavours to provide appropriate services, supportive environments and opportunities for young people.

The SWAHS is committed to the following objectives as outlined in *Action: A State Government Plan for Young People, 2000-03*:

- Promoting a positive image of young people.
- Promoting the broad social health, safety and well being 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 SWAHS runs school health programs aimed at general health as well as a school nutrition program. Other programs directed to support youth outcomes are the child and adolescent mental health program, Positive Parenting Program and Young Mums Group Program. Details of three of the programs are listed below.

Investing in Our Youth Program
In addition to regional programs the South West has been instrumental in setting up a community group within the greater Bunbury region with an emphasis upon on providing youth the ability to address and deal with mental health issues.

This program has widespread acceptance from both the community and local shires and we recognise the value of their ongoing support to this program.

This group known as the Greater Bunbury Focus Group became an incorporated body during current financial year.

School Nutrition Program
Apart from ongoing school programs the SWAHS has undertaken with local TAFE to run nutrition programs, through the South West Population Health Unit, facilitating their access to private practitioners to conduct program sessions.

School Health
The Health Service has invested significantly in the school health program throughout the region. 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. Continued emphasis is being placed on alcohol and other drugs in partnership with the South West Population Health Unit.

MAJOR CAPITAL WORKS

The projects outlined below are the capital works approved at the SWAHS level. Projects commenced and completed as part of the system-wide Capital Works Program are included in the Department of Health (Royal Street) Annual Report 2003-04.

Table 3: Major Capital Works Completed

Project Description	Year project began	Actual total cost	Estimated total cost
Organ Imaging Equipment	2004	$106,385	$106,385
Bridgetown Hospital Roof	2004	$67,265	$250,000
Total		$173,650	$356,385

Table 4: Major Capital Works Projects in Progress

Project Description	Expected year of completion	Estimated cost to complete	Estimated total cost
Fire Services Upgrade	2004	$110,622	$110,622

WASTE PAPER RECYCLING

The Western Australian government directs all agencies to operate paper recycling programs.

With the appointment of a Records Manager to the South West, this has provided greater clarity as to the need for retention of records. This program whilst in its infancy is reducing the level of print paper usage. The aim being to reduce the level of non-essential utilisation of paper based printing and records.

Non-confidential paper is being recycled into scrap paper pads for use within the SWAHS and or shredded which is distributed to individuals within the community for various purposes such as composting, mulching and worm farms.

In 2003-04 staff were educated to promote a greater awareness of when and why, the need to print, attempting to reduce the level of paper usage.

Introduction of smaller capacity confidential destruction bins to some SWAHS sites for authorised disposal of records was instigated, thus eliminating the need for multi transportation of paper based records and providing greater security over confidential records.

Introduction of the Planet Ark recycled print toner cartridges eliminating their destruction via local tips.

ENERGY SMART GOVERNMENT POLICY

Please refer to the Department of Health (Royal Street) report for this section.

REGIONAL DEVELOPMENT POLICY

Commencing in 2003-04 Government agencies were required to report on their contribution to the State's Strategic Planning Framework "Better Planning: Better Services". The Framework outlines four specific regional development objectives:

- Understanding, partnering and delivering better outcomes for regions.
- Growing a diversified economy.
- Educated, healthy, safe and supportive communities.
- Valuing and protecting the environment.

The Department of Health has developed a number of outcome priorities and strategies, which inform area health service strategic planning and service provision delivery.

Outcome Priorities

- Better health outcomes for residents of regional Western Australia.
- Substantial improvements in health and health conditions of those who are disadvantaged, including indigenous people.
- Demonstrated improvement in access to safe and sustainable regional health services.
- Greater numbers of health professionals resident in rural areas.

Service Strategies

- Implement and action a regional health service system based on strong and effective partnerships between three levels of government, other human service agencies, the non-government sector and private sector.
- Improved access to safe and sustainable primary and secondary treatment and prevention health services in regions, particularly for specialist and general practitioners, community and allied health services, and lifestyle education programs.
- Development of a regional network of health infrastructure that supports delivery of safe and sustainable health services to regional communities.
- Increased access to support services for regional people with mental illness, their carers and families.
- Development and strengthening of whole of government/community partnerships and initiatives aimed at improving the health and health conditions of indigenous people.
- Encouraging the Commonwealth Government and aged care industry to address the shortage of aged care beds.
- Attraction and retention of general practitioners, nurses, specialists and other health professionals to country areas.

Specific achievements and service provision initiatives implemented by the South West Area Health Service to address the Framework's objectives and the Department's outcome priorities and service strategies are:

- The South West Area Health Service has been a key organisation in the establishment of the "South West Community Services Planning Committee". This committee is comprised of Service Managers from those agencies providing human service. Its objectives are to build strategic alliances between agencies and to cooperate in circumstances that adds value to each agencies' services outcomes.

  A specific outcome from the Planning Committee will be to develop and implement a "South West Community Services Plan".

- A South West Health Forum is to be held in September 2004. A Community Steering Group has been formed to plan the Forum, which will allow the participants to provide input into the future directions of the SWAHS and provide guidelines outlining the process for continued community participation.

  Participation in the Health Forum is currently being finalised in consultation with the Steering Committee and on advice from the Director Citizens and Civic Unit within the Department of Premier and Cabinet.
  The forum supports the Area Health Service's key concepts of developing partnerships with and encouraging the involvement of the community in health service provision and planning, and in ensuring the community is provided with information that will enable them to understand the causes of ill health and what they can do individually and collectively to address these causal factors.

- The South West Area Health Service has establishment a partnership with the Peel South West Division of General Practitioners and the Commonwealth Department of Health and Aging to implement a "Healthy Communities Project". This project aims to bring people together in participating communities and have them consider important questions about their community's health.

The project will provide assistance in the development of community action plans and facilitate active involvement in the process of planning and creating a healthy and safe community. Six to eight sites will be involved in the project and will initially focus on Nannup, Boyup Brook, Pemberton, Augusta, Collie and Bridgetown.

- A review of health related transport issues across country WA is currently under way. This review has broad rural input and will be completed in December 2004. The review will play an important role in advising the area health service on specific transport issues and ways to improve access to health services.

- A free call telephone service, SW 24 was has been introduced for people in the South West who require immediate support with mental health issues. The service provides a single point of contact for advise, assessment, referral and information about services.

- The SWAHS has established a partnership with the Disability Services Commission to develop an integrated service delivery system for people with a disability who live in the South West.

In 2003-04 the South West Area Health Service commenced introducing evidence based approaches to service quality review and planning. This approach supports the key operational dimensions of equitable access to services, quality and evidence based.

EMPLOYEE PROFILE

The table below shows the annual average of full-time equivalent staff employed by the SWAHS by category and in comparison with 2002-03.

Table 5: Total FTE by Category

CATEGORY	2002-03	2003-04
Nursing Services	524.30	516.9
Administration & Clerical*	205.22	196.2
Medical Support*	120.22	109.1
Hotel Services*	218.03	202.7
Maintenance	22.34	29.7
Medical (salaried)	34.85	39.8
Medical (sessional)	0.00	0.00
TOTAL	1,124.96	1,094.4

* Note: These categories include the following:

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

RECRUITMENT

The SWAHS has been actively restructuring in many areas over the past year following the formation of the South West Area Health Service and the setting of priorities including "Health Communities" framework. Recruitment and selection activity has occurred for many of these positions and this has included redeployment processes where required.

Over the past few months there has been an intense period of recruitment activity in clinical management and nursing positions. The SWAHS has been successful in attracting a large group of acute care nurses from which appointments will be made as they become available over the next six months.

There continues to be difficulty recruiting to some of the allied health areas and for locum positions. The Health Service had several Enrolled Nurses that attained their Registered Nurse qualifications and are being supported through a graduate program.

The Health Service will continue to be able to access graduate nurses from the Edith Cowan University (Bunbury Campus) over the next few years. The number of graduating nurses is expected to increase to 100 during that period.

The benefits of an area wide service have resulted in improved identification and coordination of specialised staff being able to be deployed to areas where an interim need is required. Additional discretionary study leave and assistance has also been offered to retain and retrain staff in hard-to-recruit to areas.

Recruitment of medical staff into emergency medicine, general medicine, surgery and psychiatry remains difficult. The SWAHS relies on the extensive usage of recruitment agencies and overseas trained doctors, which necessitated the SWAHS being approved as an area of unmet need in these specialities.

STAFF DEVELOPMENT

SWAHS recognises the value of staff accessing professional development as a means to enhance employee performance and assisting the organisation to meet its strategic objectives.

Support for professional development:
- Consistent with relevant industrial awards or agreements.
- Consistent with the principles of fairness and equity.
- In accordance with identified training and development priorities.
- Consistence with organisational need.

Staff Development Programs
Staff development programs in 2003-04 covered different areas. Some details of the program are included below.

SWAHS Learning Opportunities and Outcomes Program (LOOP)
This is an integrated performance management and continuous learning system centred on best practice performance management principles.

The program addresses:
- Essential minimum competencies in safe practice.
- Skill gap identification.
- Promotes opportunities for flexible learning.
- Efficient use of resources in training and development.

Validator/Assessor Program
The SWAHS developed and implemented a one day validator/assessor program to provide staff with the knowledge, skills and competence to perform assessment, using SWAHS competency standards.

Basics Program
The SWAHS has developed and implemented an area wide Basics Program, which is a one day workshop to provide practical hands-on skills as a foundation for ongoing workplace based learning.

Topics of the program include:
- An overview of the SWAHS.
- An introduction to the SWAHS Learning Opportunities & Outcomes Program.
- Basic life support skills.
- Manual handling.

Occupational Safety and Health
This program includes:
- Restraint/Aggression Management – support for staff to attend “Train the trainer” programs in five person restraint.
- Training for all clinical staff in the Acute Psychiatric Unit in restraint training, including patient care assistance and security.
- Development and implementation of a Manual Handling program.

Clinical staff development courses
A number of clinical staff development courses were conducted in 2003-04.

An on-site learning opportunities and skills validation program is being supported by the Research & Development Unit with flexible whole of health service programs centred on agreed core competencies.

The Major Medical Incident Management and Support (MIMMS) program provided ongoing support of staff to attend international accredited Commanders and Team course.

The SWAHS further progressed the Revised Graduate Nurse Program.

Computer training
Training for Theatre Information Management Systems (TIMS) was sourced externally.

Professional development
Professional development course activities included:
- Certificate IV Health – An extension of the course accreditation was secured during the year with plans to transfer ongoing management to South Metropolitan Health Service Staff.
- A pilot Manager Induction Program was implemented.

WORKER'S COMPENSATION AND REHABILITATION

The following table shows the number of workers' compensation claims made through the SWAHS.

Table 6: Worker's Compensation and Rehabilitation claims

Employee category	Number of claims
Nursing Services	64
Administration and Clerical	7
Medical Support	23
Hotel Services	16
Maintenance	6
Medical (salaried)	2
Total	**118**

The above figures are a true record of all reported and documented workers' compensation claims throughout the SWAHS as provided by our insurers Riskcover. There are no hidden or cost absorbed strategies as all compensable injuries are processed as per requirements.

Occupational injury prevention programs and/or measures
A major indicator is manual handling injuries predominantly involving female nursing staff in the 39-55 age bracket. A key strategy in prevention is the coordinated training programs, including manutension, site and patient specific investigation and subsequent education sessions, and equipment evaluation. The manual handling coordinator has implemented an area wide education and training regime for staff.

The Research and Development Unit was established at an area wide level in January 2004. SWAHS Manual Handling Policy and Manual Handling Programmes have since been developed.

Key components include:
- Adoption of principles of Manutention for training programs.
- Addition of Manual Handling trainer (FTE 0.2) with manutention qualifications.
- Development and commencement of training program.
- Plan to identify, train and support a network of "Manual handling Coaches" within every work site by October 2004.
- Increase FTE in June – Manual Handling Coordinator now 0.6 FTE, Manual Handling Trainer now 0.5 FTE.

Employee rehabilitation programs and/or measures
The SWAHS Injury Management policy and specific guidelines endeavour to maximise the outcome and minimise the risk for both the employee and employer. Our objective is a reduction of lost time through injury by applying early intervention strategies that increase the potential of an injured employee's safe return to work.

Induction and orientation training assist in reducing risks associated with new and existing employees in providing a safer environment that allows a more responsible proactive approach to injury prevention. Mandatory training throughout the SWAHS is also a preventative measure towards ensuring a safe as possible working environment. Staff awareness and reporting of identified hazards in the workplace and their early rectification, contribute to minimising the possibility of staff injury.

On site inspections and task specific training has also been an effective strategy in the early intervention of identified risk to employees. These inspections, training and subsequent recommendations have been provided by qualified employees within the SWAHS or by an external provider.

Early rehabilitation intervention, and support for injured workers continue to prove valuable in effective return-to-work programs. A combination of in house and externally provided programs specific to each worker has been used effectively depending on the nature and severity of the injury. Injury management systems, policies and procedures were implemented at an Area wide level. All injured employees are contacted within 48 hours of injury and returned to work within a four week timeframe where possible in line with industry best practice.

Specialised roles have been introduced at an Area wide level to facilitate successful rehabilitation of injured employees (Manager Workforce Risk, Coordinator Injury Management and a Manual Handling Coordinator). External rehabilitation providers are utilised for speciality cases requiring intensive interventions.

INDUSTRIAL RELATIONS

In 2003-04, SWAHS underwent significant changes in terms of restructuring the services provided. Consequently these changes had flow on effects for all departments and staff.

Prior to the changes being made, extensive consultation occurred with Unions to facilitate the changes and as a result Consultative Committees across all areas were developed.

The committees consist of Union, Employee and Management representatives to ensure full consultation is adhered to in accordance with industrial provisions. The committees will continue to meet until all local issues concerning the proposed changes have reached resolution.

Corporate staff have also been made aware of State government services currently under review to provide a statewide shared service system.

A Risk Management Policy incorporating a Risk Assessment Code was introduced at a local level. The policy and code includes significant sections on Staff Risks, in particular risks that would involve complete loss of services or prolonged suspension of work due to industrial activity/disputes.

At the highest levels of risk, CEO notification is required immediately to enable priority action to be taken. All internal risks are reported through to an Issue Resolution Officer to ensure Area wide notification and resolution.

EQUITY AND DIVERSITY

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 SWAHS 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, religion or political conviction, or age, and by promoting equal opportunity for all people.

Programs and initiatives
The SWAHS 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 outcomes outlined below.

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

- The SWAHS EEO Management Plan and associated Equality and Diversity policies are currently under review.
- All SWAHS employees are aware of and have access to Health Service-specific EEO policies as well as Codes of Ethics and Conduct, which serve to underpin principles of valuing equity and diversity.

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

- EEO documentation is included in orientation kits for all new SWAHS employees. On appointment all employees receive appropriate resource material for signing and returning and receipt of EEO brochures is documented. The majority of new employees attended formal EEO training sessions in 2003-04.
- The Manager Workforce Risk, SWAHS has been delegated the roles of EEO Contact Officer for all employees.
- All SWAHS employees, including potential employees, are aware of issue resolution procedures and Public Sector Standards in Human Resource Management concerning bias and discrimination in employment practices. This is achieved through receipt of appropriate resource material for signing, returning and filing.
- No breaches of the Equal Opportunity Act occurred within the organisation for 2003-04.

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

- All SWAHS management and supervisory position Job Description Forms specify EEO responsibilities as essential selection criteria. All other positions specify EEO knowledge and awareness in the desirable criteria.
- EEO employee data is stored electronically and updated on a monthly basis.
- Management monitors data trends to ensure the diversity of the workforce is catered for. Data is 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 SWAHS has been able to meet these goals.

Table 7: Equity and Diversity

Plan or Process	Level of Achievement
EEO Management Plan	Under development.
Organisational plans reflect EEO	Organisational Service Level Agreements reflect key performance indicator requirements for EEO.
Policies and procedures encompass EEO requirements	All current policies encompass EEO requirements. Specific policies have been developed concerning non-tolerance of bullying, harassment and discrimination in the workplace.
Established EEO contact officers	Under development.
Training and staff awareness programs	Implemented through orientation program for all new employees. Reorientation of existing staff under review. Performance developments programs address deficiencies through external training.
Diversity	Policies and programs under review.

EVALUATIONS

SWAHS joined the Evaluation and Quality Improvement Program (EQuIP) accreditation under the standards of the Australian Council for Health Care Standards in November 2004.

A self-assessment was completed in November 2003 and enabled SWAHS to identify gaps against the EQuIP standards and put action plans in place for improvement.

The incorporation of the South West Area Health Service Risk Assessment Code (RAC) during self assessment has enabled the organisation to prioritise activities and actions based on consistent risk assessment. Action plans with risk ratings have been established and are being reviewed quarterly to monitor and report progress to Executive Management Group and staff.

Each service level agreement holder in SWAHS has an action plan and clearly articulates responsibility for complying with minimum standards.

Monthly reports to the CEO include the review of performance measures embodied in the service level agreements which ensures comprehensive evaluation of services provided within SWAHS.

Table 8: Evaluations

Title	Purpose of evaluation	Main Outcomes	Action taken or Proposed
Quality Indicator Program	To establish a routine reporting system for quality indicators for SWAHS	Systems for data analysis and reporting reviewed for ability to sustain routine reports within an automated system.	As individual SLA holders consolidate service delivery and performance measures are developed the quality indicator reports will increase.
Evaluation and Quality Improvement Program	External review of services against nationally recognised standards for healthcare in Australia.	SLA holders utilising common framework to improve performance through established action plans that are monitored quarterly.	SWAHS is scheduled to go through organisation wide survey by external experts as one whole organisation in November 2004.

FREEDOM OF INFORMATION

The South West Area Health Service received and dealt with the following applications under the Freedom of Information guidelines during 2003-04.

Table 9: Freedom of Information

Applications	No.
Total received 2003-04	183
Carried over from 2002-03	1
Granted - full access	76
Granted - partial or edited access[1]	102
Withdrawn by applicant	Nil
Refused	5
Other[2]	Nil

1. Includes the number accessed in accordance with section S28 of the Act.
2. Includes exemptions, deferments or transfers to other departments/agencies.

Types of documents held by the SWAHS
The types of documents held by the SWAHS include:

- medical records/client files;
- corporate and financial records;
- human resource and industrial relations files; and
- policies and procedures.

How to obtain information
The public can access documents by making an application in accordance with the *Freedom of Information Act 1992*. An application form is available to those who do not feel comfortable applying in writing. Patients can access their own medical record in accordance with SWAHS policy or in accordance with the Freedom of Information Act.

Process for obtaining information:

- Applications may be lodged with Executive Services, SWAHS.
- Applications are processed in accordance with the requirements of the Freedom of Information Act.
- Application forms, letters and brochures detailing the application, internal review and external review processes are available.

Applications and initial inquiries can be lodged with:

Freedom of Information Coordinator
South West Area Health Service
PO Box 5301
BUNBURY WA 6230
☎ (08) 97221511

RECORD KEEPING

Standard 2, Principle 6 of *State Records Principles and Standards 2002* requires that the South West Area Health Service include within its annual report an appropriate section that addresses the minimum compliance requirements of its Record Keeping Plan. These are:

- The efficiency and effectiveness of the SWAHS record keeping systems is evaluated not less than once every five years.
- The SWAHS conducts a record keeping training program.
- The efficiency and effectiveness of the record keeping training program is reviewed from time to time.
- The SWAHS induction program addresses employee roles and responsibilities in regard to their compliance with the department's record keeping plan.

The SWAHS will be implementing the following activities to ensure that all staff are aware of their record keeping responsibilities and compliance with the Record Keeping Plan:

- Training on various aspects of the SWAHS record keeping plan will be delivered to all staff.
- Record keeping system users will be made aware of their State Records Act responsibilities.
- New employees will be provided with information to ensure they are aware of their role and responsibilities in terms of record keeping.
- Performance indicators will be developed to measure the efficiency and effectiveness of the SWAHS record keeping systems.
- Reviews of the South West Area Health Service's record keeping systems will be addressed progressively by 2010.

PUBLIC INTEREST DISCLOSURES

Appointments
Due to the size and complexity of the Department of Health, a number of Public Interest Disclosure (PID) Officers have been appointed to enable appropriate and easy reporting access for all staff.

To date the following PID officers have been registered with the Office of the Commissioner for Public Sector Standards:

- Wheatbelt Health Region, Mr Mark Hazelgrave.
- North Metropolitan Health Region, Mr Jon Frame.
- South Metropolitan Health Region, Ms Tracey Bennett and Ms Diane Barr.
- Women and Children's Health Service, Ms Claire Goodson.
- Department of Health, Royal Street, Mr Les Marrable.

To streamline the communication between the Department and the Office of the Commissioner for Public Sector Standards on matters that fall within the jurisdiction of the *Public Interest Disclosure Act 2003*, the Department has appointed Mr Les Marrable, Manager Accountability, 189 Royal Street, East Perth as a Principal PID officer.

Procedures
The Department of Health has advised and will continually update staff on processes and reporting procedures associated with the *Public Interest Disclosure Act 2003* through global e-mails, staff seminars and staff induction presentations.

Progress has been made in publishing the Department's internal procedures on the intranet and full access is planned for July 2004.

The Department of Health's procedures are compliant with the Public Sector Standards Commission guidelines.

Protection
The Department of Health has ensured all PID officers are fully aware of their obligations to strict confidentiality in all issues related to public interest disclosure matters.

Files and investigation notes are maintained in locked and secure cabinets at all times with strict access to authorised personnel only.

All efforts are made to ensure maximum confidentiality is maintained in all investigations and follow up action.

Any staff member who attempts to take reprisal action or victimise another officer who has made, or intends to make, a disclosure of public information will be subject to legal action under the *Public Interest Disclosure Act 2003*.

ADVERTISING AND SPONSORSHIP

In accordance with Section 175ZE of the *Electoral Act 1907,* the Commission incurred the following expenditure in advertising, market research, polling, direct mail and media advertising:

Total expenditure for 2003-04 was $64,566.

Table 10: Advertising and Sponsorship - Expenditure by Category

Expenditure Category	Person, Agency or Organisation Name	Amount	Total
Advertising Agencies	Marketforce	$29,408	**$50,146**
	Wavelength	$5,480	
	Seabreeze Communication	$1,122	
	International Medical Recruitment	$11,007	
	College of Emergency Medicine	$1,041	
	Sensis P/L	$2,088	
Market Research Organisations	Nil	Nil	**Nil**
Polling Organisations	Nil	Nil	**Nil**
Direct Mail Organisations	Nil	Nil	**Nil**
Media Advertising Organisations	Rural Press Regional Media	$3,081	**$14,420**
	South West Printing & Publishing	$6,510	
	Radio West Broadcasting	$4,620	
	Boyup Gazette	$109	
	Harvey Community Radio	$100	

PUBLIC RELATIONS AND MARKETING

Activities
Health committees and consultation groups were established within the 16 South West communities as a collaborative approach to address social health issues in the communities.

A number of health forums were held throughout 2003-04 involving community members, stakeholders including local government and external agencies.

Participation is being maintained in external forums such as health and awareness promotional days and agricultural shows as a means of promoting health and raising the profile of hospitals, community health and related services within the region. This is assisted through the print media and by radio with the appearance of regular time slots on air and a weekly/monthly article appearing in local community newspapers.

During 2003-04 a number of community surveys were undertaken. In conjunction with outcomes derived from other collaborative mechanisms they will assist in determining future directions based upon community needs.

Dissemination of information
Information was disseminated by the following means:

- Use of local press and radio to inform the community on health issues and new service developments.
- Health promotion activities at local agricultural shows and health and promotional days.
- Health promotion 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 key local stakeholders, local government representatives and representatives of the Aboriginal communities.
- Health Service Managers and Health Professionals engaging local key community identities/groups in discussions on health and related need issues of local communities.

PUBLICATIONS

The SWAHS produced many internal and external publications during 2003-04 to provide the general public with information on health initiatives, facilities and other relevant areas of service delivery. These publications took the form of pamphlets, brochures, posters, newsletters and booklets, and included the following:

- The SWAHS staff newsletter, which is emailed to all staff and available at each facility in hard copy.
- Patient information brochures, and brochures on patient's rights and responsibilities are available at each hospital and primary care unit.
- Brochures on specific conditions and treatments are available from hospital and primary care unit.
- The SWAHS Annual Report 2002-03, is available on the Department of Health website, www.health.wa.gov.au.
- A journal published article by Daman Wallace under the heading Australian Flexible Learning Framework titled 'Flexible Learning Leaders 2003 Final Draft'.

RESEARCH AND DEVELOPMENT

The development of an area wide Research and Development function for SWAHS has resulted in the development and implementation of programs on continuous basis.

This has enabled the implementation of the SWAHS Learning Opportunities and Outcomes Program (LOOP). It is an integrated performance management and continuous learning system centred on best practice performance management principles.

On site learning opportunities and skills validation programs is being supported by the Research & Development Unit with flexible whole of health service programs centred on agreed core competencies.

These programs include:

- Basic life support/advanced life support.
- Internal and external emergency management.
- Epidural/pain management.
- Neonatal resuscitation.
- Medication.
- Ventilation.
- Triage.
- Restrain/aggression management.
- Manual handling.

During 2003-04 there has also been the implementation of a pilot orientation program.

INTERNAL AUDIT CONTROLS

Internal Audit has the role of accountability adviser and independent appraiser, reporting directly to the Director General of Health. Audits conducted were generally planned audits, however on occasion, management initiated audits or special audits were also conducted. The reviews were predominantly compliance based, however a number of operational (performance-based) reviews were conducted. Under the direction of the Director, Corporate Governance, external consultants have conducted a number of audits. All audits conducted aim to assist senior management in achieving sound managerial control.

Specific internal audits conducted over the period include:

Compliance Audits

- Hospitality, alcohol and entertainment expenditure.
- Use of mobile phones.
- Subscriptions, memberships and professional development.
- Financial returns.
- Asset management.
- Purchasing practices – Population Health Division.
- EMHS (Bentley Health Service) Hospital Ladies Auxiliary.

FAAA Health Checks

- EMHS.
- SMHS.
- NMHS.
- Population Health Division.

Payroll Audits

- Department of Health (Royal Street Divisions).
- Fremantle Hospital Health Service.
- NorPay.
- Drug and Alcohol Office.
- EMHS (Bentley Health Service).
- NMHS (Graylands, Osborne Park and Sir Charles Gairdner Hospital).
- WCHS.

Country Audits
- Goldfields and South East Coastal Health Region.
- Kimberley Health Region.
- South West Health Region.
- Great Southern Health Region.
- Pilbara Gascoyne Health Region.
- Financial Statement Close Process/Annual Report Preparation Plan.
- VMP payments.

FAAA Health Checks
- Wheatbelt.
- Goldfields.
- South West.

Operational Audits
- Call Centre (Poisons Information Centre, Health Direct and Drug & Alcohol Information Centre).
- Workers Compensation & Injury Management: Bunbury Health Service.
- Employee support strategies.
- Highly specialised drugs: WCHS.

Information Systems Audits
- EMHS: Ultra Accounts Receivable Module.
- Population Health: Physical Security.
- Telehealth report.

IT Controls.
- NMHS (Osborne Park Hospital, Graylands Selby Lemnos and Special Care Health Service).
- SMHS (Armadale Health Service).
- RPH Payroll.

Information Systems Reviews
- SMHS (Rockingham/Kwinana Health Service).
- Midwest Murchison Health Region.
- Wheatbelt Health Region.

Special/Management Initiated Audits
- Family Planning Association (Phoenix).
- PSOLIS project.
- Planning Models.

PRICING POLICY

The majority of the Department of Health's services are provided free of charge. Some classes of patients are charged fees, for example patients who have elected to be treated as private patients and compensable patients (i.e. patients for whom a third party is covering the costs, such as patients covered by workers' compensation or third party motor vehicle insurance). Where fees are charged, the prices are based on legislation or government policy, or on a cost recovery basis.

The Department's Funding and Reporting Directorate sets a schedule of fees each year to cover patients for whom fees apply. These fees are incorporated into the *Hospital (Service Charges) Regulations 1984* and the *Hospital (Service Charges for Compensable Patients) Determination 2002.*

RISK MANAGEMENT

SWAHS Risk Management policy has been approved by the Executive Management Committee and complies with Treasurers Instruction 825 and Australian/New Zealand Standard 4360:1999.

The accompanying Risk Assessment Code (RAC) is also now in use by all areas of SWAHS.

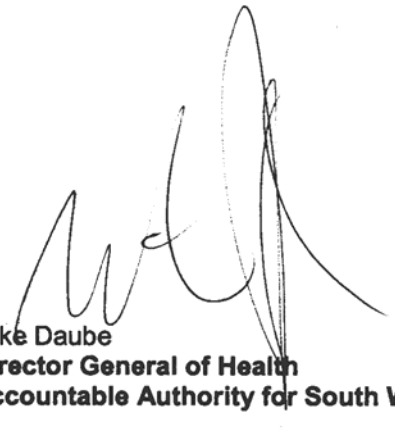
Work is continuing to evaluate the Riskcover 'Riskbase' risk register program for use by SWAHS in drawing together the three risk streams of Clinical Risk, Staff Risk and Business Risk.

The SWAHS Risk Working Party meets regularly to review all aspects of risk management and quality in line with the groups established 'Terms of Reference'.

Clinical and staff risks are effectively managed through dedicated systems and business risk is monitored through the internal/external audit process and insurance programs. Other minor areas of risk are identified through the 'Issues Management Program'.

SOUTH WEST HEALTH BOARD
CERTIFICATION OF PERFORMANCE INDICATORS
FOR THE YEAR ENDED 30 JUNE 2004

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 2004.



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

31 August 2004

AUDITOR **GENERAL**

INDEPENDENT AUDIT OPINION

To the Parliament of Western Australia

SOUTH WEST HEALTH BOARD
PERFORMANCE INDICATORS FOR THE YEAR ENDED JUNE 30, 2004

Audit Opinion
In my opinion, the key effectiveness and efficiency performance indicators of the South West Health Board are relevant and appropriate to help users assess the Health Service's performance and fairly represent the indicated performance for the year ended June 30, 2004.

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

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

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

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

D D R PEARSON
AUDITOR GENERAL
November 29, 2004

INTRODUCTION

Health is a complex area and is influenced by many factors outside of the provision of health services. Numerous environmental and social factors as well as access to, and use of, other government services have positive or negative effects on the health of the population.

The Performance Indicators outlined in the following pages, address the extent to which the strategies and activities of the Health Services contribute to the broadly stated health outcome, which is, the improvement of the health of the Western Australian community by:

- A reduction in the incidence of preventable disease, injury, disability and premature death and the extent of drug abuse.
- The restoration of the health of people with acute illness.
- An improvement in the quality of life for people with chronic disease and disability.

Different divisions of the Health Services are responsible for specific areas of the three outcomes. The largest proportion of Health Services activity is directed to Outcome 2 (Diagnosis and Treatment). To ascertain the overall performance of the health system all reports must be read. All entities contribute to the whole of health performance. These reports are:

- **Department of Health (Royal Street).**
- **Metropolitan Health Service.**
- **Hawthorn Hospital.**
- **South West Area Health Service.**
- **Peel Health Services.**
- **WA Country Health Service.**

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

Prevention and Promotion

- Community and public health services.
- Mental health services.
- Dental health services.

Diagnosis and Treatment

- Hospital services (emergency, outpatient, inpatient and rehabilitation).
- Nursing post services.
- Community health services (post discharge care).
- Mental health services.
- Dental health services.
- Obstetric services.

Continuing Care activities

- Services for frail aged and disabled people (eg Aged Care Assessments, outpatient services for chronic pain and disability, Nursing Home Type hospital care).
- Services for those with chronic illness.
- Mental health services.

There are some services, such as Community Health, which address all three of the components.

Note

Results are presented as Aboriginal and non-Aboriginal population figures where appropriate. Comparisons across time are provided where possible and appropriate.

TREASURER'S INSTRUCTION 904

Amendments to Treasurer's Instruction 904 'Performance Indicators' specify requirements for performance reporting by departments, statutory authorities and agencies effective 25 May 1999.

For clarification, the Department of Health is required to report:

- key efficiency indicators for each output, relating outputs to inputs consumed; and
- key effectiveness indicators for each outcome, relating outputs to outcomes achieved.

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.

CONSUMER PRICE INDEX (CPI) DEFLATOR SERIES

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

The calendar year series uses a similar methodology but is based on the average of the June and September quarter.

The financial year costs for the annual report can be adjusted by applying the following formula. The result will be that financial data is converted to 2001-02 dollars:

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

Table 11: Index figures for the financial and calendar years

Calendar year	1998	1999	2000	2001	2002	2003
Index (Base 2001)	90.41	91.68	95.93	100.00	103.02	105.75
Financial year	1998-99	1999-00	2000-01	2001-02	2002-03	2003-04
Index (Base 2001-02)	89.60	91.65	97.06	100.00	103.24	105.48

EFFICIENCY INDICATOR NOTE

All calculations for efficiency indicators include administrative overheads in accordance with relevant Treasury Instructions and are for annual reporting purposes only. These figures are not to be used for any other comparative purpose.

OUTCOME 1: Reducing the incidence of preventable disease, injury, disability and premature death and the impact of drug abuse

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

The services (outputs) of the Metropolitan Health Services as well as the other divisions of the Department of Health are contained on the table below. The greatest proportion of the services provided by the South West Area Health Service is directed to children. Other health services and divisions of Department of Health, for example Royal Street Division provide more services directed to prevention and surveillance of disease including those effecting the adult population.

Table 12: Respective Indicators by Health Sector for Outcome 1

	Metropolitan Health Service	Peel Health Services	South West Area Health Service	WA Country Health Service	Royal Street Division
The achievement of this component of the health objective involves activities which:					
1. Reduce the likelihood of onset of disease or injury by:					
• Immunisation programs	101A 101B	101A 101B	101A 101B	101A 101B	
• Childhood screening & appropriate referrals	105 106				
• Safety program					R101
2. Reduce the risk of long term disability or premature death from injury or illness through:					
• Surveillance					R101
3. Monitoring the incidence of disease in the population to ensure primary health measures are effective:					
	102 103 104	102 103 104	102 103 104	102 103 104	
4. Monitoring and surveillance of suicide rates and drug & alcohol use:					
					R101

101A: Rate of fully immunised children 0-6 years

This indicator reports the rate of fully immunised children 0-6 years.

Rationale
The community sets a very high priority on ensuring that the health and well being of children are safeguarded. It is important not only to restore them to good health when they become ill but also to maintain a state of 'wellness' that allows them to develop to full potential. One of the key components of this is to attempt to ensure that every child experiences the full benefit provided by appropriate and timely immunisation against disease provided by internationally recognised vaccination practices.

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.

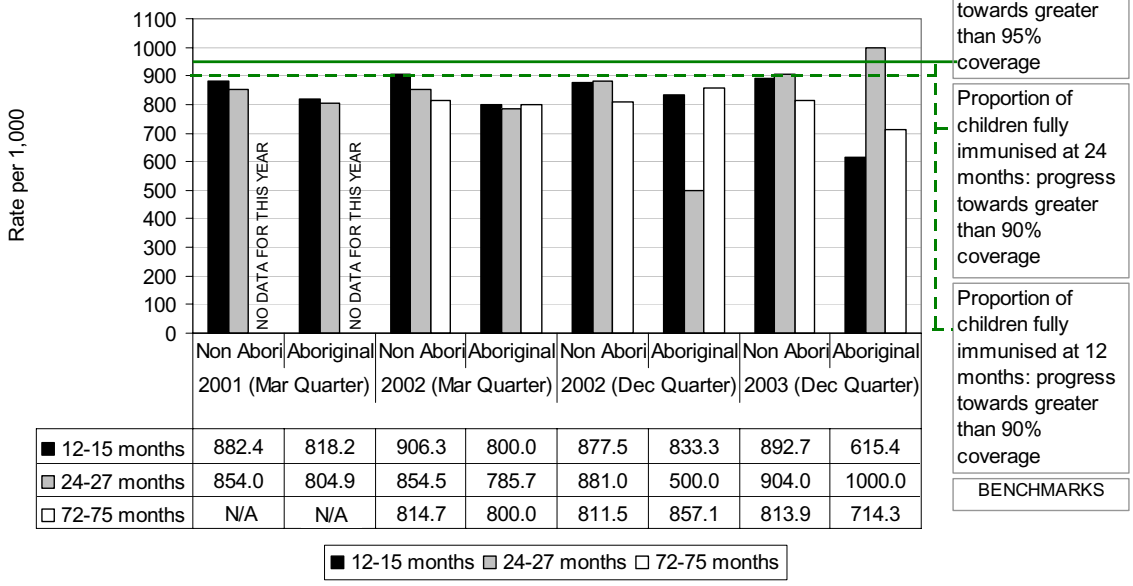
The agreed targets in the Public Health Funding Agreement are as follows:

- Proportion of children fully immunised at 12 months – progress towards greater than 90% coverage.
- Proportion of children fully immunised at two years – progress towards greater than 90% coverage.
- Proportion of children fully immunised at six years - progress towards greater than 95% coverage.

Results
The targets were reached in both the Aboriginal and non-Aboriginal 24-27 month age groups in 2003 and in the non-Aboriginal 12-15 month age group during the 2002 March quarter.

While the coverage in most age groups for the Aboriginal population was lower than the non-Aboriginal population, exceptions to this were the 72-75 month age group in the December quarter of 2002 and the 24-27 month age bracket during the December quarter of 2003. This could be an artefact of the low Aboriginal numbers in the South West community.

Figure 1: Rate of fully immunised children



	Non Abori 2001 (Mar Quarter)	Aboriginal 2001 (Mar Quarter)	Non Abori 2002 (Mar Quarter)	Aboriginal 2002 (Mar Quarter)	Non Abori 2002 (Dec Quarter)	Aboriginal 2002 (Dec Quarter)	Non Abori 2003 (Dec Quarter)	Aboriginal 2003 (Dec Quarter)
12-15 months	882.4	818.2	906.3	800.0	877.5	833.3	892.7	615.4
24-27 months	854.0	804.9	854.5	785.7	881.0	500.0	904.0	1000.0
72-75 months	N/A	N/A	814.7	800.0	811.5	857.1	813.9	714.3

Data Sources
Australian Childhood Immunisation Register (ACIR).
Australian Bureau of Statistics (ABS) population figures.

101B: Rate of hospitalisations with an infectious disease for which there is an immunisation program

This indicator reports the rate of hospitalisations with an infectious disease for which there is an immunisation program.

Rationale
There are specific communicable diseases which are preventable by vaccine and thus routine vaccination or immunisation is recommended by the National Health and Medical Research Council (NHMRC).

To provide additional information about the effect of immunisation programs, the rates of hospitalisation for treatment of the infectious diseases of measles, mumps, rubella, diphtheria, pertussis, poliomyelitis, hepatitis B and tetanus are reported.

The first three conditions are reported by 0-17 year old age groups while the remaining are reported by 0-12 year old age groups. There should be few or no individuals hospitalised for infectious diseases when an immunisation program is effective.

Results
During 2002, pertussis, or whooping cough, was the most frequently reported vaccine-preventable disease. However, while there were two non-Aboriginal and three Aboriginal episodes across the South West area in 2002, there were none in 2003.

The absence of vaccine-preventable diseases in the South West area 2003 indicates that the vaccination and immunisation schedules are effective.

Table 13: Rate of hospitalisations per 1,000 with an infectious disease for which there is an immunisation program – 0-12 years

	2000		2001		2002		2003	
	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal
Diphtheria	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Hepatitis B	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Pertussis	0.04	0.00	0.16	0.00	0.08	2.90	0.00	0.00
Poliomyelitis	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Tetanus	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

Table 14: Rate of hospitalisations per 1,000 with an infectious disease for which there is an immunisation program – 0-17 years

	2000		2001		2002		2003	
	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal
Measles	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Mumps	*	*	*	*	*	*	0.00	0.00
Rubella	*	*	*	*	*	*	0.00	0.00

* Not reported in previous years

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

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

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

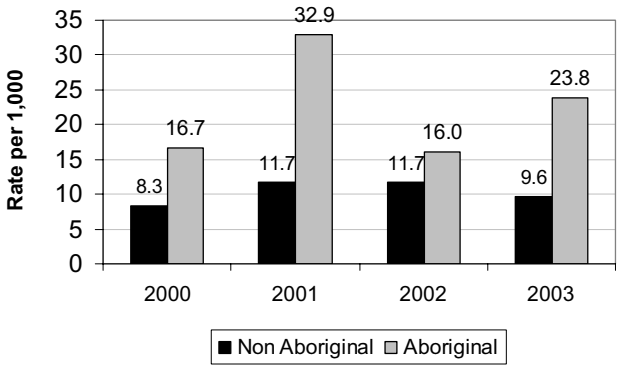
Rationale
Gastroenteritis is a condition for which a high number of patients are treated either in the hospital or in the community. It would be expected that hospital admissions for this condition would decrease as performance and quality of service in many different health areas improves.

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

It is important to note, however, that other factors such as environmental issues will also have an impact on the prevalence of transmissible diseases like gastroenteritis.

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

Figure 2: **Rate of hospitalisation for gastroenteritis 0-4 years**



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

Map 2: SWAHS region

Results
While hospitalisation rates for Aboriginals in 2003 were 23.8 per 1,000, this was based on only eight gastroenteritis hospitalisations. The non-Aboriginal rate was 9.6 per 1,000.

Four of the eight South West admissions to hospitals for Aboriginals with gastroenteritis occurred for patients living in the Bunbury area. This indicates the need for Aborigines living in this area to become more involved in Community Health Programs.

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

104: Rate of hospitalisation for respiratory conditions

This indicator reports the rate of hospitalisation for respiratory conditions.

Rationale
The percentage of children aged 0-4 years who are admitted to hospital per 1,000 population for treatment of respiratory conditions such as acute bronchitis, bronchiolitis and croup and the rate of all persons admitted for the treatment of acute asthma may be an indication of primary care services or community health strategies, such as health education.

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

Note
This indicator measures hospital separations of individuals living in a given location who may attend a hospital in their own or another Health Service. The performance of the Health Service providing the hospitalisation is not being measured.

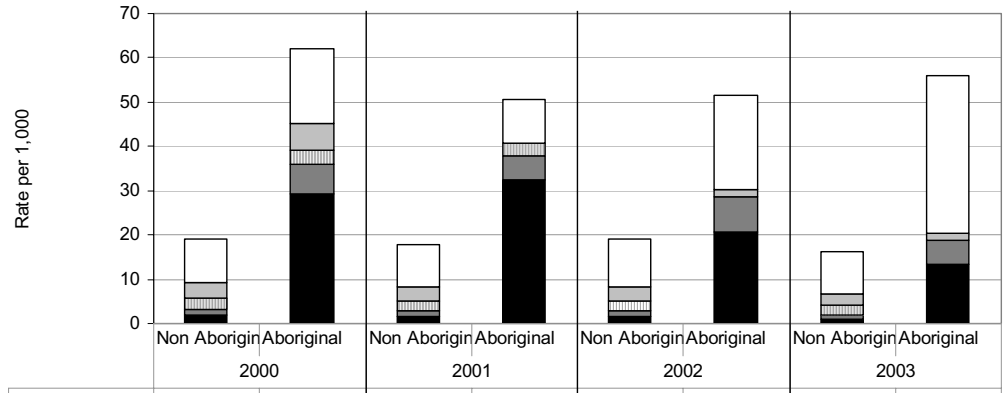
Results of Acute Asthma
Hospital rates for asthma have remained comparable over the past four years with Aboriginal rates generally higher than non-Aboriginal rates.

In the South West area in 2003, the Aboriginal rates were more than three times the non-Aboriginal rates for the 0-4 and 19-35 year old age brackets, with twelve and four hospitalisations respectively. The ten Aboriginal hospitalisations in the 35+ age group produced a rate more than twelve times the non-Aboriginal rate.

Contributing to the high Aboriginal rates for acute asthma in 2003 were six hospitalisations (one client had four admissions) in the Harvey Yarloop area in the 35+ age group. There were four admissions in both Bunbury and Warren Blackwood areas (one client with two admissions) in the 0-4 years.

In the South West the Aboriginal population is small and therefore minimal change in admissions to hospital will have a significant effect upon admission rates (one client having multiple admissions as indicated above).

Figure 3: Rate of hospitalisation for acute asthma (all ages)



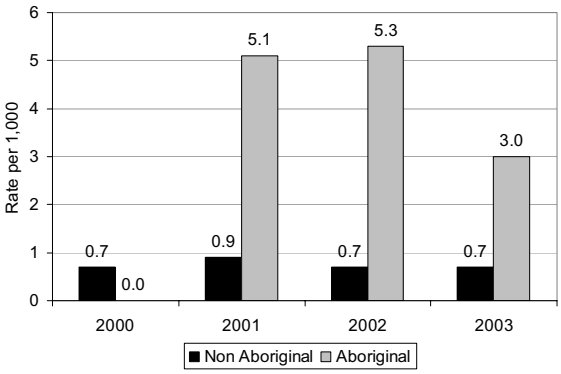
	2000		2001		2002		2003	
	Non Aborigin	Aboriginal	Non Aborigin	Aboriginal	Non Aborigin	Aboriginal	Non Aborigin	Aboriginal
0 to 4 years	9.9	16.7	9.6	10.1	10.8	21.3	9.5	35.7
5 to 12 years	3.6	6.2	3.3	0.0	3.3	1.5	2.7	1.5
13 to 18 years	2.3	2.9	2.2	2.7	2.0	0.0	2.0	0.0
19 to 34 years	1.4	6.9	1.3	5.4	1.5	8.0	0.9	5.5
35+ years	1.9	29.2	1.5	32.5	1.5	20.7	1.1	13.3

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

104: Rate of hospitalisation for respiratory conditions (cont)

Results of Acute Bronchitis

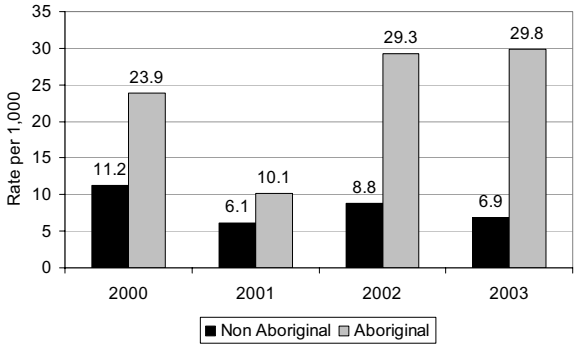
Figure 4: Rate of hospitalisation for acute bronchitis 0-4 years



While results show that admission rates in 2003 for acute bronchitis per 1,000 are higher in the Aboriginal than non-Aboriginal population, hospitalisation for acute bronchitis is extremely low across the South West area: the admissions for the whole population were comprised of one Aboriginal and six non-Aboriginal episodes.

Results of Bronchiolitis

Figure 5: Rate of hospitalisation for bronchiolitis 0-4 years



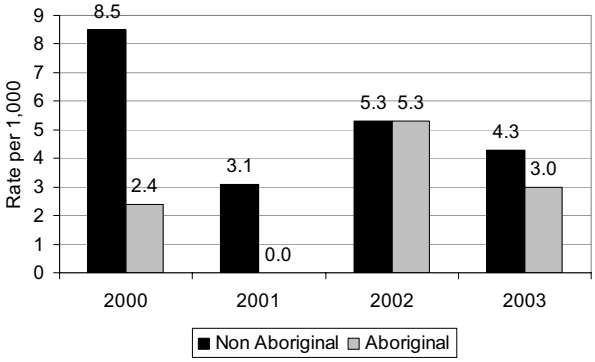
Hospitalisation rates for young children have remained comparable to last year with over four times more Aboriginals requiring hospitalisation than non-Aboriginals.

Within the South West area, the Aboriginal hospitalisation rates for patients living in the Wellington area were significantly higher. Whilst the South West has significantly smaller Aboriginal population than other regions, Wellington has the highest proportion of the group residing within its boundary.

Map 3: The South West Area Health Service

Results of Croup

Figure 6: Rate of hospitalisation for croup 0-4 years



It is worthy of note that unlike the previous respiratory conditions examined, non-Aboriginal hospitalisation rates for croup have been either the same or higher than Aboriginal rates over time. Aboriginal hospitalisation numbers for croup, however are very low.

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

110: Cost per capita of Population Health Unit

This indicator reports the cost per capita of Population Health Unit.

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

Population Health Unit supports individuals, families and communities to increase control over and improve their health. These services and programs include:

- supporting growth and development, particularly in young children (community health activities);
- promoting healthy environments;
- prevention and control of communicable diseases;
- injury prevention;
- promotion of healthy lifestyle to prevent illness and disability;
- support for self-management of chronic disease; and
- prevention and early detection of cancer.

Table 15: Cost per capita of Population Health Unit

	2003-04
Actual cost	$80.27

Data Source
Local Health Service Data Systems.

Note
As this is the first year this indicator has been reported previous years' comparisons are not available.

OUTCOME 2: Restoring the health of people with acute illness

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

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

Table 16: Respective indicators by health sector for Outcome 2

	Metropolitan Health Service	Peel Health Services	South West Area Health Service	WA Country Health Service	Royal Street Division
The achievement of this component of the health objective involves activities which:					
1. Ensures that people have access to acute care services by:					
• Prioritising access to elective surgery	200		200	200	R207
• Providing timely transport to hospital					R206
• Prioritising access to dental services	212 213				R202
2. Provide quality diagnostic services and treatment by:					
• Providing appropriate and quality admitted patient services when people are ill or injured.	201 204 205 206 208	204 205	201 204 205 206 208	204 205 206 208	R201 R204 R205
• Providing timely and appropriate ambulatory services for people who do not require admitted patient care.			202	202	
• Providing appropriate obstetric and neonatal care.	207		207	207	

200: Elective surgery waiting times

This indicator reports the elective surgery waiting times.

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

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

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

Note
This reporting rationale conforms with the Australian Health Care Agreement Reporting requirements.

Whilst the number on the waitlist has been reduced from 4807 (2003) to 4420 (current year) the ability to reduce this number is dependant upon the availability of specialists, their lists and theatre time.

This indicator is not comparable to previous year, as data has been reported in a different format.

Table 17: People admitted from the waiting list during 2003-04

	Category 1			Category 2			Category 3		
	Cases	%	Median waiting time in days	Cases	%	Median waiting time in days	Cases	%	Median waiting time in days
Percentage admitted within desirable time	795	94	7	1230	93	16	2206	98	29
Percentage not admitted within desirable time	54	6		98	7		37	2	

Data Source
Central Wait List Bureau (CWLB).

Table 18: People remaining on the waiting list as 30 June 2004

	Category 1			Category 2			Category 3		
	Cases	%	Median waiting time in days	Cases	%	Median waiting time in days	Cases	%	Median waiting time in days
Percentage not admitted (still on the waiting list) but waiting time within desirable time	42	76	12	82	56	83	414	86	90
Percentage not admitted (still on the waiting list) and waiting time over the desirable time	13	24		65	44		70	14	

Data Source
Central Wait List Bureau (CWLB).

201: Proportion of emergency department patients seen within recommended times

This indicator reports the proportion of emergency department patients seen within recommended times.

Rationale
When patients first enter an Emergency Department, they are assessed by specially trained nursing staff who judge how urgently treatment should be provided. The aim of this process known as triage is to ensure treatment is given in the appropriate time. This should prevent adverse conditions arising from deterioration in the patient's condition. Treatment within recommended times should assist in the restoration to health either during the emergency visit or the admission to hospital which may follow Emergency Department care.

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

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

Results
This indicator measures the percentage of patients in each triage category who were seen within the time periods recommended by the Australasian College for Emergency Medicine (ACEM).

The target waiting time in each triage category was met, showing good performance.

Table 19: Proportion of emergency department patients seen within recommended times

	Target	2000-01	2001-02	2002-03	2003-04
Triage category 1 (immediately)	100%	100.00%	100.00%	100.00%	100.00%
Triage category 2 (within 10 minutes)	80%	82.70%	69.30%	84.10%	80.92%
Triage category 3 (within 30 minutes)	75%	81.50%	78.00%	83.80%	84.03%
Triage category 4 (within 60 minutes)	70%	78.30%	76.80%	83.30%	84.95%
Triage category 5 (within in 2 hours)	70%	91.20%	92.20%	96.10%	96.61%

Data Source
Local Hospital Data System.

202: Rate of emergency presentations with a triage score of 4 and 5 not admitted

This indicator reports the rate of emergency presentations with a triage score of 4 and 5 not admitted.

Rationale
When patients attend hospitals they are initially received in Emergency Departments where assessment, treatment and a decision on whether to admit for further care takes place.

Triaging is an essential function of the Emergency Department where many people may present simultaneously. The aim of triage is to ensure that patients are treated in order of their clinical urgency and that patients receive timely care. While urgency refers principally to time-critical intervention and is not synonymous with severity, more patients triaged 1 and 2 are admitted to hospital than those with a score of 4 and 5.

Without care provided by staff in an Emergency Department, the restoration to health of people with an injury or a sudden illness may take longer or result in death. This indicator reports the rate of people presenting to the Emergency Department given a triage score of 4 or 5 who were assessed, and treated but did not need admitted hospital care ie were restored to health. These are the people who receive primary care in the emergency department. It does not include patients whose sickness or injury requires admitted hospital care.

This indicator reports the number of patient presentations, to hospitals where the Emergency Department does not have 24-hour cover by doctors who are trained in Emergency Medicine. The numbers of presentations include doctor attended assessments and treatment as well as nursing assessment and treatment.

Results
90% of triage 4 and 95% of triage 5 were restored to health after treatment in the emergency department.

Table 20: Rate of emergency presentations with a triage score of 4 and 5 not admitted

	2002-03	2003-04
Triage category 4	85%	90%
Triage category 5	93%	95%

Data Source
Local Health Service Data System.

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

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

Rationale
Good medical and/or surgical intervention together with good discharge planning will decrease the likelihood of unplanned hospital readmissions. An unplanned readmission is an unplanned return to hospital as an admitted patient for the same or a related condition as the one for which the patient had most recently been discharged.

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

Results
The 2003 readmission percentages for the South West Area Health Service hospitals are low. These results suggest that good clinical practice and discharge planning are in place.

Note
A return to hospital is a readmission only if the reason for this admission is the same or is related to the condition treated in the previous admission. Only actual separations, not statistical discharges, are included.

Table 21: Rate of unplanned hospital readmissions within 28 days to the same hospital for a related condition

	2002-03	2003-04
Unplanned Readmissions Rate	1.60	2.00

Data Source
Hospital Morbidity Data System.

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

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

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

While it is inevitable that some patients will need to be readmitted to hospital within 28 days, in an unplanned way, a high percentage of readmissions may indicate that improvements could be made to discharge planning or to inpatient therapy protocols.

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

Results
Social issues such as closures in milling throughout the Warren Blackwood area and a downturn in mining in Collie contributed to the increased rate for 2003. However, the readmission rate of 5.71% for the South West Area Health Service is well within the ACHS threshold rate.

Of the 16 unplanned readmissions, eight of these were attributable to two individual clients with multiple readmissions. These results suggest that good clinical practice and discharge planning are in place.

Note
A return to hospital is a readmission only if the reason for this admission is the same or is related to the condition treated in the previous admission. Only actual separations not statistical discharges are included.

Table 22: Rate of unplanned hospital readmissions within 28 days to the same hospital for a mental health condition

	2002-03	2003-04
Unplanned Readmissions Rate	2.70	5.71

Data Source
Hospital Morbidity Data System.

206: Rate of post-operative pulmonary embolism

This indicator reports the rate of post-operative pulmonary embolism.

Rationale
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 and is one of 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.

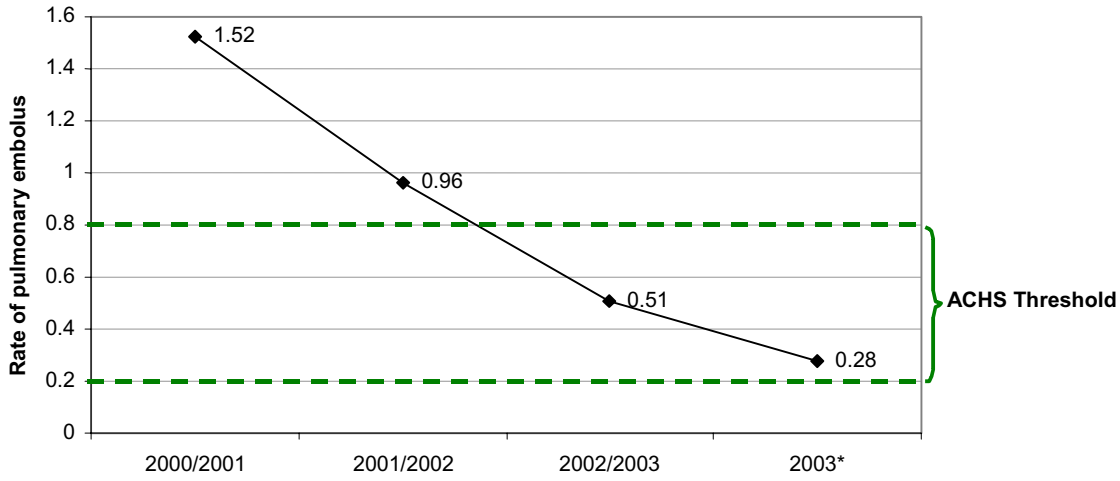
The monitoring of post-operative complications is important in ensuring the optimum recovery rate for people with acute illness.

Results
The rate of pulmonary embolus in the South West Area Health Service has been decreasing over time. For the recent twelve month periods of 1 April 2002 to 31 March 2003 and the 2003 calendar year, the rates of pulmonary embolus have fallen well within the ACHS threshold.

Only one pulmonary embolus was reported across the South West Area Health Service in 2003.

Despite the rate of pulmonary embolus falling well within the ACHS threshold, the South West Area Health Service intends to further enhance procedures to continue this downward trend.

Figure 7: Rate of pulmonary embolus



*These figures have been audited for the calendar year as opposed to a twelve month window of April to March as in previous years.

Data Source
Hospital Morbidity Data System.

207: Survival rate of live born babies with an APGAR score of 4 or less five minutes after delivery

This indicator reports the survival rate of live born babies with an APGAR score of 4 or less five minutes after delivery.

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

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

This indicator reports on the survival rate of babies with a low APGAR score at birth (an APGAR score of 4 or less at 5 minutes post delivery). A baby with a low APGAR is more likely to be premature with immature lungs or its mother had a difficult delivery than one with a higher score. This indicator measures the rate of discharge of babies with a low APGAR score and is a measure of how the care in hospital restores the baby to health.

Results
There were only three babies in the South West Area Health Service with an APGAR score of four or less five minutes after delivery in 2003, all of whom survived. While this indicates good hospital care, the numbers are too small to be conclusive.

208: Survival rates for sentinel conditions

This indicator reports the survival rates for sentinel conditions.

Rationale

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

The comparison of 'whole of hospital' survival rates between hospitals may not be appropriate due to differences in mortality associated with different diagnoses and procedures. Three 'sentinel' conditions, therefore, are reported for which the survival rates are to be measured by specified age groups.

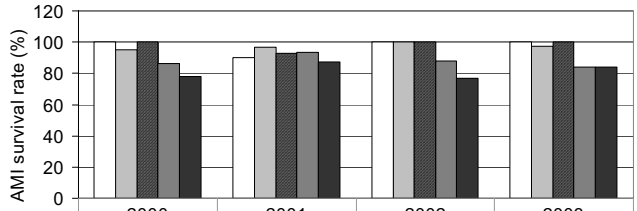
For each of these conditions – stroke, heart attack - also known as acute myocardial infarction (AMI), and fractured hip, also known as fractured neck of femur (FNOF) - a good recovery is more likely when there is early intervention and appropriate care. Additional co-morbid conditions are more likely to increase with age therefore better comparisons can be made if comparing age slices not the whole population.

This indicator measures the hospitals' performance in relation to restoring the health of people who have had a stroke, AMI, or FNOF, by measuring those who survive the illness and are discharged well. Some may be transferred to another hospital for specialist rehabilitation or to a hospital closer to home for additional rehabilitation at the end of the acute admission.

Results

Survival rates for AMI and stroke have remained relatively constant over the years. Variances in the survival after FNOF, in the 80+ age group over time could be due to the small numbers of patients within those groups. FNOF survival rates have increased over the last three years in the 80- plus age group. The high survival rates indicate effective clinical care.

Figure 8: Rate of acute myocardial infarction (AMI) survival



	2000	2001	2002	2003
0-49	100.00	90.00	100.00	100.00
50-59	95.00	96.55	100.00	97.22
60-69	100.00	93.10	100.00	100.00
70-79	86.05	93.18	87.80	84.21
80+	77.78	87.10	76.60	83.78

Figure 9: Rate of fractured neck of femur (FNOF) survival

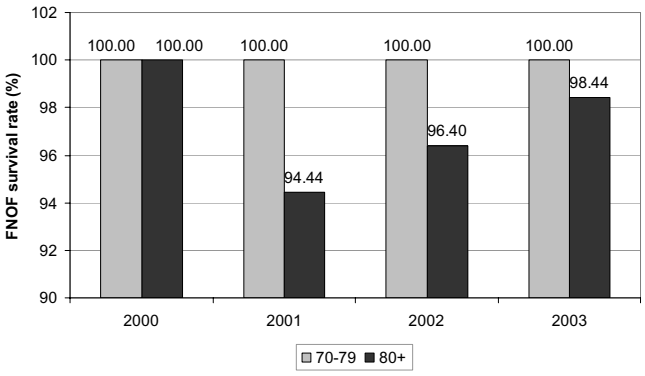
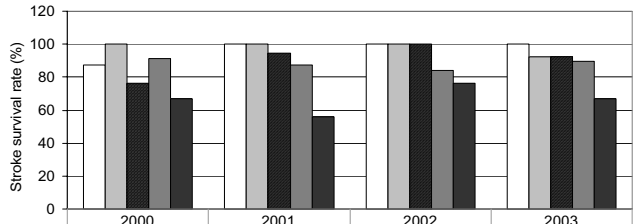


Figure 10: Rate of stroke survival



	2000	2001	2002	2003
0-49	87.50	100.00	100.00	100.00
50-59	100.00	100.00	100.00	92.31
60-69	76.50	94.70	100.00	92.31
70-79	91.30	87.30	84.20	89.74
80+	66.70	56.10	76.10	66.67

Data Sources

Hospital Morbidity Data System.

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

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

Rationale
The use of casemix 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 not necessarily equal the number of casemix adjusted separations. The magnitude of the difference will depend on the complexity of the services provided.

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.

Table 23: Average cost per casemix adjusted separation

	2001-02	2002-03	2003-04
Actual cost	$2,728	$3,330	$3,367
CPI adjusted	$2,728	$3,226	$3,192

Data Sources
Hospital Morbidity Data System (HMDS).
Local Health Service Financial System.

225: Average cost per non-admitted hospital based service

This indicator reports the average cost per non-admitted hospital based service.

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

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

Table 24: Average cost per non-admitted hospital based service

	2001-02	2002-03	2003-04
Actual cost	$128	$106	$128
CPI adjusted	$128	$102	$121

Data Sources
HA215, Data System.
Local Health Service Financial System.

226: Average cost per non-admitted occasion of service in nursing posts

This indicator reports the average cost per non-admitted occasion of service in nursing posts.

Rationale
The effective use of nursing post resources can help minimise the overall costs of providing health care, or mean that more patients can be treated for the same amount of resources.

Because of variations in patient characteristics and service types between sites and across time, there may be differences in service delivery costs. It is important to monitor the unit cost of these specialised service units, which often provide the only health service facility in rural or remote localities.

Table 25: Average cost per non-admitted occasion of service in nursing posts

	2001-02	2002-03	2003-04
Actual cost	$71.00	$150.81	$142.96
CPI adjusted	$71.00	$146.08	$135.53

Data Sources
Local Health Service Data System.
Local Health Service Financial System.

227: Average cost per bed-day for admitted patients (selected small rural hospitals)

This indicator reports the average cost per bed-day for admitted patients (selected small rural hospitals).

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

Most small hospitals do not have the advantage of economies of scale. Minimum nursing services may have to be rostered for very few patients. Accordingly the hospitals with limited beds which provide acute and Nursing Home Type Patient (NHTP) care report patient costs by bed-days.

Due to a methodology change the 2001-02 data shown within this table represents unaudited information.

Table 26: Average cost per bed-day for admitted patients (selected small rural hospitals)

	2001-02	2002-03	2003-04
Actual cost	$349	$498	$527
CPI adjusted	$349	$482	$499

Data Sources
Local Health Service Data System.
Local Health Service Financial System.

228: Average cost of Patient Assisted Travel Scheme (PATS)

This indicator reports the average cost of PATS.

Rationale
The aim of PATS is to assist permanent country residents to access the nearest medical specialist and specialist medical services.

Subsidy is provided towards the cost of travel and accommodation for patients and where necessary an escort for people who have to travel more than 100 kilometres (one way) to attend medical appointments.

Without travel assistance many people would be unable to access the services needed to diagnose or treat some conditions.

Table 27: Average cost of PATS

	2002-03	2003-04
Actual cost	$89.00	$90.62
CPI adjusted	$86.21	$85.91

Data Sources
Health Service records.
Local Health Service Financial System.

229: Average cost per bed-day in authorised mental health unit

This indicator reports the average cost per bed-day in Bunbury Regional Hospital - Acute Psychiatric Unit.

Rationale
The efficient use of hospital resources can help minimise the overall costs of providing health care, or mean that more patients can be treated with a similar amount of resources.

Because of variations in patient characteristics between sites and across time, there may be differences in service delivery costs. In order to ensure quality and cost effectiveness, It is important to monitor the unit cost (cost per bed day) of admitted patient care in authorised mental health units. These are hospitals or hospital wards devoted to the treatment and care of patients with psychiatric, mental or behavioural disorders; that are by law able to admit people as involuntary patients for psychiatric treatment.

Table 28: Average cost per bed-day in authorised mental health unit

	2003-04
Actual cost	$995

Data Sources
Mental Health Information System.
Local Health Service Financial System.

Note
As this is the first year this indicator has been reported previous years' comparisons are not available.

OUTCOME 3: Improving the quality of life of people with chronic illness and disability

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

If a client suffers from a chronic illness they have access to services and supports through a range of organisations, including non-government organisations, which are managed through the DOH (Royal St). The effectiveness and efficiency measures for those supports are reported by DOH (Royal St).

The Health Services in general will only come into contact with those clients when they become acute and require acute care. When this care is completed they are returned to the community where they can again receive ongoing (continuing) care through the other agencies and services provided.

To enable people with chronic illness or disability to maintain as much independence in their every day life as their illness permits, services are provided to enable normal patterns of living. Supports are provided to people in their own homes for as long as possible but when extra care is required long term placement is found in residential facilities. The intent is to support people in their own home for as long as possible. This involves the provision of clinical and other services which:

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

The significant areas of continuing care provided by the Health Services are in the areas of Mental Health Community Care and Aged Care. The Mental Health Community Care consists of multi-disciplinary teams including mental health nurses providing continued and regular contact with clients to ensure, prevent or delay the onset of acuity and thereby allowing them to continue to maintain as close to normal lifestyles as possible.

An important part of ensuring that services are provided to those frail aged who need them is assessment by Aged Care Assessment Teams (ACAT). Without equal access to ACAT assessments appropriate services/aged care may not be provided.

Where a person has a disability, including a younger person, they will receive support through a number of agencies including Disability Services Commission and the Quadriplegic Centre. The DOH also provides assistance to those with disabilities through the provision of Home and Community Care (HACC) services. The HACC program is administered through the DOH (Royal St). The effectiveness and efficiency indicators for HACC are reported by DOH (Royal St). The Health Services will provide acute services to those with disabilities under Outcome 2.

Table 29: Respective Indicators by Health Sector for Outcome 3

	Metropolitan Health Service	Peel Health Services	South West Area Health Service	WA Country Health Service	Royal Street Division	Hawthorn Hospital
The achievement of this component of the health objective involves activities which:						
1. Supporting people with chronic and terminal illness by:						
▪ Providing palliative care services.					R304	
▪ Providing support services to people with chronic illnesses and disabilities.	304	304	304	304		See Hawthorn Hospital report
▪ Providing appropriate home care services for the frail aged.					R302 R303	
• Providing community support for those with mental illness.	301 302	301 302	301 302	301 302		

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

This indicator reports on clients with a principal diagnosis of schizophrenia or bipolar disorder who had contact with a community-based public mental health non-inpatient services within seven and fourteen days following discharge from hospital.

Rationale

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

These community services provide ongoing mental health treatment and access to a range of rehabilitation and recovery programs outside of the hospital setting that reduce the length of hospital stays, thereby improving the patient's independent functioning and quality of life.

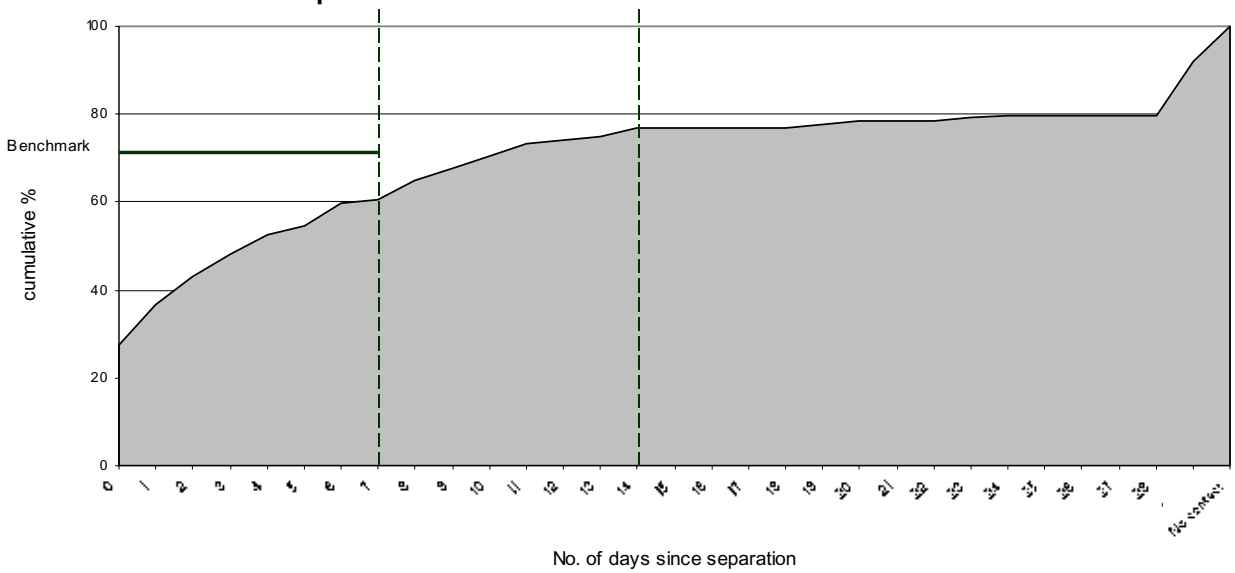
This type of continuing care for persons who have experienced an acute psychiatric episode requiring hospitalisation is essential after discharge to maintain or improve clinical and functional stability. Community psychiatric services can provide effective treatment in circumstances that would otherwise require hospitalisation should relapse occur, reducing the frequency of planned and unplanned hospital admissions.

A severe and persistent mental illness refers to clients who have psychotic disorders with severe and chronic impairment in the conduct of daily life activities. It includes those with a diagnosis of schizophrenia or bipolar disorder.

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

There is currently no agreed target benchmark figure for the proportion of clients to be seen within a seven-day period. At this stage, there appears to be some consensus among clinicians in Western Australia that a reasonable target is around 70%. The seven-day threshold and 70% target benchmark figure are pending an empirical review on their appropriateness.

Figure 11: **Cumulative percentage of schizophrenic and bipolar disorders separations from public designated mental units having contact with a community-based public mental health non-inpatient service**



Data source

Mental Health Information System, Health Information Centre, Department of Health WA.

In 2003, 60% of discharges with a principal diagnosis of schizophrenia or bipolar disorder from South West Area Health Service units resulted in contact with a community-based public mental health non-inpatient service within 7 days of discharge. Of this group 27% had contact on the day of discharge. A further 17% had contact within 8 to 14 days following discharge, which gives a total of 77% of contacts within a two-week period. Fifteen percent had contact within 15 or more days and 8% did not have any contact within a given year.

No contact may indicate that referrals, following discharge, were made to the private sector (e.g. General Practitioners, Private Psychiatrists, Private Psychologists) for which data on contacts is not available.

Explanatory notes

1. Target Group: WA residents discharged from inpatient units with a principal diagnosis of schizophrenia or bipolar disorders (ICD-10-AM range of codes F20 to F29 or F31).

2. Inpatient units: includes all Child and Adolescent, Adult, and Older Person programs at Bunbury Hospital.

3. Excludes people who:
   - Died in hospital.
   - Were transferred to another inpatient unit.
   - Re-admitted on the same day (includes statistical separations and intra hospital transfer).
   - Left against medical advice.
   - Had a same day admission or were admitted, treated and discharged on the same day.

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

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

Rationale
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, that may result in extended hospitalisation. While this can be clinically appropriately in certain circumstances people with mental illness have improved quality of life if their condition is managed with few admissions to hospital. Maintaining good mental health which may include community mental health management is preferred to 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 psychiatric (mental health diagnosis) admissions to public hospitals.

An indication of good performance would be admissions that require fewer bed days. If mental health clients are managed appropriately through community psychiatric services, the length of each hospitalisation is reduced as both clients and clinicians have confidence in the client's ability to manage in the community.

Results
The median bed days for persons under mental health community management who were admitted to hospital in the South West Health Service area was 11. Caution must be made when making comparisons to previous years as the numbers are small.

This performance indicator should be considered in conjunction with performance indicator 205.

Note
These results will not be comparable to the results in the 2002-03 Annual Report as the methodology for calculating this indicator has changed slightly over the past year.

Data for the period 1999 represents unaudited information and has been included within this table for presentation purposes.

Table 30: Median bed-days for persons under mental health community management admitted to hospital

	1999	2000	2001	2002	2003
Median bed days	8	10	8	8	11

Data Sources
Hospital Morbidity Data System.
Mental Health Information System.

304: Rate of recommended care outcomes for aged care assessments

This indicator reports the completed outcomes against the total number of accepted referrals to an ACAT.

Referred ACAT Clients
An ACAT client is usually an older person who is experiencing difficulty managing at home and/or is considering admission to residential care. However on occasion a younger person may seek ACAT assessment due to long term disability where residential care or community support is considered appropriate.

ACATs receive referrals from any source including self referral. The ACAT intake process determines the appropriateness of the referral as per the program guidelines. An ACAT comprehensive assessment will determine the older person's eligibility for services including Commonwealth subsidised aged care services. An ACAT client is not a person who requires acute medical services, post acute services or rehabilitation.

Rationale
An ACAT assessment will identify those clients who 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 and whose needs fall within the capacity of subsidised aged care services.

The assessment is the first step in ensuring the ACAT clients gain access to the appropriate services and receive care either in the community or in an institutional setting.

The 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.

A completed assessment is when a comprehensive assessment has been undertaken (and full information on the client is recorded) and has resulted in recommendations being made. This includes approvals to access Commonwealth funded programs (eg residential care, community aged care packages and some flexible care options).

If during an assessment the older person is found to require acute medical services, post acute services or rehabilitation services the assessment is recorded as incomplete. The record is also incomplete if during the process the person withdraws, moves to another services or dies before a comprehensive assessment has been completed and recommendations have been made.

Note
Commencing in 2003-04 the ACAT Program made significant amendments to the minimum data set Aged Care Assessment Teams collect on their activities. The new data set is being evaluated and revised as the new data is compiled. As a result only interim data is available for the period July-December 2003. Data collected in prior formats are not available in 2003-04 nor is the data presented in the new format comparable to previous years.

Table 31: Completed assessments as a proportion of accepted ACAT referrals

	2003
Completed assessments as a proportion of accepted ACAT referrals	98.66%

Data Source
Aged Care Assessment Program WA Evaluation Unit Minimum Data Set Reports, July to September 2003 and October to December 2003.

Note
In 2003 the ACAT Program amended the minimum data set, so only interim data is available for the period July – December 2003.

As the data is based on ACAT team coverage rather than statistical local areas, this indicator includes ACAT assessment data from Bunbury.

As this is the first year this indicator has been reported previous years' comparisons are not available.

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

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

Rationale
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 (non-admitted/ambulatory patients).

Results
In 2003-04, the average cost per person with mental illness under community management was $3,791.

Table 32: Average cost per person with mental illness under community management

	2002-03	2003-04
Actual cost	$2,316	$3,791
CPI adjusted	$2,243	$3,594

Data Source
Local Health Service Data Systems.

311: Average cost ACAT assessment

This indicator reports the average cost per ACAT assessment.

Rationale
People within targeted age groups 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.

Table 33: Average cost per ACAT assessment

	2003
Actual cost	$349

Data Sources
Local Health Service Financial System.
Aged Care Assessment Program WA Evaluation Unit Minimum Data Set Reports, July to September 2003 and October to December 2003.

Notes
In 2003 the ACAT Program amended the minimum data set, so only interim data is available for the period July – December 2003.

As the data is based on ACAT team coverage rather than statistical local areas, this indicator includes ACAT assessment data from Bunbury.

As this is the first year this indicator has been reported previous years' comparisons are not available.

313: Average cost per HACC service

This indicator reports the average cost per HACC service.

Rationale
HACC provides funding for services that support people who live at home and whose capacity for independent living is at risk of premature or inappropriate admission to long term residential care. The HACC program is a key provider of community care services to frail aged people and younger people with disabilities, and their carers.

Services include domestic assistance, social support, nursing care, personal care, allied health care, respite care, centre based day care, food services, home maintenance, home modification, transport, and other HACC services such as assessment and referral, case planning and management, and counselling, information and advocacy.

Table 34: Average cost of HACC services per person with long term disability

	2003
Actual cost	$81.01

Data sources
Local Health Services Data System.

Note
As this is the first year this indicator has been reported previous years' comparisons are not available.

CERTIFICATION OF FINANCIAL STATEMENTS
for the year ended 30 June 2004

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 financial year ending 30 June 2004 and the financial position as at 30 June 2004.

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.

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

31 August 2004

John Griffiths
Principal Accounting Officer for South West Health Board

30 August 2004

AUDITOR **GENERAL**

INDEPENDENT AUDIT OPINION

To the Parliament of Western Australia

SOUTH WEST HEALTH BOARD
FINANCIAL STATEMENTS FOR THE YEAR ENDED JUNE 30, 2004

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, the acquisition and disposal of property, and the incurring of liabilities have been in accordance with legislative provisions; and

(ii) the financial statements are based on proper accounts and present fairly in accordance with applicable Accounting Standards and other mandatory professional reporting requirements in Australia and the Treasurer's Instructions, the financial position of the Health Service at June 30, 2004 and its financial performance and cash flows for the year ended on that date.

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

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

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

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

D D R PEARSON
AUDITOR GENERAL
November 29, 2004

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

South West Health Board

Statement of Financial Performance

For the year ended 30th June 2004

	Note	2004 $	2003 $
COST OF SERVICES			
Expenses from Ordinary Activities			
Employee expenses	4	72,598,045	67,314,098
Fees for visiting medical practitioners		11,925,034	10,948,126
Patient support costs	5	14,961,416	13,302,473
Borrowing costs expense	6	225,514	250,252
Depreciation expense	7	4,142,527	4,283,105
Asset revaluation decrement	30	13,098,631	0
Capital user charge	9	7,935,820	8,175,931
Costs of disposal of non-current assets		3,192	11,581
Other expenses from ordinary activities	10	9,146,774	6,879,184
Total cost of services		134,036,953	111,164,750
Revenues from Ordinary Activities			
Revenue from operating activities			
Patient charges	11	2,962,187	3,027,518
Commonwealth grants and contributions	12a	347,720	294,780
Grants and subsidies from non-government sources	12b	146,916	248,293
Other revenues from operating activities	14a	2,118,848	2,095,053
Revenue from non-operating activities			
Donations revenue	13	114,502	133,137
Interest revenue		13,079	46,432
Proceeds from disposal of non-current assets	8	3,785	0
Other revenues from non-operating activities	14b	286,551	291,460
Total revenues from ordinary activities		5,993,588	6,136,673
NET COST OF SERVICES		**128,043,365**	**105,028,077**
Revenues from State Government			
Output appropriations	15	113,344,814	105,221,976
Liabilities assumed by the Treasurer	16	22,565	0
Resources received free of charge	17	17,432	173,333
Total revenues from State Government		113,384,811	105,395,309
Change in net assets before extraordinary items		(14,658,554)	367,232
CHANGE IN NET ASSETS		**(14,658,554)**	**367,232**
Net increase / (decrease) in asset revaluation reserve	30	2,873,900	0
Net initial adjustments on adoption of AASB 1028 "Employee Benefits"	31	0	(71,153)
Total revenues, expenses and valuation adjustments recognised directly in equity		2,873,900	(71,153)
Total changes in equity other than those resulting from transactions with WA State Government as owners		**(11,784,654)**	**296,079**

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

South West Health Board

Statement of Financial Position

As at 30th June 2004

	Note	2004 $	2003 $
CURRENT ASSETS			
Cash assets	18	2,720,088	2,604,933
Restricted cash assets	19	230,145	221,775
Receivables	20	1,816,946	1,933,336
Amounts receivable for outputs	21	1,400,000	941,000
Inventories	22	495,233	412,748
Other assets	23	216,092	256,013
Total Current Assets		6,878,504	6,369,805
NON-CURRENT ASSETS			
Amounts receivable for outputs	21	10,441,416	6,558,411
Property, plant and equipment	24	95,719,661	108,355,375
Total Non-Current Assets		106,161,077	114,913,786
Total Assets		**113,039,581**	**121,283,591**
CURRENT LIABILITIES			
Payables	25	5,735,885	4,315,853
Interest-bearing liabilities	26	131,664	116,218
Provisions	27	9,856,399	8,929,172
Other liabilities	28	518,521	2,669,905
Total Current Liabilities		16,242,469	16,031,148
NON-CURRENT LIABILITIES			
Interest-bearing liabilities	26	2,979,972	3,122,094
Provisions	27	2,682,339	4,985,896
TOTAL NON-CURRENT LIABILITIES		5,662,311	8,107,990
Total Liabilities		**21,904,780**	**24,139,138**
NET ASSETS		**91,134,801**	**97,144,453**
EQUITY			
Contributed equity	29	7,927,703	2,152,703
Reserves	30	2,873,900	0
Accumulated surplus / (deficiency)	31	80,333,198	94,991,750
Total Equity		**91,134,801**	**97,144,453**

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

South West Health Board

Statement of Cash Flows

For the year ended 30th June 2004

	Note	2004 $ Inflows (Outflows)	2003 $ Inflows (Outflows)
CASH FLOWS FROM STATE GOVERNMENT			
Output appropriations	32(c)	99,373,745	92,644,516
Capital contributions	32(c)	2,652,555	0
Holding account drawdowns	32(c)	1,006,539	0
Net cash provided by State Government		103,032,839	92,644,516
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Supplies and services		(33,919,941)	(30,402,471)
Employee costs		(73,294,688)	(68,453,579)
GST payments on purchases		(3,378,879)	(3,156,083)
Receipts			
Receipts from customers		2,885,719	2,919,282
Commonwealth grants and contributions		357,720	284,780
Grants and subsidies from non-government sources		157,916	294,793
Donations		114,502	136,902
Interest received		13,079	47,234
GST receipts on sales		299,427	346,654
GST receipts from taxation authority		3,131,508	3,012,004
Other receipts		2,414,401	3,063,817
Net cash (used in) / provided by operating activities	32(b)	(101,219,236)	(91,906,667)
CASH FLOWS FROM INVESTING ACTIVITIES			
Purchase of non-current assets	24	(1,693,864)	(1,098,644)
Proceeds from disposal of non-current assets	8	3,785	0
Net cash (used in) / provided by investing activities		(1,690,079)	(1,098,644)
Net increase / (decrease) in cash held		123,524	(360,795)
Cash assets at the beginning of the financial year		2,826,708	3,187,503
CASH ASSETS AT THE END OF THE FINANCIAL YEAR	32(a)	2,950,232	2,826,708

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

South West Health Board

Notes to the Financial Statements

For the year ended 30th June 2004

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 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 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.

(b) Basis of Accounting

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 fair value.

(c) 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.

(d) 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. Capital appropriations which are repayable to the Treasurer are recognised as liabilities.

(e) Acquisitions 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.

Assets costing less than $1,000 are expensed in the year of acquisition (other than where they form part of the group of similar items which are significant in total).

(f) Property, Plant and Equipment

Valuation of Land and Buildings

The Health Service has a policy of valuing land and buildings at fair value. The annual revaluations of the Health Service's land and buildings undertaken by the Valuer General's Office are recognised in the financial statements.

i) Land and Non-Clinical Buildings

The revaluations of land and non-clinical buildings have been undertaken on the following bases:

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

Recent valuations on this basis are equivalent to fair value.

South West Health Board

Notes to the Financial Statements
For the year ended 30th June 2004

Note 1 Significant accounting policies (continued)

ii) Clinical Buildings

The clinical buildings are valued at "Replacement Capital Value", which is defined as the cost to replace buildings constructed at current building costs with current materials on a greenfield site. All building costs are Perth based and include elements of electrical, mechanical and plumbing services. Loose and free standing furniture and equipment together with specialised medical equipment are excluded from this valuation. Buildings are depreciated using a weighted average age to determine the net carrying values. Recent valuations on this basis are equivalent to fair value.

Depreciation of Non-Current Assets

All property, plant and equipment having a limited useful life are systematically depreciated over their estimated useful lives in a manner which reflects the consumption of their future economic benefits.

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

Buildings	50 years
Leasehold improvements	Term of the lease
Computer equipment and software	5 to 15 years
Furniture and fittings	5 to 50 years
Motor vehicles	4 to 10 years
Medical Equipment	4 to 25 years
Other plant and equipment	5 to 50 years

(g) Leases

The Health Service has entered into a number of operating lease arrangements for the rent of buildings and equipment 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.

(h) Cash

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

(i) Receivables

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

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

(j) Inventories

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

(k) Payables

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

(l) Accrued Salaries

Accrued salaries (refer note 28) represent the amount due to staff but unpaid at the end of the financial year, as the end of the last pay period for that financial year does not coincide with the end of the financial year. The Health Service considers the carrying amount approximates net fair value.

(m) Interest-bearing liabilities

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

South West Health Board

Notes to the Financial Statements

For the year ended 30th June 2004

Note 1 Significant accounting policies (continued)

(n) Employee Benefits

Annual Leave

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

Long Service Leave

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

This method of measurement of the liability is consistent with the requirements of Accounting Standard AASB 1028 "Employee Benefits".

Superannuation

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

The Pension Scheme is unfunded and the liability for future payments was provided for up to 30 June 2004. The pension liabilities were assumed by the Treasurer as from 30 June 2004. The transfer was accounted for as a contribution by owner.

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.

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

The note disclosure required by paragraph 6.10 of AASB 1028 (being the employer's share of the difference between employees' accrued superannuation benefits and the attributable net market value of plan assets) has not been provided. State scheme deficiencies are recognised by the State in its whole of government reporting. The GESB's records are not structured to provide the information for the Health Service. Accordingly, deriving the information for the Health Service is impractical under current arrangements, and thus any benefits thereof would be exceeded by the cost of obtaining the information.

Deferred Salary Scheme

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

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

Employee benefit on-costs

Employee benefit on-costs are recognised and included in employee benefit liabilities and costs when the employee benefits to which they relate are recognised as liabilities and expenses. (See notes 4 and 27)

(o) Revenue Recognition

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

(p) Grants and Other Contributions Revenue

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

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

South West Health Board

Notes to the Financial Statements

For the year ended 30th June 2004

Note 1 Significant accounting policies (continued)

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

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

(r) Comparative Figures

Comparitive figures are, where appropriate, reclassified so as to be comparable with the figures presented in the current financial year.

(s) Rounding of amounts

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

Note 2 Outputs of the Health Service

Information about the Health Service's outputs and, the expenses and revenues which are reliably attributable to those outputs is set out in Note 43. The three key outputs of the Health Service are:

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. This output primarily focuses on the health and well being of populations, rather than on individuals. The programs define populations that are at-risk and ensure that appropriate interventions are delivered to a large proportion of these at-risk populations.

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 care or outpatient services and services for those people who are admitted to hospitals, oral health services and other supporting services such as patient transport and the supply of highly specialised drugs.

Continuing Care

Continuing care services are provided to people and their carers who require support with moderate to severe functional disabilities and/or a terminal illness to assist in the maintenance or improvement of their quality of life.

Note 3 Administered trust accounts

	2004 $	2003 $
Funds held in these trust accounts are not controlled by the Health Service and are therefore not recognised in the financial statements.		
a) The Health Service administers a trust account for the purpose of holding patients' private moneys.		
A summary of the transactions for this trust account is as follows:		
Opening Balance	147,854	152,889
Add Receipts		
- Patient Deposits	247,525	233,899
- Interest	936	1,075
	396,316	387,863
Less Payments		
- Patient Withdrawals	307,948	239,930
- Interest / Charges	1,003	80
Closing Balance	87,365	147,854

South West Health Board

Notes to the Financial Statements

For the year ended 30th June 2004

Note 4 Employee expenses	2004 $	2003 $
Salaries and wages (i)	56,647,643	53,999,075
Superannuation	5,978,181	5,147,028
Annual leave and time in lieu	5,692,914	5,194,006
Long service leave	2,350,858	1,145,537
Other related expenses	1,928,449	1,828,453
	72,598,046	67,314,098

(i) These employee expenses include employment on-costs associated with the recognition of annual and long service leave liability.

The related on-costs liability is included in employee benefit liabilities at Note 27.

Note 5 Patient support costs		
Medical supplies and services	6,552,019	6,096,947
Domestic charges	968,646	981,433
Fuel, light and power	1,577,918	1,468,330
Food supplies	1,790,878	1,746,357
Patient transport costs	1,495,412	1,305,367
Purchase of external services	2,576,543	1,704,038
	14,961,416	13,302,473

Note 6 Borrowing costs expense		
Interest paid	225,514	250,252
	225,514	250,252

Note 7 Depreciation expense		
Buildings	2,808,813	2,890,636
Computer equipment and software	339,720	402,725
Furniture and fittings	61,857	254,696
Motor vehicles	28,712	45,942
Medical Equpment	716,704	0
Other plant and equipment	186,721	689,106
	4,142,527	4,283,105

Note 8 Net gain / (loss) on disposal of non-current assets		
a) Proceeds from disposal of non-current assets	3,785	0
b) Gain / (Loss) on disposal of non-current assets:		
Land and buildings	0	(1,388)
Computer equipment and software	0	(4,988)
Medical equipment	1,372	0
Other plant and equipment	(779)	(5,205)
	593	(11,581)

Note 9 Capital user charge		
	7,935,820	8,175,931

A capital user charge rate of 8% has been set by the Government for 2003/04 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.

South West Health Board

Notes to the Financial Statements

For the year ended 30th June 2004

Note 10 Other expenses from ordinary activities	2004 $	2003 $
Motor vehicle expenses	443,040	596,055
Insurance	949,118	582,702
Communications	897,170	815,484
Printing and stationery	462,215	544,201
Rental of property	299,408	242,236
Audit fees - external	0	149,353
Bad and doubtful debts expense	2,240	9,697
Repairs, maintenance and consumable equipment expense	2,364,170	2,251,053
Other	3,729,413	1,688,403
	9,146,774	6,879,184

Note 11 Patient charges

Inpatient charges	2,835,215	2,912,649
Outpatient charges	126,972	114,870
	2,962,187	3,027,518

Note 12 Grants and contributions

a) Commonwealth grants and contributions		
CAEP Funding	306,494	138,776
Safety Inovations In Practice (SIIP)	0	44,000
Integrated Diabetes Program	0	37,800
DH & AC Administered Carer Funding	17,678	7,491
Speech Therapy Funding	0	2,500
HFS Rural56 DHA Administered Program	0	25,988
Podiatry Monitoring For Diabetes Program	0	7,000
PGR Nutrition Small Grant	0	45
Rural Chronic Disease Initiative	12,958	31,180
Manjim-up & Physical Project	10,590	0
	347,720	294,780
b) Grants and subsidies from non-government sources		
CAEP Funding	0	150,089
Safety Inovations In Practice (SIIP)	5,000	11,000
Integrated Diabetes Program	61,314	31,567
HACC Funding	5,000	7,194
Warren Blackwood Mental Health Project	0	24,400
Health Education / Promotion Activities (Asthma) Program	0	361
South West Clinical Placement Program	0	23,625
Keep Diabetes At Bay	0	57
Drug Education Project - Collie	25,000	0
Health Professional Consumer Presentations	103	0
PDSP Program	8,643	0
In Home Respite - Augusta	582	0
Community Care Respite - Nannup	23,650	0
In Home Support - Nannup	5,124	0
Warren Blackwood Speech Pathology Service	12,500	0
	146,916	248,293

Note 13 Donations revenue

General public contributions	114,502	133,137
	114,502	133,137

South West Health Board

Notes to the Financial Statements

For the year ended 30th June 2004

Note 14 Other revenues from ordinary activities	2004 $	2003 $
a) Revenue from operating activities		
Recoveries	1,619,460	1,508,634
Use of hospital facilities	430,252	462,897
Other	69,135	123,522
	2,118,848	2,095,053
b) Revenue from non-operating activities		
Rent from properties	97,822	102,165
Boarders' accommodation	183,507	179,265
Other	5,223	10,030
	286,551	291,460
	2,405,399	2,386,514

Note 15 Output appropriations

Appropriation revenue received during the year:		
Output appropriations	113,344,814	105,221,976

Output appropriations are accrual amounts reflecting the full cost of outputs delivered. 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.

Note 16 Liabilities assumed by the Treasurer

Superannuation	22,565	0

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

Note 17 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 (i)		
- Audit services	0	152,000
Other		
- Transfer of generator from Rockingham Hospital	15,000	21,333
- Volumetric infusion pump from Collie Lions Club	2,432	0
	17,432	173,333

Where assets or services have been received free of charge or for nominal consideration, the Health Service recognises revenues (except where the contribution of assets or services is in the nature of contributions by owners, in which case the Health Service shall make a direct adjustment to equity) 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.

(i) Commencing with the 2003-04 audit, the Office of the Auditor general will be charging a fee for auditing the accounts, financial statements and performance indicators. The fee for the 2003-04 audit ($152,000) will be due and payable in the 2004-05 financial year.

South West Health Board

Notes to the Financial Statements

For the year ended 30th June 2004

	2004	2003
Note 18 Cash assets	$	$
Cash on hand	58,420	67,640
Cash at bank - general	2,310,499	2,205,046
Cash at bank - donations	351,169	332,247
	2,720,088	2,604,933
Note 19 Restricted cash assets		
Cash assets held for specific purposes		
Cash at bank	230,145	221,775
	230,145	221,775

Restricted assets are assets, the uses of which are restricted, by specific legal or other externally imposed requirements.

Note 20 Receivables		
Patient fee debtors	362,306	480,447
GST receivable	383,564	507,593
Other receivables	1,073,316	1,030,662
	1,819,186	2,018,703
Less: Provision for doubtful debts	(2,240)	(85,367)
	1,816,946	1,933,336
Note 21 Amounts receivable for outputs		
Current	1,400,000	941,000
Non-current	10,441,416	6,558,411
	11,841,416	7,499,411
Balance at beginning of year	7,499,411	4,447,725
Additions to holding account	5,807,732	5,790,002
Less holding account drawdowns	(1,465,727)	(2,738,316)
Balance at end of year	11,841,416	7,499,411

This asset represents the non-cash component of output appropriations which is held in a holding account at the Department of Treasury and Finance. It is restricted in that it can only be used for asset replacement or payment of leave liability.

Note 22 Inventories		
Supply stores - at cost	387,247	347,916
Pharmaceutical stores - at cost	95,436	53,564
Engineering stores - at cost	12,550	11,268
	495,233	412,748
Note 23 Other assets		
Prepayments	216,092	256,013
	216,092	256,013

South West Health Board

Notes to the Financial Statements

For the year ended 30th June 2004

Note 24 Property, plant and equipment	2004 $	2003 $
Land		
At cost	0	6,651,000
At fair value	9,524,900	0
	9,524,900	6,651,000
Buildings		
Clinical:		
At cost	0	98,438,566
Accumulated Depreciation	0	(5,802,139)
	0	92,636,427
At fair value	77,478,673	0
Accumulated Depreciation	(6,363)	0
	77,472,310	0
Total of clinical buildings	77,472,310	92,636,427
Non-Clinical:		
At cost		974,022
Accumulated depreciation		(50,457)
	0	923,565
At fair value	915,254	0
Accumulated depreciation	(65)	0
	915,189	0
Total of non clinical buildings	915,189	923,565
Total of all land and buildings	87,912,399	100,210,992
Computer equipment and software		
At cost	1,895,590	1,974,782
Accumulated depreciation	(862,124)	(803,789)
	1,033,466	1,170,993
Furniture and fittings		
At cost	608,867	3,101,804
Accumulated depreciation	(126,058)	(462,216)
	482,809	2,639,588
Motor vehicles		
At cost	185,773	187,748
Accumulated depreciation	(138,401)	(111,182)
	47,372	76,566
Medical Equipment		
At cost	6,951,917	0
Accumulated depreciation	(2,015,986)	0
	4,935,931	0
Other plant and equipment		
At cost	1,275,927	5,618,908
Accumulated depreciation	(380,141)	(1,410,652)
	895,786	4,208,256
Works in progress		
Buildings under construction	357,521	48,980
Other Work in Progress	54,377	0
	411,898	48,980
Total of property, plant and equipment	95,719,661	108,355,375

South West Health Board

Notes to the Financial Statements

For the year ended 30th June 2004

Note 24 Property, plant and equipment (continued)	2004 $	2003 $

The revaluation of land and buildings was performed in June 2004 in accordance with an independent valuation by the Valuer General's Office. Fair value has been determined on the basis of current market buying values for land and non-clinical buildings and replacement capital values for clinical buildings. The valuations were made in accordance with a policy of five yearly revaluation. In 2004, the revaluation of freehold land and buildings to fair value was performed in June 2004 in accordance with an independent valuation by the Valuer General's Office as a result of the initial application of AASB 1041 (AAS 38).

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	112,434	980,790
Paid as cash by the Health Service from capital contributions	1,543,902	22,400
Paid as cash by the Health Service from other funding sources	37,528	95,454
Paid by the Department of Health	200,523	943,236
Gross payments for purchases of non-current assets	1,894,387	2,041,880

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.

	2004 $
Land	
Carrying amount at start of year	6,651,000
Revaluation increments / (decrements)	2,873,900
Carrying amount at end of year	9,524,900
Buildings	
Carrying amount at start of year	93,559,992
Other additions	263,162
Revaluation increments / (decrements)	(13,098,631)
Depreciation	(2,808,813)
Transfer between asset classes	471,789
Carrying amount at end of year	78,387,499
Computer equipment and software	
Carrying amount at start of year	1,170,993
Other additions	362,694
Depreciation	(339,720)
Transfer between asset classes	(4,139)
Write-off of assets	(156,362)
Carrying amount at end of year	1,033,466
Furniture and fittings	
Carrying amount at start of year	2,639,588
Additions	52,613
Disposals	(176,919)
Depreciation	(61,857)
Transfer between asset classes	(1,925,309)
Write-off of assets	(45,307)
Carrying amount at end of year	482,809
Motor vehicles	
Carrying amount at start of year	76,566
Depreciation	(28,712)
Carrying amount at end of year	47,372

South West Health Board

Notes to the Financial Statements
For the year ended 30th June 2004

Note 24 Property, plant and equipment (continued)	2004 $	2003 $
Medical Equipment		
Carrying amount at start of year	0	
Other additions	990,634	
Disposals	(2,413)	
Depreciation	(716,704)	
Transfer between asset classes	4,883,510	
Write-off of assets	(219,096)	
Carrying amount at end of year	4,935,931	
Other plant and equipment		
Carrying amount at start of year	4,208,256	
Other additions	227,716	
Disposals	(295,649)	
Depreciation	(186,721)	
Transfer between asset classes	(2,954,062)	
Write-off of assets	(103,754)	
Carrying amount at end of year	895,786	
Works in progress		
Carrying amount at start of year	48,980	
Additions	362,918	
Carrying amount at end of year	411,898	
Total property, plant and equipment		
Carrying amount at start of year	108,355,375	
Additions	2,731,526	
Disposals	(474,981)	
Revaluation increments / (decrements)	(10,224,731)	
Depreciation	(4,142,527)	
Write-off of assets	(525,001)	
Carrying amount at end of year	95,719,661	

Note 25 Payables		
Trade creditors	3,593,823	2,472,188
Accrued expenses	2,120,284	1,843,665
Accrued interest	21,778	0
	5,735,885	4,315,853

Note 26 Interest-bearing liabilities		
Current liabilities:		
Western Australian Treasury Corporation loans	23,514	20,891
Department of Treasury and Finance loans	108,150	95,327
	131,664	116,218
Non-current liabilities:		
Western Australian Treasury Corporation loans	498,943	524,565
Department of Treasury and Finance loans	2,481,030	2,597,529
	2,979,972	3,122,094
Total interest-bearing liabilities	3,111,637	3,238,312
Western Australian Treasury Corporation (WATC) loans		
Balance at beginning of year	545,455	567,949
Less repayments this year	(22,999)	(22,493)
Balance at end of year	522,457	545,455

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.

South West Health Board

Notes to the Financial Statements

For the year ended 30th June 2004

Note 26 Interest-bearing liabilities (continued)	2004 $	2003 $
Department of Treasury and Finance loans		
Balance at beginning of year	2,692,856	2,791,703
Less repayments this year	(103,676)	(98,846)
Balance at end of year	2,589,180	2,692,856

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.

Note 27 Provisions

Current liabilities:		
Annual leave and time in lieu	7,272,265	6,356,064
Long service leave	2,584,134	2,379,840
Superannuation	0	193,268
	9,856,399	8,929,172
Non-current liabilities:		
Long service leave	2,594,816	2,396,141
Deferred salary scheme	87,523	37,742
Superannuation	0	2,552,014
	2,682,339	4,985,896
Total employee benefit liabilities	12,538,739	13,915,068

(i) The settlement of annual and long service leave liabilities give rise to the payment of superannuation and other employment on-costs. The liability for such on-costs is included here. The associated expense is included under Employee expenses at Note 4.

(ii) The superannuation liability has been established from data supplied by the Government Employees Superannuation Board.
Under the revised arrangement with the Department of Treasury and Finance (DTF), pension liabilities are transferred to the Treasurer and reported centrally by DTF as from 30 June 2004.

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

Note 28 Other liabilities

Accrued salaries	518,521	2,669,905
	518,521	2,669,905

Note 29 Contributed equity

Equity represents the residual interest in the net assets of the Health Service. The Government holds the equity interest in the Department on behalf of the community. The asset revaluation reserve represents that portion of equity resulting from the revaluation of non-current assets.

Balance at beginning of the year	2,152,703	2,007,349
Capital contributions (i)	2,794,845	145,354
Contribution by owners (ii)	2,980,155	0
Balance at end of the year	7,927,703	2,152,703

(i) Capital Contributions have been designated as contributions by owners and are credited directly to equity in the Statement of Financial Position.

(ii) Transfer of pension liabilities to the Treasurer ($2,980,155).

South West Health Board

Notes to the Financial Statements

For the year ended 30th June 2004

Note 30 Reserves	2004 $	2003 $
Asset revaluation reserve (i):		
Balance at beginning of the year	0	0
Net revaluation increments / (decrements) :		
- Land	2,873,900	0
Balance at end of the year	2,873,900	0
Asset revaluation decrements recognised as an expense (iii):		
Buildings	13,098,631	0
	13,098,631	0

(i) The asset revaluation reserve is used to record increments and decrements on the revaluation of non-current assets. Revaluation increments and decrements are offset against one another within the same class of non-current assets.

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

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

Note 31 Accumulated surplus / (deficiency)

Balance at beginning of the year	94,991,750	94,695,670
Change in net assets	(14,658,554)	367,232
Net initial adjustments on adoption of AASB 1028 "Employee Benefits"	0	(71,153)
Balance at end of the year	80,333,198	94,991,750

Note 32 Notes to the statement of cash flows

a) **Reconciliation of cash**

Cash assets at the end of the financial year 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 18)	2,720,088	2,604,933
Restricted cash assets (Refer note 19)	230,145	221,775
	2,950,232	2,826,707

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)	(101,219,236)	(91,906,667)
Increase / (decrease) in assets:		
GST receivable	(124,029)	(131,375)
Other receivables	(75,488)	(310,700)
Inventories	82,485	(113,109)
Prepayments	(39,921)	191,286
Decrease / (increase) in liabilities:		
Doubtful debts provision	83,127	47,982
Payables	(1,420,032)	(837,580)
Accrued salaries	2,151,384	1,212,513
Provisions	(1,603,825)	(148,546)
Income received in advance	0	0
Non-cash items:		
Depreciation expense	(4,142,527)	(4,283,105)
Net gain / (loss) from disposal of non-current assets	593	(11,581)
Interest paid by Department of Health	(225,514)	(250,252)
Capital user charge paid by Department of Health	(7,935,820)	(8,175,931)
Donation of non-current assets	0	0
Asset revaluation decrements	(13,098,631)	0
Superannuation liabilities assumed by the Treasurer	(22,565)	0
Resources received free of charge	(17,432)	(173,333)
Special health service purchase programs	0	(4,076)
Other	(435,934)	(133,603)
Net cost of services (Statement of Financial Performance)	(128,043,365)	(105,028,077)

South West Health Board

Notes to the Financial Statements

For the year ended 30th June 2004

Note 32 Notes to the statement of cash flows (continued)	**2004**	**2003**
	$	**$**
c) **Notional cash flows**		
Output appropriations as per Statement of Financial Performance	113,344,814	105,221,976
Capital appropriations credited directly to Contributed Equity (Refer Note 29)	2,794,845	145,354
Holding account drawdowns credited to Amounts Receivable for Outputs (Refer Note 21)	1,465,727	2,738,316
	117,605,386	108,105,645
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	(31,523)	(32,893)
Repayment of interest-bearing liabilities to WA Treasury Corporation	(22,999)	(22,493)
Interest paid to Department of Treasury & Finance	(193,991)	(217,359)
Repayment of interest-bearing liabilities to Department of Treasury & Finance	(103,676)	(98,846)
Capital user charge	(7,935,820)	(8,175,931)
Accrual appropriations	(5,807,732)	(5,790,002)
Capital works expenditure	(474,802)	0
Capital subsidy transferred to equity	0	(1,123,611)
Other non cash adjustments to output appropriations	(2,003)	5
	(14,572,547)	(15,461,129)
Cash Flows from State Government as per Statement of Cash Flows	103,032,839	92,644,516

Note 33 Revenue, public and other property written off or presented as gifts

a) Revenue and debts written off.	21,674	9,697

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

Note 34 Remuneration of members of the accountable authority and senior officers

Remuneration of members of the accountable authority
The Director General of Health is the Accountable Authority for South West Health Board. The

Director General of Health's remuneration is paid by the Department of Health.

Remuneration of senior officers
The number of Senior Officers other than senior officers reported as members of the Accountable Authority, whose total of fees, salaries, superannuation and other benefits for the financial year, fall within the following bands are:

$30,001 - $40,000	0	1
$50,001 - $60,000	0	2
$60,001 - $70,000	0	3
$70,001 - $80,000	0	8
$90,001 - $100,000	1	5
$100,001 - $110,000	2	4
$110,001 - $120,000	1	2
$130,001 - $140,000	1	0
$140,001 - $150,000	0	1
$170,001 - $180,000	0	1
$210,001 - $220,000	1	1
$230,001 - $240,000	1	0
$240,001 - $250,000	1	0
Total	8	28
	$	**$**
The total remuneration of senior officers is:	1,254,062	2,607,754

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

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

South West Health Board

Notes to the Financial Statements

For the year ended 30th June 2004

Note 35 Commitments for Expenditure

	2004 $	2003 $
a) **Capital expenditure commitments**		
Capital expenditure commitments, being contracted capital expenditure additional to the amounts reported in the financial statements, are payable as follows:		
Within one year	0	171,210
	0	171,210
The capital commitments include amounts for:		
- Buildings	0	0
b) **Operating lease commitments:**		
Commitments in relation to leases contracted for at the reporting date but not recognised as liabilities, are payable as follows:		
Within one year	559,317	333,456
Later than one year, and not later than five years	708,557	113,467
Later than five years	290,204	0
	1,558,078	446,923

These commitments are all inclusive of GST.

Note 36 Contingent liabilities and contingent assets

The Health Service has no contingent liabilities or contingent assets.

Note 37 Events occurring after reporting date

There were no events occurring after reporting date which have significant financial effects on these financial statements.

Note 38 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

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

Note 39 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.

South West Health Board

Notes to the Financial Statements

For the year ended 30th June 2004

Note 40 The Impact of Adopting International Financial Reporting Standards

The International Financial Reporting Standards (IFRSs) will be applicable to reporting periods beginning on or after 1 January 2005. The Australian Accounting Standards Board (AASB) has adopted a convergence policy under which the Australian Accounting Standards are converged with their IFRS equivalents. The AASB will issue Australian equivalents to IFRSs, and Urgent Issues Group abstracts to harmonise with the International Financial Reporting Standards issued by the International Accounting Standards Board. The South West Health Board will prepare its first Australian-equivalents-to-IFRSs financial statements for the year ending 30 June 2006.

The Department of Health has established a structure of project teams to manage the transition to IFRSs and report to executive management. These project teams include members representing pertinent function areas within the health sector, an internal audit officer, an expert consultant from an accounting firm and representatives from the Department of Treasury and Finance and the Valuer General's Office. The actions that have been undertaken include the preparation of a timetable, identification of system changes and training of staff. Considerable progress has been made on the projects for impairment of assets and revaluation of land and buildings. To date the project teams have analysed most of the Standards and have identified a number of accounting policy changes that will be required. A Treasurer's Instruction will be issued for application within the Western Australian public sector to mandate an accounting treatment and disclosure where there are alternatives under the IFRSs.

The following are the key differences in accounting policies identified to date that are expected to arise from adopting Australian equivalents to IFRSs:

(a) Impairment of assets

Under AASB 136, the Australian equivalent to IAS 36 "Impairment of Assets", assets will be measured at the recoverable amount if there is an indication of impairment.

This will result in a change to the current accounting policy, under which assets are not required to be measured at their recoverable amounts.

(b) Inventories

Under AASB 102, the Australian equivalent to IAS 2 "Inventories", inventories held for distribution will be measured at the lower of cost and current replacement cost, rather than the lower of cost and net realisable value, which will apply to other general inventories.

This will result in a change to the current accounting policy, under which all classes of inventories are valued at lower of cost and net realisable value.

(c) Employee benefits

Under the AASB 119, the Australian equivalent to IAS 19 "Employee Benefits", annual leave that are not short term employee benefits, will be measured at present value.

This will result in a change to the current accounting policy, under which liabilities for annual leave are measured at nominal amounts in all circumstances.

The above should not be regarded as a complete list of changes in accounting policies that will result from the transition to IFRSs, as not all Standards have been analysed as yet. For these reasons it is not yet possible to quantify the impacts of the transition to IFRSs on South West Health Board's reported financial position and financial performance.

South West Health Board
Notes to the Financial Statements
For the year ended 30th June 2004

Note 41 Explanatory Statement

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

Reasons for significant variations between actual results with the corresponding items of the preceding reporting period are detailed below. Significant variations are those greater than 10% or $5,000,000

	Note	2004 Actual $	2003 Actual $	Variance $
Statement of Financial Performance - Expenses				
Employee expenses		72,598,045	67,314,098	5,283,947
Fees for visiting medical practitioners		11,925,034	10,948,126	976,908
Patient support costs	(a)	14,961,416	13,302,473	1,658,943
Borrowing costs expense		225,514	250,252	(24,738)
Depreciation expense		4,142,527	4,283,105	(140,578)
Asset revaluation decrement		13,098,631	0	13,098,631
Capital user charge		7,935,820	8,175,931	(240,111)
Other expenses from ordinary activities	(b)	9,146,774	6,879,184	2,267,590
Statement of Financial Performance - Revenues				
Patient charges		2,962,187	3,027,518	(65,331)
Commonwealth grants and contributions	(c)	347,720	294,780	52,940
Grants and subsidies from non-government sources	(d)	146,916	248,293	(101,377)
Other revenues from operating activities		2,118,848	2,095,053	23,795
Donations revenue	(e)	114,502	133,137	(18,635)
Interest revenue	(f)	13,079	46,432	(33,353)
Proceeds from disposal of non-current assets		3,785	0	3,785
Other revenues from non-operating activities		286,551	291,460	(4,909)
Output appropriations	(g)	113,344,814	105,221,976	8,122,838
Liabilities assumed by the Treasurer		22,565	0	22,565
Resources received free of charge	(h)	17,432	173,333	(155,901)

(a) Patient support costs
The increase primarily due to a new service "South West 24" which increased expenses by ($400,000), a backlog of Pathcentre accounts ($400,000) being paid this financial year due to negotiations over the Pathcentre fees and charges and a slight increase in the use of agency nurses.

(b) Other expenses from ordinary activities
Increase in expense due mainly to a legal settlement of $1,184,000, asset disposal expenses of $525,001, increase in insurance costs (RiskCover & Strathearn) of $366,400, increases in motor vehicle lease payments and purchases of external services - management.

(c) Commonwealth grants and contributions
The increase is primarily due to a change in classification of commonwealth grants and other grants. The total of commonwealth grants and other grants only differ from prior year by $48,000 which is not considered material.

(d) Grants and subsidies from non-government sources
As above.

(e) Donations revenue
Public donations by nature are not under the control of the health service and will vary from year to year.

(f) Interest revenue
All health services were consolidated into a single SWAHS bank account which does not attract interest, the only interest recorded during the financial year was from the donations accounts, therefore collections in this area decreased.

(g) Output appropriations
The increase in output appropriations was due primarily to an increase in recurrent funding (cash subsidy) of approximately $8,600,000 in the current financial year.

(h) Resources received free of charge
The decrease was caused by the introduction of the full cost recovery of audit services by the Office of the Auditor General. The audit fee for the 2003-04 audit will be due and payable in the 2004-05 financial year. Accordingly, no expense or corresponding revenue has been recognised in the 2003-04 financial year.

South West Health Board
Notes to the Financial Statements
For the year ended 30th June 2004

Note 41 Explanatory Statement (continued)

(B) Significant variations between estimates and actual results for the financial year

Details and reasons for significant variations between these estimates and actual results are detailed below. Significant variations are considered to be those greater than 10% of budget.

	Note	2004 Actual $	2004 Estimates $	Variance $
Operating expenses				
Employee expenses	(a)	72,598,045	67,547,253	5,050,792
Other goods and services	(b)	61,438,908	48,317,547	13,121,361
Total expenses from ordinary activities		134,036,953	115,864,800	18,172,153
Less: Revenues from ordinary activities	(c)	(5,993,588)	(6,074,000)	80,412
Net cost of services		128,043,365	109,790,800	18,252,565

(b) Other goods and services
SWAHS land, clinical and non-clinical buildings were revalued at 30 June 2004, which resulted in an unexpected revaluation decrement of $13,098,631 due primarily to the South West Health Campus being incorrectly valued at completion date of the campus..

Notes to the Financial Statements

For the year ended 30th June 2004

Note 42 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 2004							
Financial Assets							
Cash assets	0.0%	0	0	0	0	2,720	2,720
Restricted cash assets	3.8%	230	0	0	0	0	230
Receivables						1,819	1,819
		230	0	0	0	4,539	4,769
Financial Liabilities							
Payables						5,736	5,736
Interest-bearing liabilities							
- W A Treasury Corporation loans	5.8%		24	100	399		522
- Department of Treasury & Finance loans	7.3%		108	485	1,996		2,589
		-	132	585	2,395	5,736	8,848
Net financial assets / (liabilities)		230	(132)	(585)	(2,395)	(1,197)	(4,078)
As at 30th June 2003							
Financial Assets	0.0%	2,759	0	0	0	2,001	4,760
Financial Liabilities	6.8%	0	116	3,123	0	4,316	7,555

b) **Credit risk exposure**

All financial assets are unsecured. Amounts owing by other government agencies are guaranteed and therefore no credit risk exists in respect of those amounts. The carrying amounts of financial assets recorded in the financial statements, net of any provisions or losses, represent the Health Service's maximum exposure to credit risk.

c) **Net fair values**

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

Notes to the Financial Statements

For the year ended 30th June 2004

Note 43 Output information

	Prevention & Promotion		Diagnosis & Treatment		Continuing Care		Total	
	2004 $	2003 $	2004 $	2003 $	2004 $	2003 $	2004 $	2003 $
COST OF SERVICES								
Expenses from Ordinary Activities								
Employee expenses	3,324,990	5,210,111	67,697,677	57,654,525	1,575,378	4,449,462	72,598,045	67,314,098
Fees for visiting medical practitioners	546,167	847,385	11,120,094	9,377,070	258,773	723,671	11,925,034	10,948,126
Patient support costs	685,233	1,029,612	13,951,520	11,393,568	324,663	879,293	14,961,416	13,302,473
Borrowing costs expense	10,328	19,369	210,292	214,341	4,894	16,542	225,514	250,252
Depreciation expense	189,728	331,513	3,862,906	3,668,479	89,893	283,113	4,142,527	4,283,105
Asset revaluation decrement	599,918	0	12,214,473	0	284,240	0	13,098,631	0
Capital user charge	363,461	632,817	7,400,152	7,002,685	172,207	540,429	7,935,820	8,175,931
Costs of disposal of non-current assets	146	896	2,977	9,919	69	766	3,192	11,581
Other expenses from ordinary activities	418,922	532,449	8,529,367	5,892,021	198,485	454,714	9,146,774	6,879,184
Total cost of services	6,138,893	8,604,152	124,989,458	95,212,608	2,908,602	7,347,990	134,036,953	111,164,750
Revenues from Ordinary Activities								
Revenue from operating activities								
Patient charges	135,669	234,330	2,762,239	2,593,069	64,279	200,119	2,962,187	3,027,518
Commonwealth grants and contributions	15,925	22,816	324,249	252,479	7,546	19,485	347,720	294,780
Grants and subsidies from non-government sources	6,729	19,218	136,999	212,663	3,188	16,412	146,916	248,293
Other revenues from operating activities	97,043	162,157	1,975,826	1,794,413	45,979	138,483	2,118,848	2,095,053
Revenue from non-operating activities						0		
Donations revenue	5,244	10,305	106,773	114,032	2,485	8,800	114,502	133,137
Interest revenue	599	3,594	12,196	39,769	284	3,069	13,079	46,432
Proceeds from disposal of non-current assets	173	0	3,530	0	82	0	3,785	0
Commercial activities	0	0	0	0	0	0	0	0
Other revenues from non-operating activities	13,124	22,559	267,209	249,635	6,218	19,266	286,551	291,460
Total revenues from ordinary activities	274,506	474,979	5,589,021	5,256,060	130,061	405,634	5,993,588	6,136,673
NET COST OF SERVICES	**5,864,387**	**8,129,173**	**119,400,437**	**89,956,548**	**2,778,541**	**6,942,356**	**128,043,365**	**105,028,077**
Revenues from State Government								
Output appropriations	5,191,193	8,144,181	105,694,039	90,122,622	2,459,582	6,955,173	113,344,814	105,221,976
Assets assumed / (transferred)	0	0	0	0	0	0	0	0
Liabilities assumed by the Treasurer	1,033	0	21,042	0	490	0	22,565	0
Resources received free of charge	799	13,416	16,255	148,460	378	11,457	17,432	173,333
Total revenues from State Government	5,193,025	8,157,597	105,731,336	90,271,082	2,460,450	6,966,630	113,384,811	105,395,309
CHANGE IN NET ASSETS	**(671,362)**	**28,424**	**(13,669,101)**	**314,534**	**(318,091)**	**24,274**	**(14,658,554)**	**367,232**

Abbreviations

ABS	Australian Bureau of Statistics
ACAT	Aged Care Assessment Team
ACEM	Australasian College for Emergency Medicine
ACHS	Australian Council of HealthCare Standards
ACIR	Australian Childhood Immunisation Register
AIDS	Acquired Immunodeficiency Syndrome
AMI	Acute Myocardial Infarction
APGAR	Activity (muscle tone/movement), Pulse, Grimace (reflex), Appearance (skin colour - blue etc), Respiration
CEO	Chief Executive Officer
CPI	Consumer Price Index
CWLB	Central Wait List Bureau
DOH	Department of Health
DSC	Disability Services Commission
EEO	Equal Employment Opportunity
EMHS	East Metropolitan Health Service
EQUIP	Evaluation and Quality Improvement Program
FNOF	Fractured Neck of Femur
FOI	Freedom of Information
FTE	Full Time Equivalent
GP	General Practitioner
HACC	Home and Community Care
HIC	Health Information Centre
HIV	Human Immunodeficiency Virus
HMDS	Hospital Morbidity Data System
ISO	International Standards Organisation
IT	Information Technology
LOOP	Learning Opportunities and Outcomes Program
MIMMS	Major Medical Incident Management and Support
MOU	Memorandum of Understanding
NHMRC	National Health Medical Research Council
NMHS	North Metropolitan Health Service
NHTP	Nursing Home Type Patient
PATS	Patient Assisted Travel Scheme
PID	Public Interest Disclosure
PSOLIS	Psychiatric Services Online Information System
PSWDGP	Peel South West Division of GPs
RAC	Risk Assessment Code
RFDS	Royal Flying Doctor Service
RPH	Royal Perth Hospital
SARS	Severe Acute Respiratory Syndrome
SHMT	State Health Management Team
SLA	Statistical Local Area
SMHS	South Metropolitan Health Service
SWAHS	South West Area Health Service
TIMS	Theatre Information Management Systems
TTY	Teletypewriter
VMP	Visiting Medical Practitioner
WCHS	Women's and Children's Health Service

Glossary of Terms

Australian Council on Healthcare Standards (ACHS)
The ACHS is an independent, not-for-profit organisation, dedicated to improving the quality of health care in Australia through continual review of performance, assessment and accreditation.

Acute Myocardial Infarction (AMI)
Also known as a heart attack. It literally means sudden death of heart muscle. AMI results in sudden, severe chest pain that occurs when a portion of the heart no longer receives oxygen-rich blood, usually due to total or near-total blockage of a coronary artery by a blood clot formed in an area already narrowed by plaque. The surrounding heart muscle dies and the heart stops working effectively

APGAR Score
The Apgar score is given to newborns and occurs right after a baby's birth. The Apgar test is usually given to a baby twice: once at 1 minute after birth, and again at 5 minutes after birth. Rarely, if there are serious problems with the baby's condition and the first two scores are low, the test will be scored for a third time at 10 minutes after birth. Five factors are used to evaluate the baby's condition, heart rate (pulse), breathing (rate and effort), activity, grimace (reflex irritability) and appearance (skin colouration) and each factor is scored on a scale of 0 to 2.

Deep Vein Thrombosis
This is another name for blood clots that form in the deep veins of the legs and pelvis. People recovering from abdominal surgery are at increased risk for these clots, as are overweight individuals. Symptoms may include pain, swelling or no symptoms at all. If untreated, the clot could travel to the lungs.

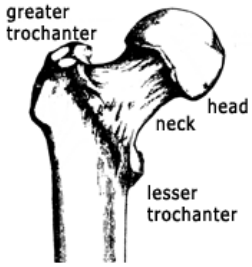
ECG (Electrocardiogram)
Electrocardiogram (ECG or EKG) is the graphic record of the heart's electrical currents obtained with the electrocardiograph, an instrument designed for recording the electrical currents that traverse the heart and initiate its contraction.

Hospital Morbidity Data System (HMDS)
Hospital Morbidity Data System is part of the Health Data Collection program of the Health Information Centre Directorate. The HMDS collects in-patient discharge summary data from all public and private hospitals in Western Australia.

Human Immunodeficiency Virus (HIV)
A retrovirus of the subfamily lentivirus that causes acquired immunodeficiency syndrome (AIDS). The most common type of HIV is HIV-1, identified in 1984. HIV-2, first discovered in West Africa in 1986, causes a loss of immune function and the subsequent development of opportunistic infections identical to HIV-1 infections. The two types developed from separate strains of simian immunodeficiency virus.

Ischaemic Heart Disease
A serious problem caused by inadequate circulation of blood to the heart muscle. The blood flow to the heart is reduced due to a narrowing of heart arteries by cholesterol deposits. Ischemic heart disease is often the major underlying disorder for heart attacks as well as the chronic condition of angina. Ischemic heart disease is also called coronary artery disease.

Fractured Neck of Femur
The femur or thigh bone is the longest, largest and strongest bone of the human body. The femur's head forms a ball-and-socket joint at the hip. Classically, this is a fracture of old age that effects men and women in their seventies and eighties. It is often caused when diseases such as osteoporosis have weakened the bone.



Pertussis
Commonly called "whooping cough, pertussis is an infectious disease marked by a severe, dry cough. The prevalence of Pertussis can be reduced through immunisations.

Public Interest Disclosure (PID)
The *Public Interest Disclosure Act 2003* commenced operation on 1 July 2003. The object of the Act is to:

- facilitate the disclosure of public interest information;
- provide protection for those who make disclosures; and
- provide protection for those who are the subject of a disclosure.

This is achieved by:

- protecting the person making the disclosure from legal or other action;
- providing for the confidentiality of the identity of the person making the disclosure and a person who is the subject of a disclosure; and
- providing remedies for acts of reprisal and victimisation that occur substantially because the person has made a disclosure.

State Health Management Team (SHMT)
The SHMT was first established in November 2001. The SHMT assists the Director General of Health in leading and managing the State health system.

Vancomycin Resistant Enterococci (VRE)
Enterococci are bacteria found in the faeces of most humans and many animals. The commonest infections caused by enterococci are urinary tract infections and wound infections. These, and a variety of other infections, including infection of the blood stream (bacteraemia), heart valves (endocarditis) and the brain (meningitis) can occur in severely ill patients in hospital. Enterococci also frequently colonise open wounds and skin ulcers. Enterococci are amongst the most antibiotic resistant bacteria isolated from humans. Vancomycin is an antibiotic used to treat serious infections. Sometimes, the enterococci germs become resistant to certain antibiotics, including Vancomycin. This means the drugs are no longer effective against them, making it harder to treat infection. These resistant germs are called Vancomycin Resistant Enterococci (VRE).