Government of **Western Australia**
Department of **Health**

WA Country Health Service

Annual Report 2011–12

Delivering a **Healthy WA**

Government of **Western Australia**
Department of **Health**

WA Country Health Service

Annual Report
2011-12

WA Country Health Service
189 Wellington Street, East Perth
Western Australia 6004
Telephone: (08) 9223 8500
Fax: (08) 9223 8599
Website: www.wacountry.health.wa.gov.au

Statement of Compliance

HON DR KIM HAMES MLA
MINISTER FOR HEALTH

In accordance with section 61 of the Financial Management Act 2006, I hereby submit for your information and presentation to Parliament, the Annual Report of the WA Country Health Service for the financial year ended 30 June 2012.

The Annual Report has been prepared in accordance with the provisions of the *Financial Management Act 2006*.

KIM SNOWBALL
DIRECTOR GENERAL OF HEALTH
ACCOUNTABLE AUTHORITY

20 September 2012

Contents

Illustrations

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

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Overview of Agency

WA Health Vision Statement

Our Vision

Healthier, longer and better quality lives for all Western Australians

Our Mission

To improve, promote and protect the health of Western Australians by:

- **Caring for individuals and the community**
- **Caring for those who need it most**
- **Making best use of funds and resources**
- **Supporting our team**

Our Values

WA Health's Code of Conduct identifies the values that we hold as fundamental in our work and describes how these values translate into action.

Our values can be summarised as:

Care - Respect - Excellence
Integrity - Teamwork - Leadership

Executive Summary

Over the past year, WA Health worked harder than ever through one of its busiest years to date. Hospital activity was unprecedented, with emergency department presentations and elective surgery numbers reaching an all time high and GP shortages more challenging than ever. Despite escalating demands on our entire system, we performed well in the key areas of safety and quality. Our strong performance is testament to our consistent focus on forward planning, continuous improvement and innovative reform.

In our community of 2.34million, our aim is to provide access to health care for rural and regional Western Australians consistent with their health needs. In our quest to do this we have invested in both infrastructure and our front line health workers.

Delivering a Healthy WA

WACHS, as part of WA Health, is aligned to the four key pillars of our WA Health Strategic Intent 2010–2015:

- Caring for individuals and the community
- Caring for those who need it most
- Making best use of funds and resources
- Supporting our team.

WACHS is the largest country health system in Australia and among the largest in the world, delivering comprehensive health services to half a million people, 10 per cent of whom are Aboriginal. Across its 70 regional and remote hospitals, WACHS handles almost as many emergencies as the combined metropolitan hospitals, plus almost as many births as King Edward Memorial Hospital.

Caring for individuals and the community

As always, WACHS has worked hard to promote and protect the health of its rural and regional communities, and ensure country Western Australians have access to high quality healthcare when they need it.

WACHS has also continued to focus on ways to meet the challenges of distance and rapid population growth associated with the strong economic growth in this State. As always, partnerships with organisations like the Royal Flying Doctor Service (RFDS) have been critical, with RFDS transporting 289 critically ill country patients to tertiary hospitals in Perth, a large majority from the northwest.

The $565 million Southern Inland Health Initiative – an investment that has been unprecedented in regional health - has delivered on a number of key objectives over the past year. It has seen an increase in the number of doctors and primary health nurse practitioners working in the country.

Telehealth also expanded its reach, and the first intra-region link-up between Albany and Katanning occurred. An agreement has also been signed between Western Australia and the Northern Territory that will see improved videoconferencing infrastructures between the two jurisdictions.

Caring for those who need it most

We are committed to ensuring people in greatest need can access health services in a timely manner.

While most Western Australians experience amongst the world's best health outcomes, Aboriginal people in this State do not. Improving Aboriginal health is the top health priority for WACHS. This has largely been focused on delivery of improvements under the National Partnership Agreements on Closing the Gap and Indigenous Early Childhood Development strengthening joint planning and engagement with Aboriginal Community Controlled Health Services.

The State Government has committed $117 million to Closing the Gap and through WACHS is working closely with the Regional Aboriginal Health Planning Forums to develop and improve services for Aboriginal people. Under COAG initiatives, 98 programs statewide have been established, and of the 400 new Closing the Gap positions created, 70 per cent are in regional and remote areas.

In addition to services provision, WACHS is dedicated to increasing employment of Aboriginal people throughout its services.

WACHS also continued to provide quality mental health services under contract to the Mental Health Commission. A new mental health unit was also opened in Broome enabling 80 per cent of local patients to be treated closer to home.

Making Best Use of Funds and Resources

Progress continued across country WA, as part of WA Health's multi-billion dollar capital works program to transform regional hospitals and health services to better meet the challenges of a diverse and widespread population. Infrastructure projects include new or improved health campuses at Bunbury, Busselton, Albany, and Kalgoorlie. Additional funding was announced in the 2012 State Budget to develop a new facility at Karratha and redevelop Carnarvon, Exmouth and Esperance Health Campuses.

Supporting Our Team

WACHS is committed to supporting and strengthening the skills and potential of its employees. In 2011-12, we continued to focus on sustainable strategies and initiatives to attract, recruit and retain the best people into our workforce.

WACHS provided a record number of training places for medical graduates who began internships in WA Health hospitals at the start of 2012. We also welcomed hundreds of new graduate nurses and Assistant in Nursing (AIN) graduate trainees to boost our nursing workforce in the acute care setting.

As part of WA Health's commitment to increasing our Aboriginal workforce, WACHS stepped up its efforts to employ more Aboriginal people and support them to develop their skills and leadership potential. Our efforts have been guided by the WA Health Aboriginal Cultural Learning Framework and Aboriginal Workforce Strategic Intent which were both launched in 2011-12.

We recognise the valuable role that every WACHS employee plays in delivering a quality health service and thank all staff for their valuable contribution over the past year.

Kim Snowball
DIRECTOR GENERAL

26 September 2012

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WA Country Health CEO Summary

The current economic environment provides many challenges and the biggest challenge for the WA Country Health Service (WACHS) is continuing to improve our service delivery in the face of attendances at our emergency rooms across regional Western Australia growing at a rate of about 5% each year. I am very pleased to report that WACHS is meeting this challenge head-on, working together with the community to revitalise healthcare for country patients.

The important state-wide service reforms continue, underpinning our commitment to improve safety and quality care throughout our hospital and health care sites. Seven WACHS hospitals are involved in the National Emergency Access Target (NEAT) initiative to improve patient access to emergency care and patient flow through the hospitals.

NEAT builds on the success of WA's Four Hour Rule program which saw the seven WACHS hospitals consistently reach the 85 per cent target over the past year.

Our massive $1.5 billion capital works program rolls on, with new hospital works and redevelopments under way in several regions, with particular emphasis on improving our regional emergency departments. This significant capital works program will bring world class health care closer to home for people living in regional and remote Western Australia.

Capital works milestones achieved in the 2011-12 financial year include completion of a new Paediatric Ward and 14 bed Acute Mental Health inpatient unit to finalise Stage 2 of the Broome Hospital Redevelopment; completion of the final $3.2 million stage of the Ngnowar Aerwah Residential Rehabilitation Facility in Wyndham; the official opening of the South West Radiation Oncology facility in Bunbury in July 2011; completion of enabling works on the site of the new Busselton Health Campus, with construction due to commence in September 2012 and continuation of works on the $55.8 million Stage One Redevelopment of the Kalgoorlie Health Campus.

The substantial State Government investment into country health through the Royalties for Regions fund continues to provide a fairer share of resources for health services in country WA. During 2011-12 there were a number of announcements of Royalties for Regions funding for new WACHS capital projects including a $31.3 million ($18.8 million of Royalties for Regions funding) Stage One Redevelopment of Esperance Health Campus, $26.8 million ($20.8 million from Royalties for Regions) to redevelop the Carnarvon Health Campus and $8.075 million Royalties for Regions funds to redevelop the Exmouth Multipurpose Service.

WA Health and its partners are now implementing the fourth and final year of the 'Closing the Gap' National Partnership Agreement (NPA) which has seen a raft of new initiatives funded to improve the health and lives of Aboriginal people living in rural and remote areas. Given the achievements of the program to date, the WA Country Health Service's Aboriginal Health Improvement Unit has worked with industry partners to develop a blueprint and business case for Aboriginal health reform beyond 2013. This business case aims to consolidate progress and expand to include a number of community identified priorities that will enable greater advancement towards 'Closing the Gap' for Aboriginal Western Australians.

As one of the largest investments into regional health in Western Australia's history, the $565 million Royalties for Regions funded Southern Inland Health Initiative has met significant milestones in its first year of operation. Thirteen new doctors have moved into the southern inland region and are now participating in the new Emergency Department and primary health care model and 76 doctors have signed up to work in the Emergency Department networked model and are delivering services throughout the region.

Extensive service planning has been held across the southern inland catchment, along with building condition audits at 37 sites. These will assist in the scoping and prioritisation of the proposed $325 million infrastructure program.

These achievements across WACHS over the past financial year have enabled us to provide better access to high quality health services for people living in regional WA. This will continue to be the focus for the WA Country Health Service moving forward.

In order to make the State's public health system even more responsive and accountable to the community, the Minister for Health announced in 2011 the introduction of five new health services, each with a high-level Governing Council made up of community members and clinicians. The WA Country Health Service is now served by two Governing Councils – one for the Northern and Remote Country Health Service and one for the Southern Country Health Service. This overhaul of WA Health's governance arrangements augers well for the future of health care across the state.

Ian Smith
Chief Executive Officer
WA Country Health Service

Address & Location

WACHS – Area Office
189 Wellington Street, EAST PERTH WA 6004
Postal Address
PO Box 6680
EAST PERTH BUSINESS CENTRE, WA 6892
Phone: (08) 9223 8500
Fax: (08) 9223 8599
Web – Area Office and Regions
www.wacountry.health.wa.gov.au

WACHS – Kimberley
Yamamoto House
Unit 4, 9 Dampier Terrace, BROOME WA 6725
Postal Address
Locked Bag 4011, BROOME WA 6725
Phone: (08) 9194 1600
Fax: (08) 9194 1666

WACHS – Pilbara
Morgan Street, PORT HEDLAND WA 6721
Postal Address
PO Box 63, PORT HEDLAND WA 6721
Phone: (08) 9158 1795
Fax: (08) 9158 1472

WACHS – Midwest
45 Cathedral Avenue,
GERALDTON WA 6530
Postal Address
PO Box 22, GERALDTON WA 6531
Phone: (08) 9956 2209
Fax: (08) 9956 2421

WACHS – Wheatbelt
Shop 2, Northam Boulevard
178 Fitzgerald Street, NORTHAM WA 6401
Postal Address
PO Box 690, NORTHAM WA 6401
Phone: (08) 9622 0700
Fax: (08) 9622 0701

WACHS – Goldfields
The Palms
68 Piccadilly Street, KALGOORLIE WA 6430
Postal Address
PO Box 716, KALGOORLIE WA 6433
Phone: (08) 9080 5710
Fax: (08) 9080 5724

WACHS – Great Southern
Callistemon House
Warden Avenue, ALBANY WA 6331
Postal Address
PO Box 165, ALBANY WA 6331
Phone: (08) 9892 2662
Fax: (08) 9842 1095

WACHS – South West
Street & Postal address
4th floor, Bunbury Tower
61 Victoria Street, BUNBURY WA 6230
Phone: (08) 9781 2350
Fax: (08) 9781 2381

Revitalising WA Country Health Services

During 2010-11 the WA Country Service launched its strategic direction, '***Revitalising WA Country Health Services 2009-2012'*** which outlines the way forward for health service delivery in regional WA over three years. This follows on from the WA Country Health Service (WACHS) Strategic Plan 2007-2010, titled *Foundations for Country Health Services*. The purpose, values and actions outlined in the strategic direction for 2009-2012, are specific to the WA Country Health Service, and evolved through consultation with WACHS staff and community members throughout regional WA.

Our Purpose	**Working together for a healthier country WA**
What we stand for	**A fair share for country health** Securing a fair share of resources and being accountable for their use. **Service delivery according to need** Improving service access based on need and improving health outcomes **Closing the gap to improve Aboriginal Health** Improving the health of Aboriginal people **Workforce stability and excellence** Building a skilled workforce and a supportive workplace
Our Values	**Community** Country hospitality, where there is openness, generosity and cooperation. Building healthy and empowered communities and teams, being inclusive, working together, valuing each other and the difference we can all make. A 'can-do' attitude. **Compassion** Commitment to caring for others with consideration, appreciation, understanding, empathy, kindness and respect. Listening and being heard. **Quality** Always striving to provide the best possible care and service through questioning and review, high standards, innovation, creativity, learning and improving. All of us being part of the solution. **Integrity** Building trust based on openness, honesty, accountability and valuing and respecting others' opinions and points of view. Demonstrating the values. Respectful communication and relationship building. Being mindful of the legacy we hand on to future staff and communications. **Justice** Achieving equity and fairness, showing cultural respect, valuing and embracing diversity and respecting confidentiality. Treating everyone equally. Speaking up when there is injustice. Transparency.

Services Provided

Direct patient services

- accident and emergency medicine
- acute medical
- acute mental health
- acute surgical
- anaesthetics
- antenatal classes
- cardiology
- dermatology
- dental services
- ear, nose and throat
- endocrinology
- gastroenterology
- general surgery
- genetics
- gynaecology and obstetrics
- hospital in the home
- nephrology
- occupational medicine
- oncology
- ophthalmology
- orthopaedics
- pain management
- pacemaker clinic
- paediatrics
- plastic surgery
- primary health care / general practice
- podiatry
- psychiatry and psychology
- radiation oncology
- renal dialysis
- rheumatology
- same day surgery
- urology
- diabetes education and care coordination
- respiratory education and care coordination
- cancer – care coordination
- hospital admission risk prevention – care coordination
- home oxygen – care coordination
- palliative care – care coordination

Medical support services

- Aboriginal health services
- ambulance and patient transport
- audiology
- dietetics
- general physician
- medical imaging
- occupational therapy
- pathology
- pharmacy
- physiotherapy
- podiatry
- rehabilitation
- respiratory medicine
- social work
- speech pathology
- sexual health
- sub-acute care

Community and support services

- aged and residential care
- alcohol and drug treatment
- child and maternal health
- community health
- community mental health
- community midwifery
- diabetes management and education
- disaster preparedness
- disease control
- health promotion
- health screening
- home and community care
- immunisation
- meals on wheels
- medi hotel services
- palliative care
- respite

Other services

- administration and corporate
- engineering / supply / maintenance
- hotel and catering
- medical records
- telehealth

Pecuniary Interests

Senior officers of the WA Country Health Service have declared no pecuniary interests in 2011-12.

Accountable Authority

The Director General of Health, Mr Kim Snowball, is the accountable authority for the WA Country Health Service.

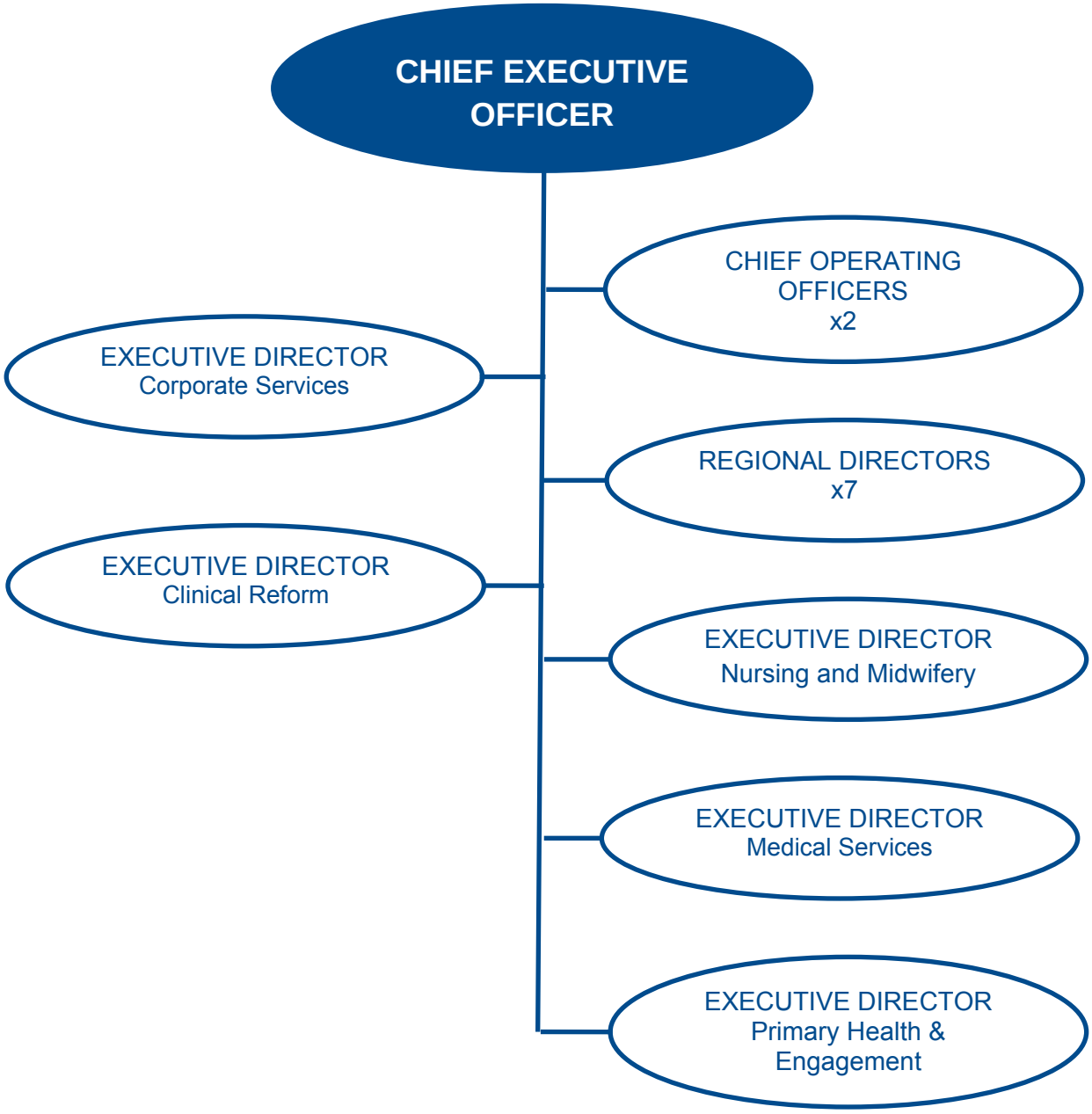
Senior Officers

The senior officers, as at 30 June 2012, for WACHS and their areas of responsibility are listed below:

Table 1: Senior officers – WACHS Senior Officers as at 30 June 2012

Area of Responsibility	Title	Name	Basis of Appointment
WA Country Health Service	Chief Executive Officer	Ian Smith	Substantive
Area Operations	Chief Operating Officer - Northern & Remote Country Health Service	Shane Matthews	Acting
Area Operations	Chief Operating Officer - Southern Country Health Service	Tina Chinery	Acting
Corporate Services	Executive Director	Graeme Jones	Substantive
Nursing and Midwifery	Executive Director	Marie Baxter	Substantive
Medical Services	Executive Director	Dr Meredith Arcus	Acting
Clinical Reform	Executive Director	Dr Felicity Jefferies	Substantive
Primary Health and Engagement	Executive Director	Melissa Vernon	Acting
Regional Operations	Regional Director Goldfields	Geraldine Ennis	Substantive
Regional Operations	Regional Director Great Southern	Susan Kay	Substantive
Regional Operations	Regional Director Kimberley	Kerry Winsor	Substantive
Regional Operations	Regional Director Midwest	Margaret Denton	Acting
Regional Operations	Regional Director Pilbara	Ron Wynn	Substantive
Regional Operations	Regional Director South West	Grace Ley	Substantive
Regional Operations	Regional Director Wheatbelt	Caroline Langston	Acting

WA Country Health Service Management Structure



2011-12 WA Country Health Service

The WA Country Health Service (WACHS) is the largest country health service in Australia and one of the biggest in the world, delivering a range of comprehensive health services to more than 519,000 people, including over 46,000 Aboriginal people (ABS projections 2011), over a vast 2.5 million square kilometres area.

The breadth and scope of the WACHS is vast, with services being planned and delivered for a particularly diverse and sprawling population with widely varying health needs. A highly transient population of tourists also exists in many of its regions.

Across its 70 hospitals WACHS handles almost as many emergency presentations as hospitals in the metropolitan area combined and almost as many births as the State's major maternity hospital. As well as the many regional hospitals, there are also a number of smaller health centres and nursing posts spread across country WA.

The range of health services provided covers primary health care, emergency and hospital services, population health, mental health, Aboriginal health, and community and aged care.

The WA Country Health Service is committed to *"Working together for a healthier country WA"*. Our dedicated and committed staff work hard to deliver safe, high quality and accessible health care to regional and remote Western Australia.

WACHS has established a network of District Health Advisory Councils across all regions which are made up of a wide range of community representatives and other consumers. The councils engage, consult and interact with the WA Country Health Service to provide valuable input and feedback to improve health services for our local communities.

WA Country Health Service regions

WACHS consists of seven administrative regions supported by the Area Office in Perth. They are the Kimberley, Pilbara, Midwest, Wheatbelt, Goldfields, South West and the Great Southern. Each region is governed by a Regional Director who reports to the WA Country Health Service Chief Executive Officer through a Chief Operating Officer.

Each of the seven WACHS regions provides an extensive range of health services, including hospital, mental health, aged care, public health, community health, primary health, Aboriginal health, child health, pharmacy and health transport services. Other essential providers of health care within the regions include private general medical practitioners, private and visiting medical specialists and allied health professionals, non-government and community-based organisations, Aboriginal community controlled health organisations, and other government agencies.

Kimberley

Covering an area of around 421,450 square kilometres, WACHS Kimberley has main hospitals situated at Broome, Derby and Kununurra with smaller hospitals located in Fitzroy Crossing, Halls Creek and Wyndham. There are also remote area nursing posts

in some of the remote Aboriginal communities. The Kimberley's population has steadily grown over the last decade and is estimated at over 36,000 based on ABS 2011 projections. Generally, Kimberley residents are young, with 80 percent being younger than 45 years of age, and highly mobile. Aboriginal people comprise 46 percent of the population. Population density is very low (0.08 people per sq km) creating a challenge for health service delivery and accessibility.

Pilbara

The WA Country Health Service Pilbara covers an area of around 508,000 square kilometres. The main hospitals are situated at South Hedland (Hedland Health Campus), Karratha (Nickol Bay Hospital), Newman and Tom Price. There are also a number of remote area nursing posts in some of the smaller towns and in Aboriginal communities. The Pilbara resources boom has resulted in the region's rapid population growth to the current number of more than 49,000, people based on ABS 2011 projections. (about half are residents and the rest are ('fly in – fly out' workers), including around 14% Aboriginal people. Consequently, the necessity to expand and improve the health services within the Pilbara is fundamental to the continued success of the region.

Midwest

The WA Country Health Service Midwest covers an area of around 605,000 square kilometres, with its main hospitals situated at Geraldton, Carnarvon, Meekatharra and Mullewa. There are also a number of health centres and nursing posts across the region. About 60% of the population of the Midwest, over 66,000 based on ABS 2011 projections, reside in Geraldton and the vast majority of the region's population lives on the coast. The area has an Aboriginal population of around 12% and an increasing proportion of aged people.

Wheatbelt

The WA Country Health Service Wheatbelt covers an area of around 155,300 square kilometres. The main hospitals are situated at Northam, Narrogin, Merredin and Moora and there are also a number of nursing posts in the smaller communities. The population of the Wheatbelt is estimated to be more than 78,000 people with a progressing median age based on ABS 2011 projections. About 4% of the population are Aboriginal Australians. One of the noted idiosyncrasies of the Wheatbelt is its scattered population dispersion which has made attracting and retaining health practitioners difficult in some parts of the region.

Goldfields

Covering an area of approximately 770,500 square kilometres, the WA Country Health Service Goldfields' main hospitals are situated at Kalgoorlie and Esperance. There are also a number of health centres and nursing posts across the region. The permanent population of the Goldfields is estimated at around 60,000 based on ABS 2011 projections boosted by a significant number of workers who fly in from Perth to work on remote mining sites. It is estimated that Aboriginal people make up about 8% of the region's population.

South West

The WA Country Health Service South West covers an area of about 24,000 square kilometres with a permanent population of around 167,000 based on ABS 2011 projections as well as attracting a high number of tourists every year. Around 3% of the permanent population are Aboriginal Australians. The main hospitals are located at Bunbury (South West Health Campus), Busselton, Bridgetown, Collie and Margaret River.

Great Southern

The total land area covered by the WA Country Health Service Great Southern is approximately 39,000 square kilometres. The area has a population of around 60,000 based on ABS 2011 projections, of which 3% are Aboriginal people. A high proportion of older people live in the main centres. The main hospitals are located at Albany, Denmark and Katanning.

2011-12 Key Service Delivery Facts

In 2011-12 WACHS had a total cost of service of $1.212 billion averaging $3.32 million expenditure per day.

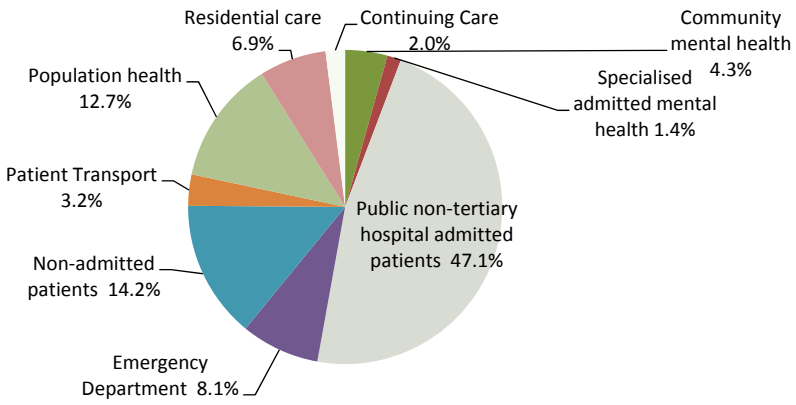
WACHS hospitals and/or health facilities:

- addressed the health care needs of an approximate residential population of 520,000 (2011) living in an area of approximately 2.5 million square kilometres;
- provided 118,475 separations with an average length of stay of 2.6 days;
- admitted 16,883 cases for elective surgery, of which 95% were within the category admission wait time boundary;
- attended to 399,397 persons visiting a rural emergency department or service;
- provided over 917,034 occasions of non-admitted health care at either a rural hospital or nursing post;
- funded 75,100 patient assisted travel trips;
- provided 186,400 residential care bed-days;
- provided 1,105 inpatient admissions to three specialised mental health units;
- in 2011 provided 121,398 occasions of ambulatory mental health care to 12,075 persons; and
- delivered 4,525 babies in 2011.

WACHS Expenditure by Service 2011-12

The following graph details the WACHS expenditure against service types as reported for the 2011-12 efficiency key performance indicators. Expenditure includes contracted emergency services provided under contract by private providers and the statewide public dental health service.

Figure 1: Expenditure by service 2011-12



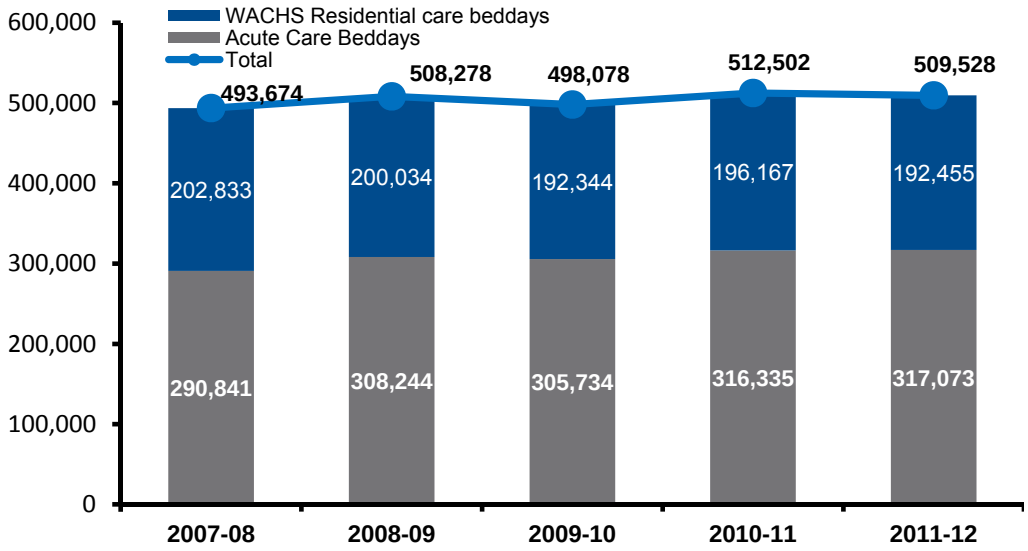
Note: This expenditure does not include Corporate Overheads.

General WACHS Health Care Activity Trends

Admitted and residential care hospital activity

Bed-day activity for residential and acute admissions in WACHS hospitals has remained relatively stable with a total 3.2% increase across the period 2007-12.

Figure 2: Bed-days 2007-12

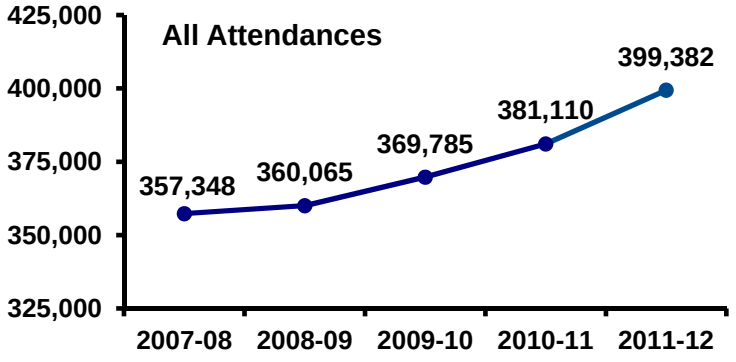


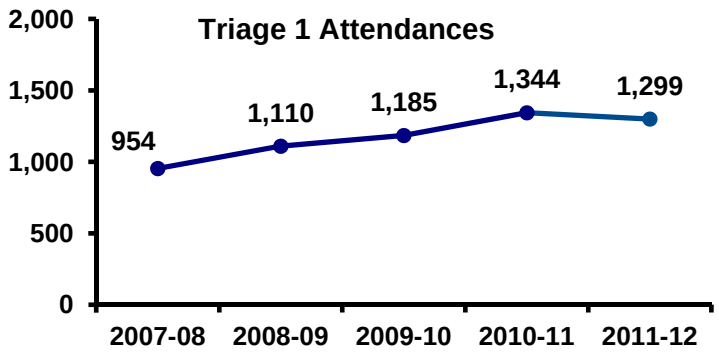
Emergency services activity

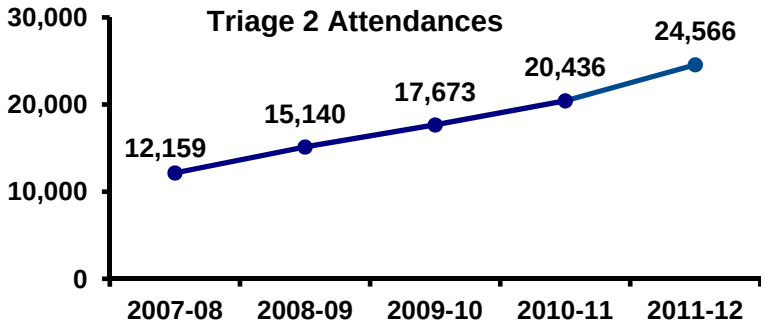
Generally attendances at WACHS emergency departments and services have been steadily increasing over recent years with the period 2007 to 2012 seeing an 11.8% increase, with a 4.8% increase in 2011-12 when compared to last year. While this information demonstrates general workload growth, it is also relevant to assess in which acuity (triage) categories some of this work is occurring.

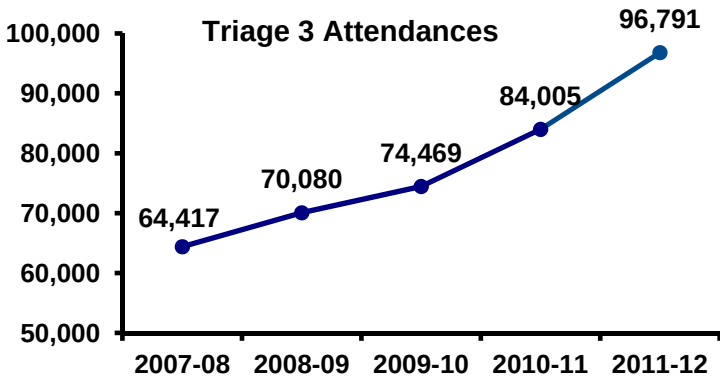
The following figures show specific activity and performance information for country hospital emergency attendances. Attendances for triage categories have grown significantly in categories 1 to 4, while attendances reported for the less urgent category, Triage 5, have fallen.

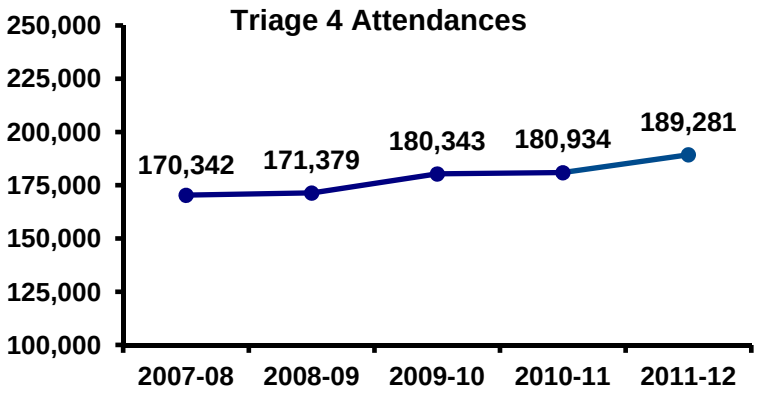
Figure 3: Emergency data 2007-12

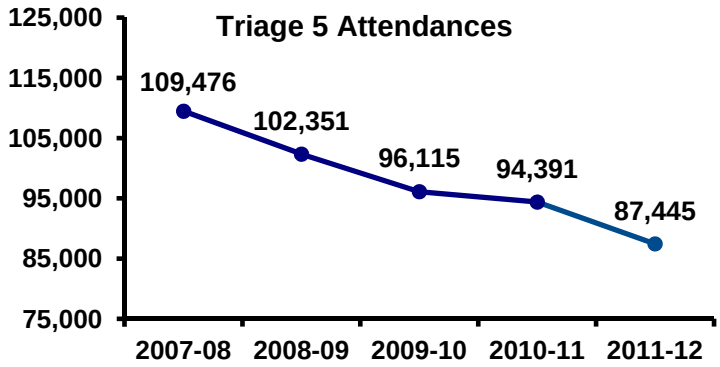



Triage 1 Attendances
2,000
1,500
1,000
500
0
954
1,110
1,185
1,344
1,299
2007-08
2008-09
2009-10
2010-11
2011-12


Triage 2 Attendances
30,000
20,000
10,000
0
12,159
15,140
17,673
20,436
24,566
2007-08
2008-09
2009-10
2010-11
2011-12


Triage 3 Attendances
100,000
90,000
80,000
70,000
60,000
50,000
64,417
70,080
74,469
84,005
96,791
2007-08
2008-09
2009-10
2010-11
2011-12

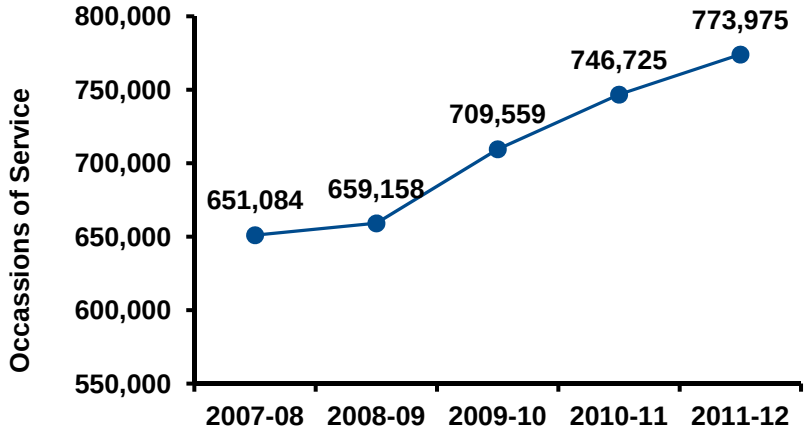

Triage 4 Attendances
250,000
225,000
200,000
175,000
150,000
125,000
100,000
170,342
171,379
180,343
180,934
189,281
2007-08
2008-09
2009-10
2010-11
2011-12



Non-admitted patient activity (excluding emergency activity)

In the five year period 2007-12, there has been an 18.9% increase in non-admitted patient activity across WACHS.

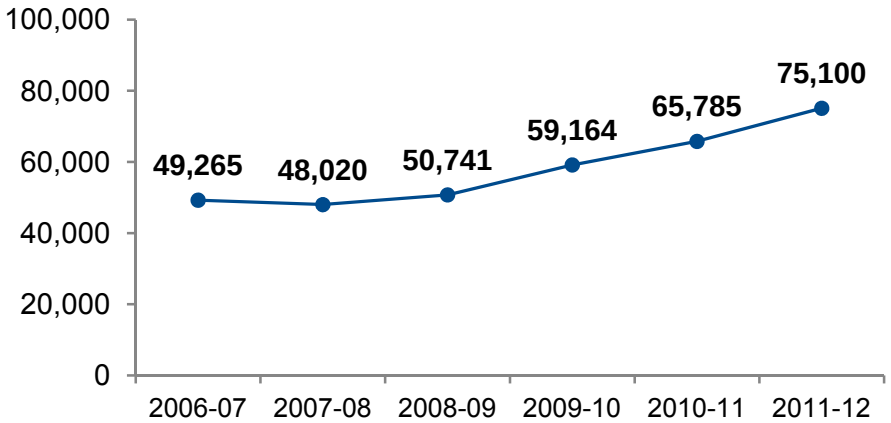
Figure 4: Non-admitted patient activity data 2007-12



Patient transport activity

In the period 2006-12 WACHS has seen a 33.5% increase in the number of PATS trips to enable rural patients to attend specialist services either in major regional centres or in Perth. Compared to 2010-11, assisted trips provided in 2011-12 saw a 14.2% increase.

Figure 5: Patient transport activity

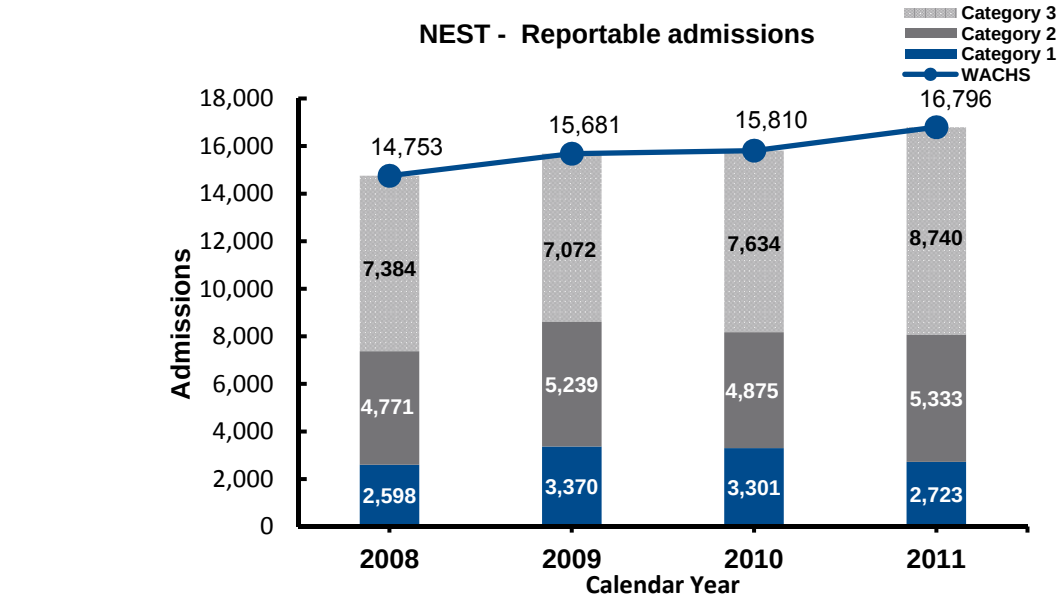


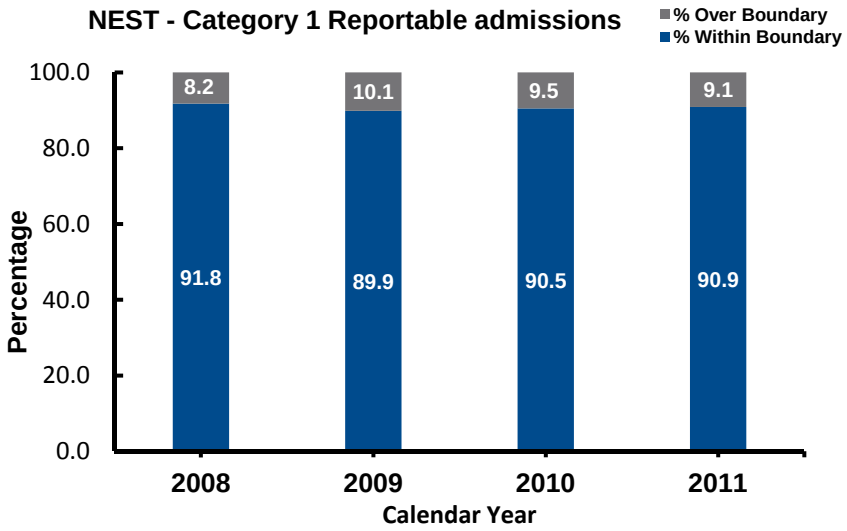
Elective Surgery

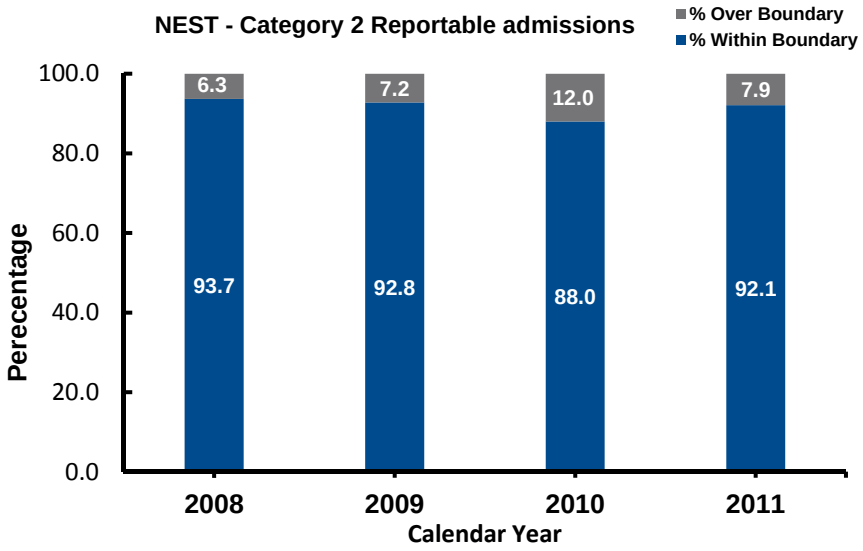
Commencing 2012, the National Health Reform Agreement (NPA) on Improving Public Health Services will require the States and Territories to measure performance under the National Elective Surgery Target (NEST) reporting criteria and performance targets.

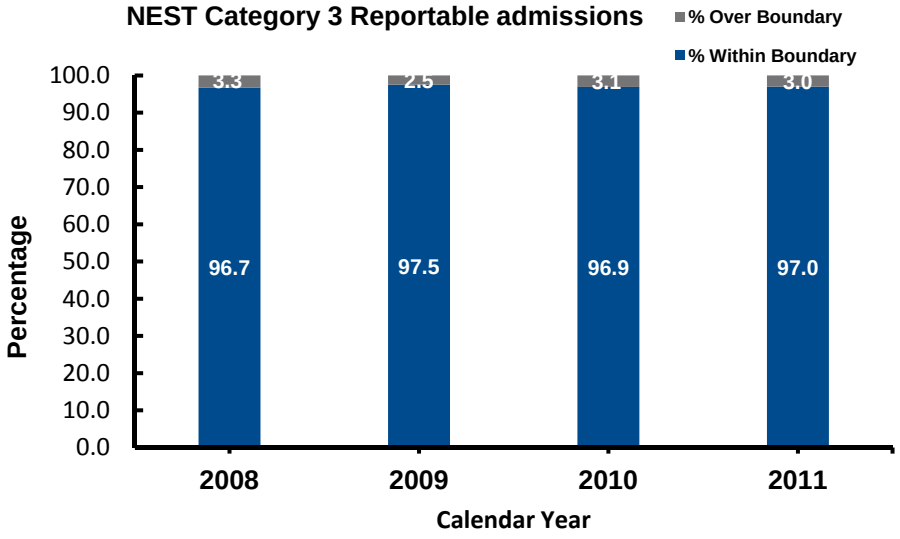
To provide a comparative context to this reporting change, the following figures show activity and performance information for admitted elective surgery and cases as at 31 December for the period 2008-11 for the WA Country Health Service. Category boundaries of: Category 1 = 30 days; Category 2 = 90 days; and Category 3 = 365 days remain with performance targets for each category applicable as at 31 December each year. Performance targets do not apply to the information provided below.

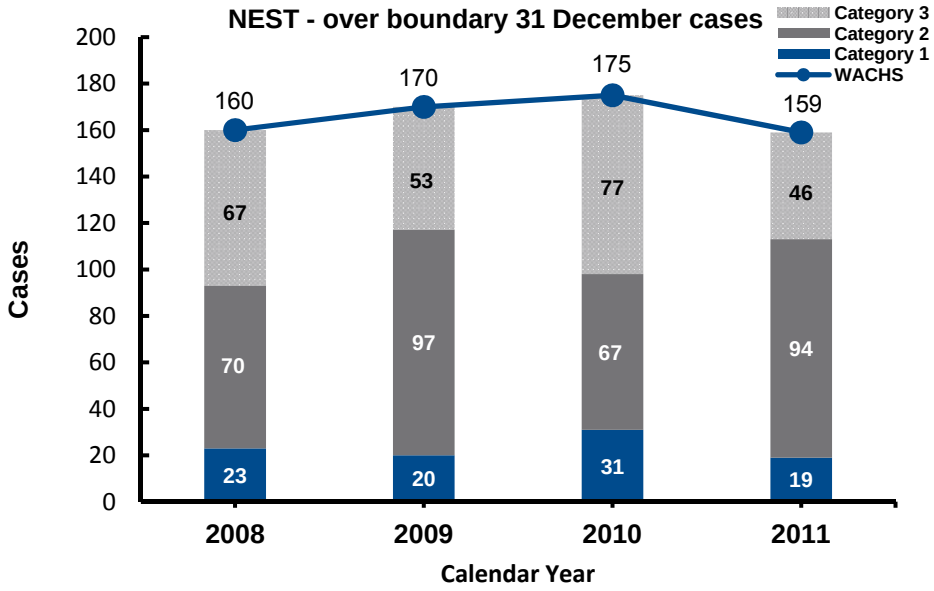
Figure 6: Elective Surgery – NEST Calendar Years 2008-11

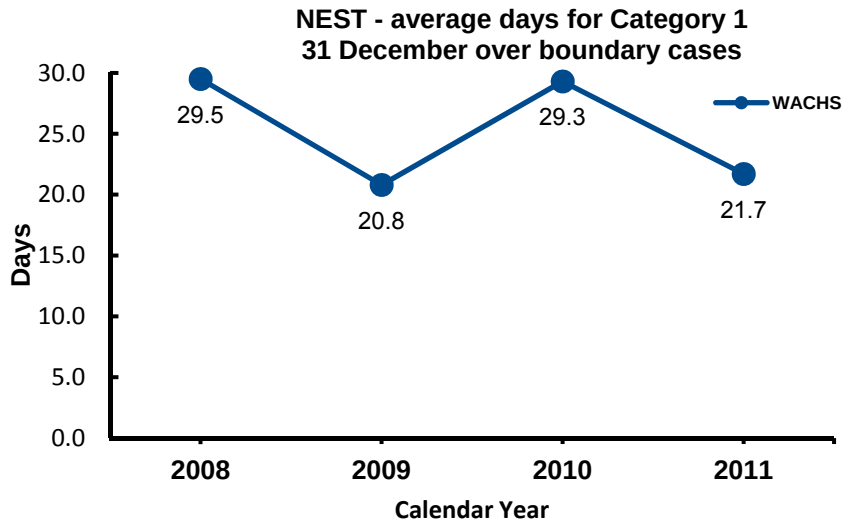


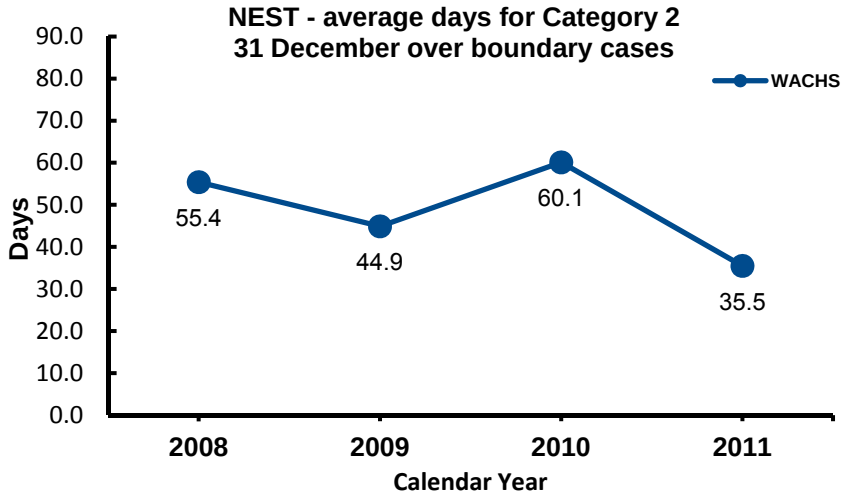


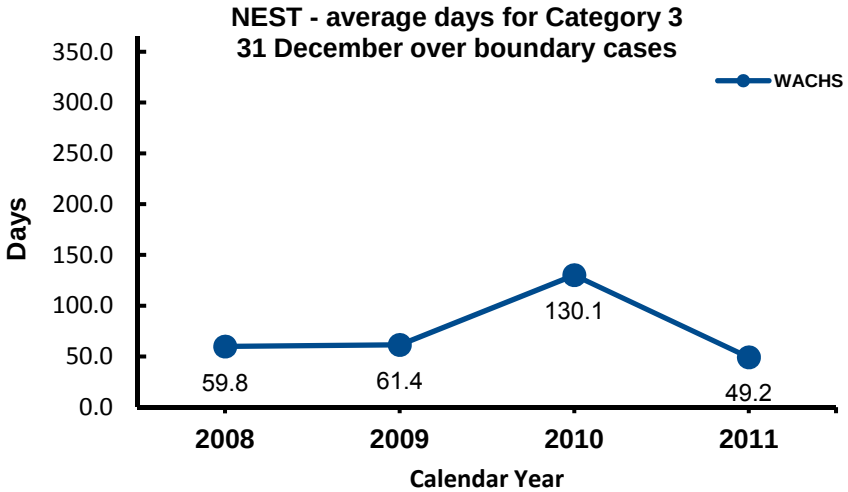

NEST - Category 2 Reportable admissions
% Over Boundary
% Within Boundary
Perecentage
100.0
80.0
60.0
40.0
20.0
0.0
6.3
7.2
12.0
7.9
93.7
92.8
88.0
92.1
2008
2009
2010
2011
Calendar Year


NEST Category 3 Reportable admissions
% Over Boundary
% Within Boundary
Percentage
100.0
90.0
80.0
70.0
60.0
50.0
40.0
30.0
20.0
10.0
0.0
3.3
2.5
3.1
3.0
96.7
97.5
96.9
97.0
2008
2009
2010
2011
Calendar Year


NEST - over boundary 31 December cases
Category 3
Category 2
Category 1
WACHS
Cases
200
180
160
140
120
100
80
60
40
20
0
160
170
175
159
67
53
77
46
70
97
67
94
23
20
31
19
2008
2009
2010
2011
Calendar Year

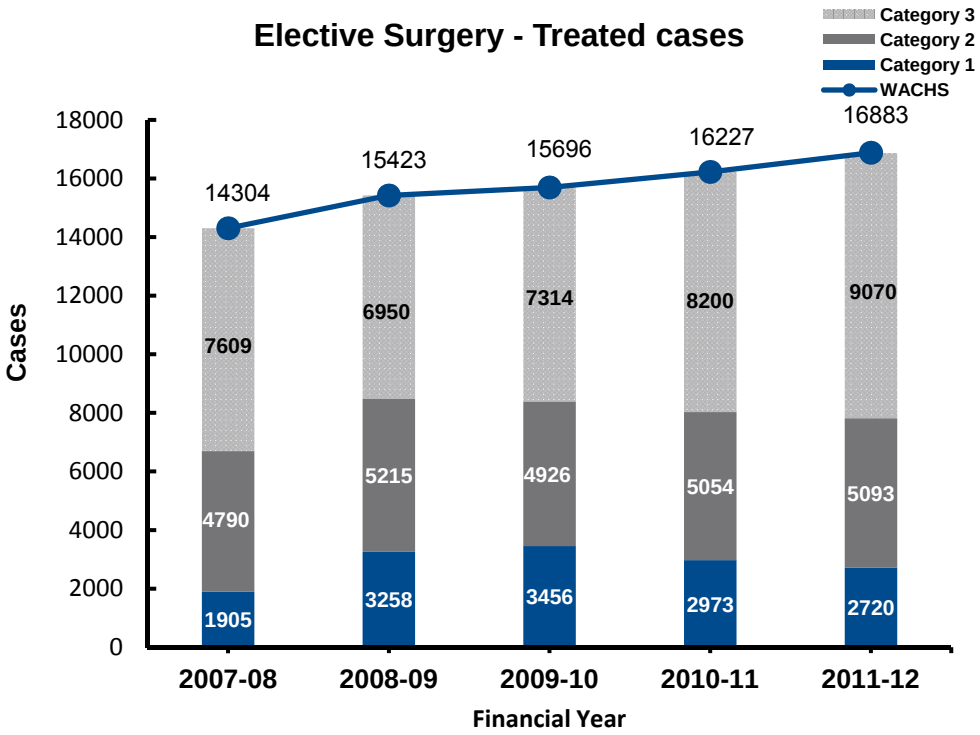

NEST - average days for Category 1
31 December over boundary cases
WACHS
Days
30.0
25.0
20.0
15.0
10.0
5.0
0.0
29.5
20.8
29.3
21.7
2008
2009
2010
2011
Calendar Year


NEST - average days for Category 2
31 December over boundary cases
WACHS
Days
90.0
80.0
70.0
60.0
50.0
40.0
30.0
20.0
10.0
0.0
55.4
44.9
60.1
35.5
2008
2009
2010
2011
Calendar Year


NEST - average days for Category 3
31 December over boundary cases
WACHS
Days
350.0
300.0
250.0
200.0
150.0
100.0
50.0
0.0
59.8
61.4
130.1
49.2
2008
2009
2010
2011
Calendar Year

For the financial year as previously reported in the Annual Report, WACHS hospitals have maintained the steady increase in elective surgery cases treated in recent years, an 18% increase across the period 2007-12. For the three elective surgery urgency categories for the same period, there have been increases of 42.8%, 6.3% and 19.2% for Categories 1, 2 and 3 respectively.

Figure 7: Elective Surgery – Treated cases 2007-12



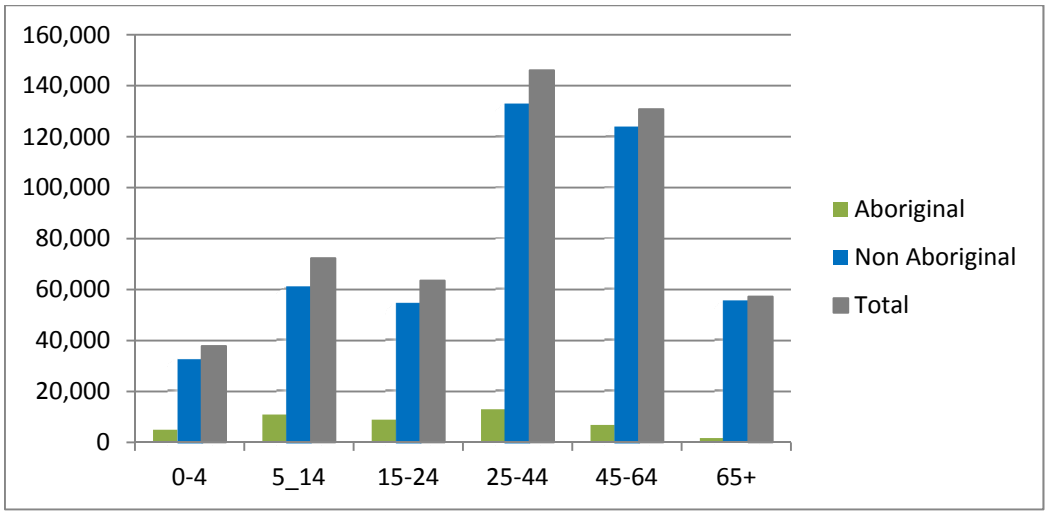
Snapshot of Population Health for WA Country Areas

Demographics

Approximately 23% (22.7%) of the State population reside in country WA, of which 52% are male and 48% female. The majority of the population is aged 25-64 years, though country WA has a slightly larger percentage of children aged 0-14 years compared to the State (22.1% vs. 19.3%).

Aboriginal people account for 9.2% of the area's population which is greater than the State average (3.3%)[1].

Figure 8: Population profile for WACHS



Health and Wellbeing

While it is widely accepted that health risk factors such as smoking, cholesterol, diet and exercise impact on health, it is also known that a number of other factors play a role in determining health status and the health and wellbeing of a community. Collectively, these factors are known as health determinants.

Each year WA Health commissions a general health and wellbeing survey conducted independently across the State. This survey collates self-reported health information from randomly selected respondents. The following is a summary of some of that health related information for 2011.

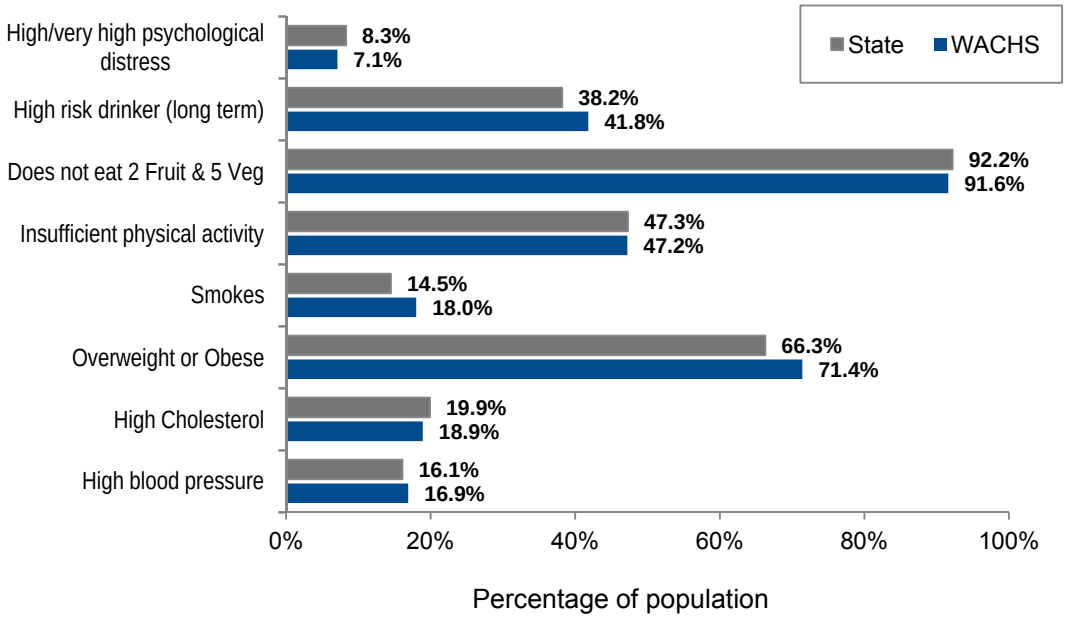
In 2011, a total of 18.0% of country residents reported that they were current smokers, while 41.8% were found to be drinking at levels considered to be high risk for long term harm. This was particularly true for males compared to females (54.0% vs. 28.3%).

[1] Figures based on 2010 Estimated Resident Populations

Approximately 9 in 10 (91.6%) of respondents were found to not be eating the recommended serves of fruit and vegetables, 47.2% were found to not undertake the required amount of physical activity necessary for a health benefit , while one in 3 individuals (32.7%) were reported as obese. A significantly higher proportion of males than females were found to be overweight or obese (75.4% vs. 66.6%).

Also, approximately 1 in 5 respondents (18.9%) stated that they had high cholesterol, while 16.9% reported high blood pressure.

Figure 9: Prevalence of Lifestyle and Physiological Risk Factors for persons 16 years and over in 2011



In 2011 approximately 1 in 5 (19.9%) of repondents aged 16 and over reported that they had been diagnosed as having arthritis by a doctor (see Figure 10). Other chronic health conditions diagnosed by a doctor in the country population were diabetes (6.4%), cancer (5.9%), and heart disease (5.8%).

Commonly used health services reported by country respondents were primary health care services (87.0%), followed by dental health services (50.4%), allied health services (48.4%) and hospital health care services (31.2%).

In the past 12 months a significanly higher proportion of WACHS residents reported using hospital based health services compared with their metropolitan counterparts (31.2% vs. 25.3%), while fewer reported using dental health services (50.4% vs. 56.2%).

Figure 10: Prevalence of self-reported doctor diagnosed health conditions for persons 16 years and over in 2011

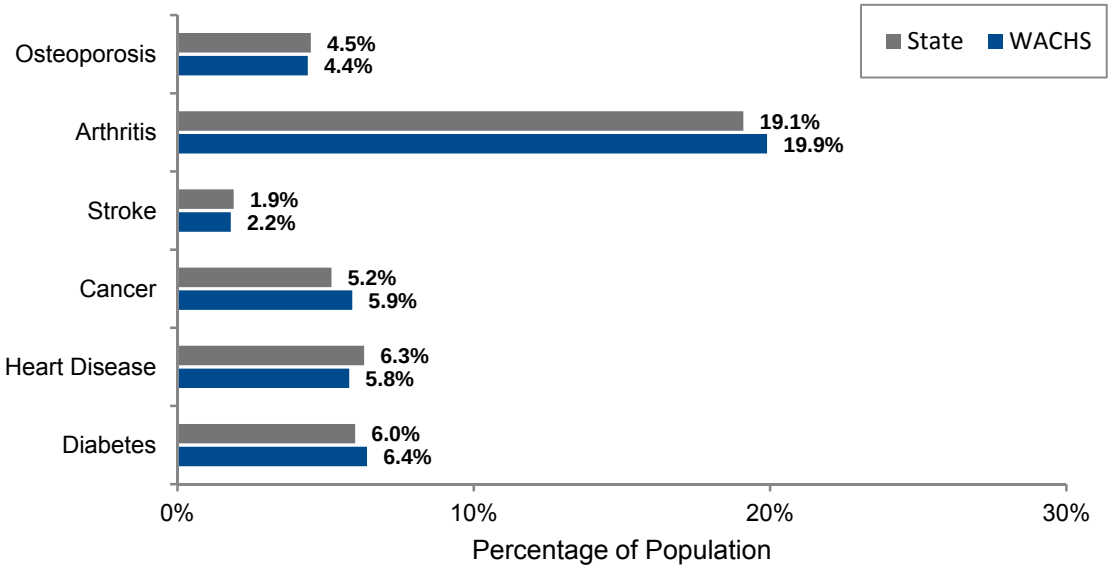
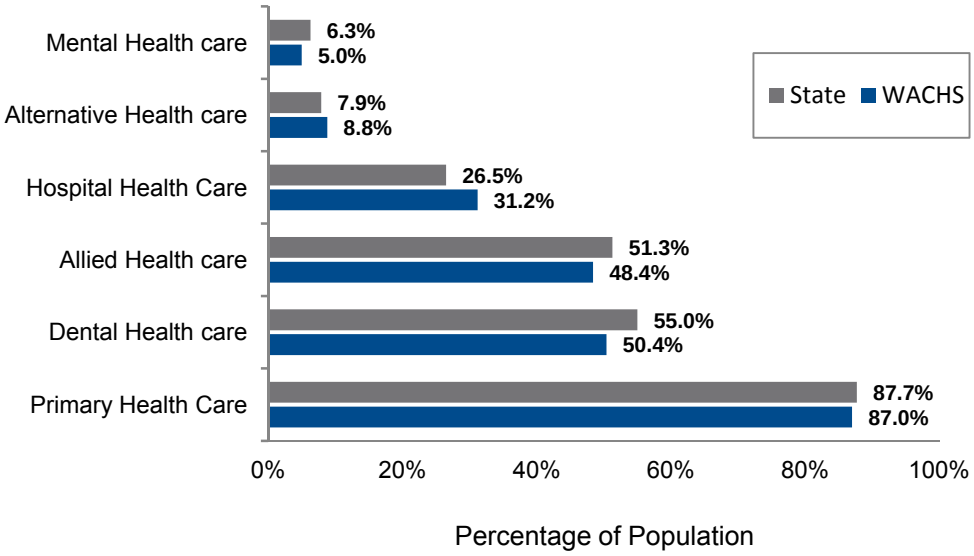
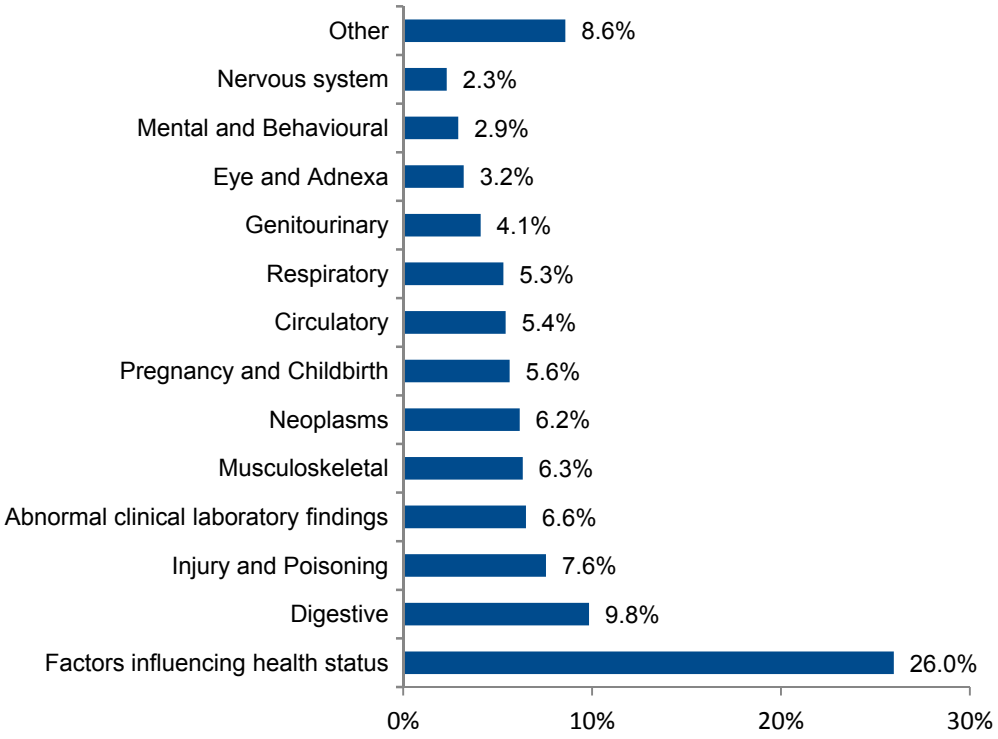


Figure 11: Self-reported health service utilisation in the past twelve months for persons 16 years and over in 2011



In 2011 the major reason for hospital admissions was "Other factors affecting health status" (26%). This includes medical treatments such as chemotherapy and dialysis.

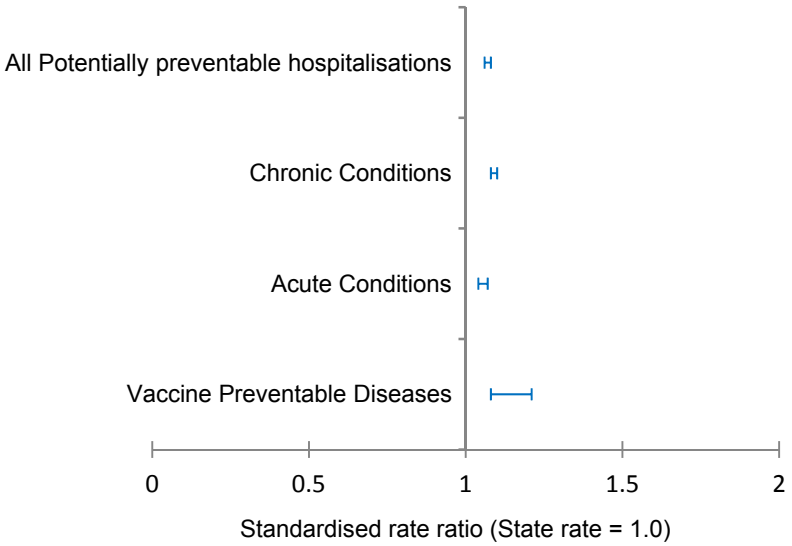
Figure 12: Major reasons for admission to a hospital by WACHS residents in 2011



In 2010 it is estimated 14,524 country hospital admissions could potentially have been prevented and the potential cost saving would be approximately $89 million. From 2006 and 2010 when compared to the State rates, WACHS potentially preventable hospitalisation rates due to vaccine preventable conditions, acute conditions, and chronic conditions were found to be greater.

From 2005 and 2010 the rate of potentially preventable hospitalisations for Aboriginal people in WACHS regions was 4.7 times higher than the non-Aboriginal rate.

Figure 13: Total potentially preventable hospitalisations rate ratio for WACHS residents from 2006- 2010[2]



[2] The WACHS standardised rate ratio is compared to the State standardised ratio of 1.0. A ratio of 1 means that the WACHS rate is the same as the State, and a value of 2 indicates the WACHS rate is twice that of the State.

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Delivering a **Healthy WA**

Significant Issues Impacting the Agency

2011-12 Highlights & Significant Issues

2011-12 Year In Review

The WA Country Health Service's strategic direction 'Revitalising WA Country Health Service 2009-2012' outlines the way forward for health service delivery in regional WA.

During 2011-12, the WA Country Health Service (WACHS) under its strategic direction, *Revitalising WA Country Health Service 2009-2012,* continued its mission to improve, promote and protect the health of Western Australians living in rural and remote areas by:

- Securing a fair share of resources and being accountable for their use;
- Improving service access based on need and improving health outcomes;
- Improving the health of Aboriginal people; and
- Building a skilled workforce and a supportive workplace.

- In all the decisions and actions that WACHS undertakes staff are committed to maintaining the core values of the organisation by:
- Community - Empowering communities and teams;
- Compassion - Considering others;
- Quality - Providing the best possible care and service to the community with integrity;
- Integrity – Building trust based on honesty, accountability and respect for others; and
- Justice – Showing respect and fairness by treating all people equally and embracing diversity.

Identified priorities for 2011-12 were to continue to build on the successes of previous years through local hospital reforms, improvements in safety and quality of care, and meeting increased service demand. Also, a primary focus was to support Statewide initiatives including the Four Hour Rule, elective surgery, Aboriginal health and working with the Council of Australian Governments to improve public hospital services across the Nation.

Many achievements were made in meeting the above priorities.

Major hospital building and redevelopment programs

Albany Health Campus redevelopment

The $170.4 million Albany Health Campus will provide improved and expanded health services for the Great Southern region, and has been funded by Royalties for Regions as well as the State and Australian governments, with active participation by the Community Reference Group. Demolition and early works for the construction of the Campus have been in progress since January 2011, and the campus is on target for completion and opening in mid 2013. The new Campus will feature an improved and expanded range of services that include a bigger emergency department, more mental health beds, upgrading renal dialysis and cancer services, and increased surgical services. Approximately 60-70% of the construction workforce for the project has been recruited locally.

Royalties for Regions Funding of $4.26 million has also recently been awarded to form part of the $5 million budget to replace the current four-bed hospice with an eight-bed facility to be built next to the new health facility.

Figure 14: Section of Albany Health Campus in construction

Kimberley Capital Works

A number of major building and redevelopment projects for the WACHS - Kimberley have been completed including:

- A new Paediatric Ward and 14 bed Acute Mental Health inpatient unit as part of the Broome Hospital Redevelopment;
- The final $3.2 million stage of the Ngnowar Aerwah Residential Rehabilitation Facility in Wyndham;
- The delivery of seven new hospital staff houses in Kununurra, the purchase of two additional houses in Kununurra, and one Ngnowar Aerwah staff house in Wyndham, together with accommodation for nursing staff at Kalumburu;
- New landfill compounds in Warmun and Kalumburu ($200,000);
- Installation of a Water Chlorination unit in Kalumburu ($500,000); and
- Installation of a Calcium removal system for the Warmun Community water supply ($160,000).

Esperance Health Campus Redevelopment

In May 2012 State Cabinet endorsed the $31.3 million Stage One Redevelopment of the Esperance Health Campus. This project is jointly funded with $18.8 million from the State Government's Royalties for Regions program and $12.5 million from the WA Health capital expenditure program. The redevelopment will include the expansion and upgrade of the ED and the operating theatres, construction of a Day Surgery Unit, and refurbishment of existing maternity wards.

Carnarvon Health Campus and Exmouth Multipurpose Service Redevelopment

Planning is underway for the State Government endorsed $34.9 million redevelopment of health services in the Gascoyne region. The Carnarvon Health Campus (CHC) and the Exmouth Multipurpose Service (EMPS) will share $29.1 million funding from the State Government's Royalties for Regions program with the CHC receiving almost $6 million from the WA Country Health Service. Under the redevelopments, CHC will receive a new ambulatory health care facility to accommodate community mental health services, and the co-location of all ambulatory and primary care services, as well as a

new four-chair renal service in the redeveloped ED. The EMPS' new Ambulatory Health Care Facility will accommodate general practitioners and child health services.

Redevelopment of Critical Care facilities at Bunbury Hospital

WACHS is undertaking a major redevelopment of critical care facilities and services at Bunbury Hospital. Completion of the fit out and equipping of the 4 intensive care unit beds has occurred. An acting intensive care unit (ICU) Medical Director position has been established and active recruitment for an Intensive Care specialist and specialist physicians in Australia and overseas is underway. Work has commenced on the construction of a new 27 bay ED.

Busselton Health Campus

The $120.4 million Busselton Health Campus (BHC) remains on target to begin construction in mid 2012 and to be completed in mid 2014. Detailed designing of the Campus has started with the concept plan for construction, and the development of the schematic design that includes details concerning individual rooms and departments, being finalised. Construction planning has commenced with State and Commonwealth environmental approvals being provided. Identification of the builder of choice and preparation of the site are underway. Transition planning has also commenced so that services are ready to move into the new facility when it is completed.

Karratha Health Campus

On receiving an additional $57.15 million from the 2012 State Budget, a total of $207.1 million will now fund the construction of the new health campus in Karratha to replace the ageing Nickol Bay Hospital, and the Warambie community and population health centre. The additional funds will allow the development of a 'one stop shop' for health care, bringing together in the one place services such as acute care, population health, community mental health, and drug services. As a result, the new site will have the capacity to support potential partnerships with other private and non-government health care providers. This is the largest expenditure on a single health infrastructure project in country WA to date, and site works are due to commence in 2013.

Kalgoorlie Health Campus

Works continue on the $55.8 million Stage One redevelopment of the Kalgoorlie Health Campus. The project, which includes $15.8 million Royalties for Regions funding, is being completed in phases so that clinical services can continue. Phase one, a three bedroom palliative care addition, was opened in December 2010. Construction started on phase two in January 2011 and is due to be completed in September 2012. Work on the final phase is scheduled to start in 2013.

Medical Imaging Equipment

WACHS continues to implement the national 'capital sensitivity' initiative that supports health services to improve the quality of diagnostic imaging services by upgrading and replacing aged equipment as appropriate. Key milestones achieved in 2011-12 have included the deployment of mobile x-ray units for remote x-ray operator sites, commencement of the removal of wet x-ray chemistry and change to a digital image processing system, and the installation of six CT scanners.

Major country health initiatives

Closing the Gap in Aboriginal Health Outcomes

WA Health and it's partners are now implementing the fourth and final year of the 2009-2013 'Closing the Gap National Partnership Agreement'. There are currently 99 Aboriginal specific services and 317 positions (69% Aboriginal) being delivered by the government, non-government organisation and Aboriginal Community Controlled sectors across the five priority areas:

- Tackling smoking – 13 programs;
- A healthy transition to adulthood - 24 programs including the Statewide Specialist Aboriginal Mental Health Service;
- Aboriginal health is everyone's business – 16 Programs;
- Primary health care services that can deliver – 26 programs; and
- Fixing the gaps and improving the patient journey – 23 programs.

Consolidating the achievements of the programs to date, the WACHS Aboriginal Health Improvement Unit has worked with industry partners to develop a blue print and business case for Aboriginal health reform beyond 2013. This business case aims to consolidate and expand on progress including a number of community identified priorities that will enable greater advancement towards 'Closing the Gap' for Aboriginal Western Australians.

Southern Inland Health Initiative

The Southern Inland Health Initiative is one of the largest investments into regional health in Western Australia's history. Funded by the Royalties for Regions program, the Initiative will invest $240 million over a 5 year period towards building health services and its workforce, and $325 million on a capital works program to improve health infrastructure in the southern inland catchment.

In the first year of the initiative, 13 new doctors joined general practices in the area and are now participating in the Emergency Department roster initiative that enables the community to access emergency care 24 hours per day, seven days per week (24/7). Towns that have benefited from the 24/7 Emergency Rosters include Esperance, Northam, Merredin and Narrogin. Twelve hour ED doctor coverage plus a further 12 hour close on-call cover is now available daily in the hospitals in these towns. Manjimup, Bridgetown, Collie and Katanning have a close on-call doctor around the clock, seven days a week. Also, a further 76 doctors are delivering services throughout the region as part of the ED networked model.

Recently, primary health Nurse Practitioners have been contracted to work in the Northam, Narrogin, Katanning and Merredin districts. Supported by Primary Health Care Integration Coordinators, they will work toward improving patient access to primary health care services and support general practitioners in the region.

Telehealth equipment across the southern inland catchment is being installed to enable patients to receive specialist support and advice closer to home.

Extensive service planning has been undertaken across the southern inland catchment, along with building condition audits at 37 sites. These will assist in the scoping and prioritisation of the proposed $325 million infrastructure program.

Pilbara Health Initiative

The Pilbara Health Initiative is a $38.2 million partnership between the State Government's Royalties for Regions program and major Pilbara industries (BHP Billiton Iron Ore, Woodside, Chevron, North West Shelf Venture and Rio Tinto) that aims to boost health services in the region.

In 2011-12 the ability to respond to emergency situations has improved, a result of education programs and employment of emergency staff. Medical specialist services across the West Pilbara have also increased.

The Indigenous Employment Program has continued to provide opportunities to Aboriginal people within the Pilbara. This has enabled WA Health to respond to the needs of Aboriginal staff, and support them in further developing their professional and personal goals. The program was awarded the 'Improvement in the Workplace Environment Award' and the 'Director General's Choice Award' at the 2011 WA Health Awards.

Emergency departments at hospitals around the region have benefitted from the installation of wireless networking, and Newman Hospital has had a refurbishment of the Medical Imaging department, with new general x-ray and dental x-ray equipment being installed. Three one bedroom self contained modular accommodation units for staff have been also been installed on site at Newman.

Pilbara Cardiovascular Screening Program

An investigation into the need for cardiac services in the Pilbara, inclusive of community consultation, was completed in July 2011. In April 2012 a revised business case was submitted to the Department of Regional Development and Lands to support the development of the Memorandum of Understanding for the provision of cardiac services in the Pilbara.

Service delivery according to need in Country Western Australia

Improving surgical and emergency waiting times for country patients

Elective Surgery Program – NEST

As part of the National Health Reform Agreement (NHRA) a National Elective Surgery Target (NEST) has been established that requires:

- All elective surgery patients for all urgency categories to be treated within clinically recommended times; and
- Admission numbers for patients waiting beyond the recommended wait times for surgery, admission numbers must be maintained or be below the baseline.

The NEST program commenced on 1 January 2012 with progressive performance targets to be met by WACHS over a 4 year period (see Tables below).

As at July 2011, 91%, 92% and 97% of patients for urgency categories 1 to 3 were treated within clinically recommended times respectively. Average overdue wait time (days) for patients waiting beyond the recommended time for treatment as at 2011 were well below the agreed 2010 baseline per urgency category i.e., Category 1- 22 vs. 27 days; Category 2 - 35 vs. 90 days; Category 3 - 49 vs. 87) (see Table below).

To achieve NEST WACHS aims to own and direct the management of their elective surgery waitlists to ensure the delivery of services within the required performance parameters are based on the 'first on first off' principle for similar cases.

Part 1: Improvement in Patients treated within 'Clinically Recommended' Time

Table 2: Admissions within boundary (by calendar year)

NEST – Urgency Category	Baseline	Target				
		2012	2013	2014	2015	2011 Actual
Urgency Cat 1	87.4%	94%	100%	100%	100%	91%
Urgency Cat 2	79.2%	84%	90%	95%	100%	92%
Urgency Cat 3	97.2%	98%	99%	99%	100%	97%

Part 2: Reduction in 'Long Waits'

Table 3: Average overdue wait time (days) for patients waiting beyond the recommended time

NEST – Urgency Category	Baseline (31/12/10)	Target as at 31 December				
		2012	2013	2014	2015	2011 Actual
Urgency Cat 1	**27**	**0**	**0**	**0**	**0**	**22**
Urgency Cat 2	**90**	**68**	**45**	**23**	**0**	**35**
Urgency Cat 3	**87**	**65**	**44**	**22**	**0**	**49**

Four Hour Rule Program – NEAT

The Four Hour Rule Program involves significant redesign activity across 17 WA Health hospital sites, seven of which are WACHS sites. The Program aims to improve the quality of patient care and reduce pressure on staff and services by streamlining processes from admission through to discharge, to ensure that patients arriving at EDs are seen and admitted, discharged or transferred within a four-hour timeframe.

The Program utilises a rigorous clinical service redesign methodology tailored to suit the needs of WA Health. The program was implemented across seven nominated hospitals in Bunbury, Albany, Broome, Geraldton, Kalgoorlie, Port Hedland, and Nickol Bay. All stages of implementation of the Program are now in the end phase of the cycle.

In 2011-12 the WACHS sites have consistently reached the set target with 85 per cent of ED patients being seen within 4 hours. This improved performance has been against a continuing growth in attendances of approximately 5% per annum.

Improving rural cancer services for country patients

New chemotherapy units are currently under construction in Albany and Kalgoorlie. The new six chair, one bed chemotherapy unit, part of the new Albany Health Campus development, is due to be completed in March 2013. The new Kalgoorlie Health Campus will include a new four chair, one bed chemotherapy unit, which is scheduled for completion in January 2014. Chemotherapy units will also be constructed at Narrogin and Northam as part of the Southern Inland Health Initiative to strengthen health services in the southern inland region. Planning is under way for the construction of a six chair, one bed chemotherapy unit at Geraldton.

The Rural Cancer Services Model is being implemented with support from the WA Cancer and Palliative Care Network.

Maintaining aged and continuing care programs for our older adults

Aged Care

A number of key milestones to support the health care needs of our older adults have been achieved in 2011-12 including:

- Commencement of a 3 year quality review project covering all residential care in 30 Multi-Purpose Services and small country hospitals;
- Further expansion of the Subacute program with appointment of a Psychogeriatrician in the South West region;
- Development of business cases for additional inpatient rehabilitation beds in the South West and Great Southern, the expansion of outpatient clinics, and Stroke services in the Midwest, Goldfields, South West and Great Southern WACHS regions;
- Successful negotiations with the Commonwealth for a Multi-Purpose Service model for Carnarvon Hospital;
- Finalisation of a concept paper for a Residential Aged Care and Dementia Investment project; and
- Funding for the national 'Long Stay Older Patients' initiative for a further 4 years, and ongoing funding for the Friend in Need - Emergency (FINE) initiative.

Ensuring country communities continue to have access to primary or community based health services

Indigenous Early Childhood Development

With two years remaining on the National Partnership Agreement on Indigenous Early Childhood Development 2009 to 2014, all 26 services across WA are now fully operational. A total of 90 positions have been created across the Government, NGO and Aboriginal Community Controlled sector which aim to increase access to services across the two main areas of delivery:

- Element 2: Improved ante-natal, pre-pregnancy, and sexual/reproductive health for Western Australian Aboriginal women and teenagers - 12 programs.
- Element 3: Increased access and use of child and parent health services for Aboriginal families.

Mental Health Services Planning

WACHS is a major provider of mental health services designed to improve the quality of life and care of Western Australians with mental illness. In 2011-12 a new Statewide

Specialist Aboriginal Mental Health Service (SSAMHS) was implemented, as well as a Mental Health Professional On-line Development (MHPOD) initiative. Child and Youth Services received additional staffing resources and the Mabu Liyan Kimberley Mental health Unit was opened. Preparation of a position paper for integrating service delivery for people with co-occurring drug and alcohol disorders has also commenced.

Telehealth

The Southern Inland Health Initiative (SiHi) has enabled a restructure of the Statewide Telehealth Service that delivers health care services at a distance to patients via communication technology. Key milestones toward improvement of telehealth services achieved in 2011-12 have included:

- The appointment of the Regional Telehealth Manager for the Southern Country Health Service;
- Installation of standardised software across the state onto videoconferencing machines along with 38 new or existing rural sites that have received upgraded equipment;
- Establishment of a scheduling system for clinical activity following enhancement of the telehealth booking system (MMEx);
- Establishment of a centralised statewide Telehealth helpdesk currently providing assistance to an average of 130 requests per month;
- The development of new clinical services in Paediatric ear, nose and throat, Endocrinology, Podiatry, Maternity and Respiratory Medicine. Other expanded services include Plastic Surgery, Pain Medicine and Psychological Oncology;
- The development of a governance framework for Telehealth that includes the re-establishment of the Statewide Telehealth Advisory Group, and the creation of a state-wide strategic plan 2012 - 2014 and a supporting operational plan;
- An agreement between Western Australia and the Northern Territory for the purchase and installation of new videoconferencing equipment into the Kimberley region along with developing interoperability and dial plans between the videoconferencing infrastructures of the two jurisdictions; and
- The finalisation of a framework for Telehealth in WA inclusive of the public, private and non government sectors.

Renal Dialysis Plan

The WACHS Renal Dialysis Plan was completed in 2010. Implementation of Phase 1 is underway with a $45m grant from the Australian Government for capital development.

The Pilbara Dialysis Plan was completed in January 2012 and implementation will occur in line with the WACHS renal plan.

WACHS Renal Clinical Lead Dr Steve Wright from RPH has been appointed for one session per week to provide renal clinical advice and leadership.

The renal telehealth pilot in the WACHS - Goldfields has been running since early 2012, providing a telehealth clinic to Kalgoorlie approximately every eight weeks. WACHS metropolitan based nephrologist visits Kalgoorlie weekly, with one visit in eight provided from Perth via the renal telehealth pilot. There are plans to extend the service to other Goldfields sites such as Laverton and Warburton. Consideration will be given to introducing a similar service in other regions.

An interim dialysis service commenced in Fitzroy Crossing hospital in July 2012. Two dialysis chairs have been set up in one of the two bed wards. This service can accommodate a maximum of eight patients, and is an interim service until a more permanent four chair facility is established in 2014-15.

Royal Flying Doctor Service

The Royal Flying Doctor Service (RFDS) is funded by the State Government to provide aeromedical interhospital patient transport for patients being transferred from one hospital to another. In 2008-09 the State Government approved increased funding of $68.5 million over five years to the RFDS with the aim of increasing RFDS capacity and improved response times for inter-hospital patient transfers. The approved increase in infrastructure has been fully implemented with the purchase of five aircraft to replace ageing aircraft and three new aircraft to expand the fleet from 11 to 14 aircraft. The increased RFDS capacity has resulted in improved response times for inter-hospital patient transfers.

In 2011-12, the RFDS had provided interhospital patient transfers for 5,480 country patients over 6.9 million kilometres, an increase of 6.3% in patient numbers and 5.5% in kilometres for the same period in 2010-11. In this time period approximately 80% of priority 1 calls (patients with a life threatening condition which is time critical) were responded to within 75 minutes in line with the performance target for achievement (80%). This is a marked improvement when compared to response times in 2010-11 (79.6%) and 2009-10 (76.4%).

Royalties for Regions funding of up to $3 million over 3 years were also approved in 2009-10 to underwrite a Medical Jet Service pilot, which commenced in October 2009 with the financial support of Rio Tinto Iron Ore. In 2011-12, the State Government contributed $1.17 million to cover the jet's 2010-11 operating shortfall. The jet service reduces the flight times for country patients in the State's Northwest and has the capacity to carry up to 6 patients. In 2011-12 the service transported 289 critically ill country patients to tertiary hospitals in Perth, with 86% of patients being from the State's Northwest. The jet was used economically with 69% of flights carrying 2 or more patients.

Patient Assisted Travel Scheme

The Patient Assisted Travel Scheme (PATS) election commitment has been fully implemented. 'Royalties for Regions' provided an additional $30.8 million from 2008-09 to 2011-12 to reduce the financial burden on country residents who need to travel more than 100kms one way to access the nearest eligible medical specialist services. Improvements included increases for kilometre road travel and the patient accommodation subsidies, as well as increased support to patients, particularly the aged, disabled, and people who require treatment for cancer.

Trends since January 2009 show an increase in demand for PATS. It is forecast that the total number of trips for 2011-12 financial year will be approximately 77,000, with an estimated $35 million provided in subsidies.

Priorities for 2012-13

In 2012-13 WACHS will continue to build on the successes of previous years through hospital reforms, improvements to the safety and quality of care and meeting increased service demand. The Health Service will play a central role in key statewide initiatives around emergency services, elective surgery, Aboriginal health and Activity Based Funding and Management.

In the coming year, the WA Country Health Service will continue to build on the successes of previous years through major building and redevelopment programs, clinical services planning to support service delivery and health outcomes of country residents, and to continue to focus on Aboriginal health, and building a sustainable workforce.

In addition, WACHS will continue it's commitment to the National Health Reform Agreement (NHRA), following the establishment of two new country Health Services (Northern and Remote Country Health Service and Southern Country Health Service), and associated Governing Councils in July 2012. This reform is designed to embed greater community input and control of health services, and to increase accountability and community confidence in strategic direction-setting and service development and delivery across country WA. The NHRA also provides an opportunity for WACHS to further invest in a number of areas, including emergency and elective reform and sub-acute care to improve patient outcomes.

Major country health initiatives

Southern Inland Health Initiative

As this important initiative moves into its second year, doctor recruitment will continue to be a priority, as will commencement of infrastructure upgrades across several hospital sites in the SIHI region in 2012-13. There will also be a continued focus to ensure the new medical model is appropriate for health care in the SIHI communities.

The Primary Health Care Demonstration Site Program is entering the selection and preliminary planning phases of the program in communities that choose to 'opt in' to the process. These sites will be one-stop shop health care facilities that will focus on the promotion of good health, the prevention and early detection of illness and management of chronic health conditions and provide a range of health care services dependent on the local needs of the community.

Telehealth

During 2012/13, the restructure of the statewide Telehealth Service will continue as will the rollout of new videoconferencing technology into regional and metropolitan health services to further enhance service delivery.

National Health Reform Agreement programs: National Emergency Access Target (NEAT) and National Elective Surgery Target (NEST)

WACHS will continue to focus on meeting and improving service delivery in emergency departments and managing wait times for elective surgery as part of the National Health Reform Agreement NEAT and NEST programs. Over the coming year, WACHS will

finalise emergency department redevelopments at Bunbury, Broome and Nickol Bay Hospitals.

WACHS will continue to manage activity targets (inpatient, emergency department and outpatient) per the National Activity Based Funding (ABF) initiative that aims to enhance public accountability and provide efficient delivery of health services. Building capacity and capability in managing services in an ABF environment is challenging, particularly for regions in the Northwest.

Closing the Gap in Aboriginal Healh Outcomes

Given the achievements of this initiative to date, the WA Country Health Service Aboriginal Health Improvement Unit has worked with industry partners to develop a blue print and business case for Aboriginal health reform beyond 2013. This business case aims to consolidate progress and expand to include a number of community identified priorities that will enable greater advancement towards Closing the Gap for Aboriginal Western Australians.

Aboriginal Employment

The WA Country Health Service will continue to implement the Aboriginal Employment Strategy and investigate opportunities to increase Aboriginal employment in WACHS regions. WACHS will focus on developing a mentoring training package for the workforce to support and assist new Aboriginal employees.

Medical Imaging Equipment

WACHS continues to implement the National 'capital sensitivity' initiative that supports health services to improve the quality of diagnostic imaging services by upgrading and replacing aged equipment as appropriate. Removal of wet x-ray chemistry and change to digital image processing in the form of computed radiography will continue, with digital x-ray equipment to be installed at Karratha and Carnarvon, and four ultrasound machines at Narrogin, Derby, Kununurra and Northam.

Patient Administration System (WebPAS)

There will be a significant focus by WACHS on the implementation of a new web-based Patient Administration System and patient billing system that will initially 'go-live' at the new Albany Health Campus. The new webPAS is an important initiative that will improve the transfer and sharing of patient information to users at other health sites and facilities in country WA. This is significant change and improvement for WACHS and will support our staff to provide safe, quality health care to the public.

Governing Councils

WACHS will continue to work with and develop the Governing Councils for the Northern and Remote Country Health Service, and the Southern Country Health Service. The Governing Councils include community members and clinicians who bring skills and experience as well as shared commitment to providing quality health services to the communities in the regions they represent.

Council members have a specific responsibility for ensuring effective engagement with community and clinical stakeholders and ensuring their interests are reflected in health service planning and reporting.

Aboriginal Employment

The WA Country Health Service will continue to implement the Aboriginal Employment Strategy and investigate opportunities to increase Aboriginal employment in WACHS

regions. WACHS will focus on developing a mentoring training package for the workforce to support and assist new Aboriginal employees.

Major hospital building and redevelopment programs

Albany Health Campus Redevelopment

The new Albany Health Campus will open in the first half of 2013 and will deliver a streamlined health service in a contemporary and innovative hospital.

The campus will have strong links with the region's smaller hospitals and other health providers to offer improved support for all clinical services. Construction of the new hospice building will commence in 2013 to replace the current four-bed hospice with an eight-bed facility.

Kimberley Capital Works

The $22.2 million Royalties for Regions funding will enable the redevelopment of up to six Remote Health Clinics across the North West of Western Australia. These include:

- the redevelopment of the Broome ED scheduled for completion in July 2012;
- Stage 2 of the ED redevelopment ($8m), funded under the National Partnership Agreement (NPA) will commence in September 2012;
- construction of replacement staff accommodation in Halls Creek ($1.6 million);
- construction of additional staff accommodation in Wyndham;
- construction of a $4 million Community Care facility in Kalumburu;
- completion of the $20.5 million Integrated Primary Health Centre and a $5.15 million Short Stay Patient Accommodation facility in Kununurra; and
- $1.9 million grant under the National Partnership agreement to fund a new CT scanner at Kununurra Hospital.

Esperance Health Campus Redevelopment

In May 2012 State Cabinet endorsed the $31.3 million Stage one redevelopment of Esperance Health Campus. The redevelopment will include the expansion and upgrade of the ED and the operating theatres, construction of a Day Surgery Unit, and refurbishment of existing maternity wards. In 2012-13 progress toward redevelopment of the Campus will include appointment of a project manager by August 2012, and an architect by September 2012. A project definition plan will be completed by the end of 2012.

Carnarvon Health Campus Redevelopment and Exmouth Multipurpose Service Redevelopment

Planning is underway for the State Government endorsed $34.9 million redevelopment of health services in the Gascoyne region that includes the CHC and the EMPS. In 2012-13 the redevelopment planning and Project Working Groups will be initiated and will include for both sites, completion of the:

- project definition planning phase with functional brief by December 2012;
- schematic design phase, design development, and contract documentation as at September 2013; and
- award of the construction tender by December 2013.

Critical Care at Bunbury Hospital

The WACHS major redevelopment of critical care facilities and services at Bunbury Hospital continues with the formal opening of the intensive care unit planned for mid 2012-13. Construction of the new ED is progressing with 19 bays expected to be completed in 2012-13 and a further eight additional bays in 2013-14. Work has also commenced on fitting out the existing ED to accommodate the 10 bay short stay unit, and enhancement of the fast track facility to a total of 27 ED bays.

Busselton Health Campus

Construction of the Busselton Health Campus, due for completion in 2014, will progress with the following due for achievement in 2012-13:

- Completion of enabling works prior to the start of the main construction;
- Assessment of tenders and negotiations for the main construction contract;
- Commencement of work under the main construction contract;
- Finalisation of the design in consultation with the construction contractor and user groups;
- Continued preparation for the transition of services to the new facility; and
- Work with State and Commonwealth regulators to comply with the conditions of the environmental approvals.

Karratha Health Campus

Significant planning, including transitional planning of the new health campus in Karratha will occur over the next twelve months. This will include completion of the project planning and development phase as well as exploring private partnerships to co-locate on the health campus, improving the continuum of care and choice for the community of West Pilbara.

Kalgoorlie Health Campus

Work on the Kalgoorlie Health Campus continues with a new building on site which creates a new front entrance, houses a new ED, High Dependency Unit, and Medical Imaging Department, expected to be operational before the end of 2012. The contract for the construction of the next phase which includes specialist outpatient clinics and allied health services will go to tender before the beginning of 2013.

Delivering a **Healthy WA**

Key Performance Indicators

Certification Statement

WA COUNTRY HEALTH SERVICE
CERTIFICATION OF PERFORMANCE INDICATORS
FOR THE YEAR ENDED 30 JUNE 2012

I hereby certify the performance indicators are based on proper records, are relevant and appropriate for assisting users to assess the performance of the WA Country Health Service and fairly represent the performance of the health service for the financial year ended 30 June 2012.

Kim Snowball
DIRECTOR GENERAL OF HEALTH
ACCOUNTABLE AUTHORITY

20 September 2012

Audit Opinion

Auditor General

INDEPENDENT AUDITOR'S REPORT

To the Parliament of Western Australia

WA COUNTRY HEALTH SERVICE

Report on the Financial Statements
I have audited the accounts and financial statements of the WA Country Health Service.

The financial statements comprise the Statement of Financial Position as at 30 June 2012, the Statement of Comprehensive Income, Statement of Changes in Equity and Statement of Cash Flows for the year then ended, and Notes comprising a summary of significant accounting policies and other explanatory information.

Director General's Responsibility for the Financial Statements
The Director General is responsible for keeping proper accounts, and the preparation and fair presentation of the financial statements in accordance with Australian Accounting Standards and the Treasurer's Instructions, and for such internal control as the Director General determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility
As required by the Auditor General Act 2006, my responsibility is to express an opinion on the financial statements based on my audit. The audit was conducted in accordance with Australian Auditing Standards. Those Standards require compliance with relevant ethical requirements relating to audit engagements and that the audit be planned and performed to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Health Service's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances. An audit also includes evaluating the appropriateness of the accounting policies used and the reasonableness of accounting estimates made by the Director General, as well as evaluating the overall presentation of the financial statements.

I believe that the audit evidence obtained is sufficient and appropriate to provide a basis for my audit opinion.

Opinion
In my opinion, the financial statements are based on proper accounts and present fairly, in all material respects, the financial position of the WA Country Health Service at 30 June 2012 and its financial performance and cash flows for the year then ended. They are in accordance with Australian Accounting Standards and the Treasurer's Instructions.

Report on Controls
I have audited the controls exercised by the WA Country Health Service during the year ended 30 June 2012.

Controls exercised by the WA Country Health Service are those policies and procedures established by the Director General to ensure that the receipt, expenditure and investment of money, the acquisition and disposal of property, and the incurring of liabilities have been in accordance with legislative provisions.

7th Floor Albert Facey House 469 Wellington Street Perth MAIL TO: Perth BC PO Box 8489 Perth WA 6849 TEL: 08 6557 7500 FAX: 08 6557 7600

Director General's Responsibility for Controls
The Director General is responsible for maintaining an adequate system of internal control to ensure that the receipt, expenditure and investment of money, the acquisition and disposal of public and other property, and the incurring of liabilities are in accordance with the Financial Management Act 2006 and the Treasurer's Instructions, and other relevant written law.

Auditor's Responsibility
As required by the Auditor General Act 2006, my responsibility is to express an opinion on the controls exercised by the WA Country Health Service based on my audit conducted in accordance with Australian Auditing and Assurance Standards.

An audit involves performing procedures to obtain audit evidence about the adequacy of controls to ensure that the Health Service complies with the legislative provisions. The procedures selected depend on the auditor's judgement and include an evaluation of the design and implementation of relevant controls.

I believe that the audit evidence obtained is sufficient and appropriate to provide a basis for my audit opinion.

Opinion
In my opinion, the controls exercised by the WA Country Health Service are sufficiently adequate to provide reasonable assurance that the receipt, expenditure and investment of money, the acquisition and disposal of property, and the incurring of liabilities have been in accordance with legislative provisions during the year ended 30 June 2012.

Report on the Key Performance Indicators
I have audited the key performance indicators of the WA Country Health Service for the year ended 30 June 2012.

The key performance indicators are the key effectiveness indicators and the key efficiency indicators that provide information on outcome achievement and service provision.

Director General's Responsibility for the Key Performance Indicators
The Director General is responsible for the preparation and fair presentation of the key performance indicators in accordance with the Financial Management Act 2006 and the Treasurer's Instructions and for such controls as the Director General determines necessary to ensure that the key performance indicators fairly represent indicated performance.

Auditor's Responsibility
As required by the Auditor General Act 2006, my responsibility is to express an opinion on the key performance indicators based on my audit conducted in accordance with Australian Auditing and Assurance Standards.

An audit involves performing procedures to obtain audit evidence about the key performance indicators. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the key performance indicators. In making these risk assessments the auditor considers internal control relevant to the Director General's preparation and fair presentation of the key performance indicators in order to design audit procedures that are appropriate in the circumstances. An audit also includes evaluating the relevance and appropriateness of the key performance indicators for measuring the extent of outcome achievement and service provision.

I believe that the audit evidence obtained is sufficient and appropriate to provide a basis for my qualified audit opinion.

Basis for Qualified Opinion
Controls over the initial recording of waiting time data used for the effectiveness indicators "Percentage of emergency service patients seen within recommended times (major rural hospitals)" were inadequate. Audit tests of a sample of attendance and treatment times identified a significant number of differences between source records and the database. Consequently, I was unable to determine whether this effective indicator was fairly presented.

Qualified Opinion
In my opinion, except for the possible effects of the matter described in the Basis for Qualified Opinion paragraph, the key performance indicators of the WA Country Health Service are relevant and appropriate to assist users to assess the Health Service's performance and fairly represent indicated performance for the year ended 30 June 2012.

Emphasis of Matter
As reported by the Health Service in the key performance indicators, the effectiveness indicators for "Rate of unplanned hospital readmissions within 28 days to the same hospital for a related condition" and "Rate of unplanned hospital readmissions within 28 days to the same hospital for a mental health condition" are based on the sample period September to November 2011. My opinion is not modified in respect of this matter.

Matter of Significance
WA Country Health Service has received approval from the Under Treasurer to remove the "Elective Surgery Waiting Times" Key Performance Indicator (KPI) from the audited KPIs for the year ended 30 June 2012. The approval is conditional on the inclusion of unaudited performance indicators measuring elective surgery waiting times in the agency's 2011-12 Annual Report and that elective surgery waiting times be reinstated as an audited KPI following the successful definition of national elective surgery waiting time indicators. My opinion is not modified in respect of this matter.

Independence
In conducting this audit, I have complied with the independence requirements of the Auditor General Act 2006 and Australian Auditing and Assurance Standards, and other relevant ethical requirements.

Matters Relating to the Electronic Publication of the Audited Financial Statements and Key Performance Indicators
This auditor's report relates to the financial statements and key performance indicators of the WA Country Health Service for the year ended 30 June 2012 included on the Health Service's website. The Health Service's management are responsible for the integrity of the Health Service's website. This audit does not provide assurance on the integrity of the Health Service's website. The auditor's report refers only to the financial statements and key performance indicators described above. It does not provide an opinion on any other information which may have been hyperlinked to/from these financial statements or key performance indicators. If users of the financial statements and key performance indicators are concerned with the inherent risks arising from publication on a website, they are advised to refer to the hard copy of the audited financial statements and key performance indicators to confirm the information contained in this website version of the financial statements and key performance indicators.

COLIN MURPHY
AUDITOR GENERAL
FOR WESTERN AUSTRALIA
Perth, Western Australia
20 September 2012

Performance Management Framework

The Western Australian Government has five strategic goals. These broad, high-level government goals are supported at agency level by more specific desired outcomes. These outcomes contribute to the achievement of the high-level government goals.

The Government of Western Australia uses an outcomes-based management framework to illustrate the contribution by agencies to achievement of Whole of Government goals.

The current Whole of Government goals are:

- **State Building – Major Projects.**
  Building strategic infrastructure that will create jobs and underpin Western Australia's long-term economic development.

- **Financial and Economic Responsibility.**
  Responsibly managing the State's finances through the efficient and effective delivery of services, encouraging economic activity and reducing regulatory burdens on the private sector.

- **Outcomes-Based Service Delivery.**
  Greater focus on achieving results in key service delivery areas for the benefit of all Western Australians.

- **Stronger Focus on the Regions.**
  Greater focus on service delivery, infrastructure investment and economic development to improve the overall quality of life in remote and regional areas.

- **Social and Environmental Responsibility.**
  Ensuring that economic activity is managed in a socially and environmentally responsible manner for the long-term benefit of the State.

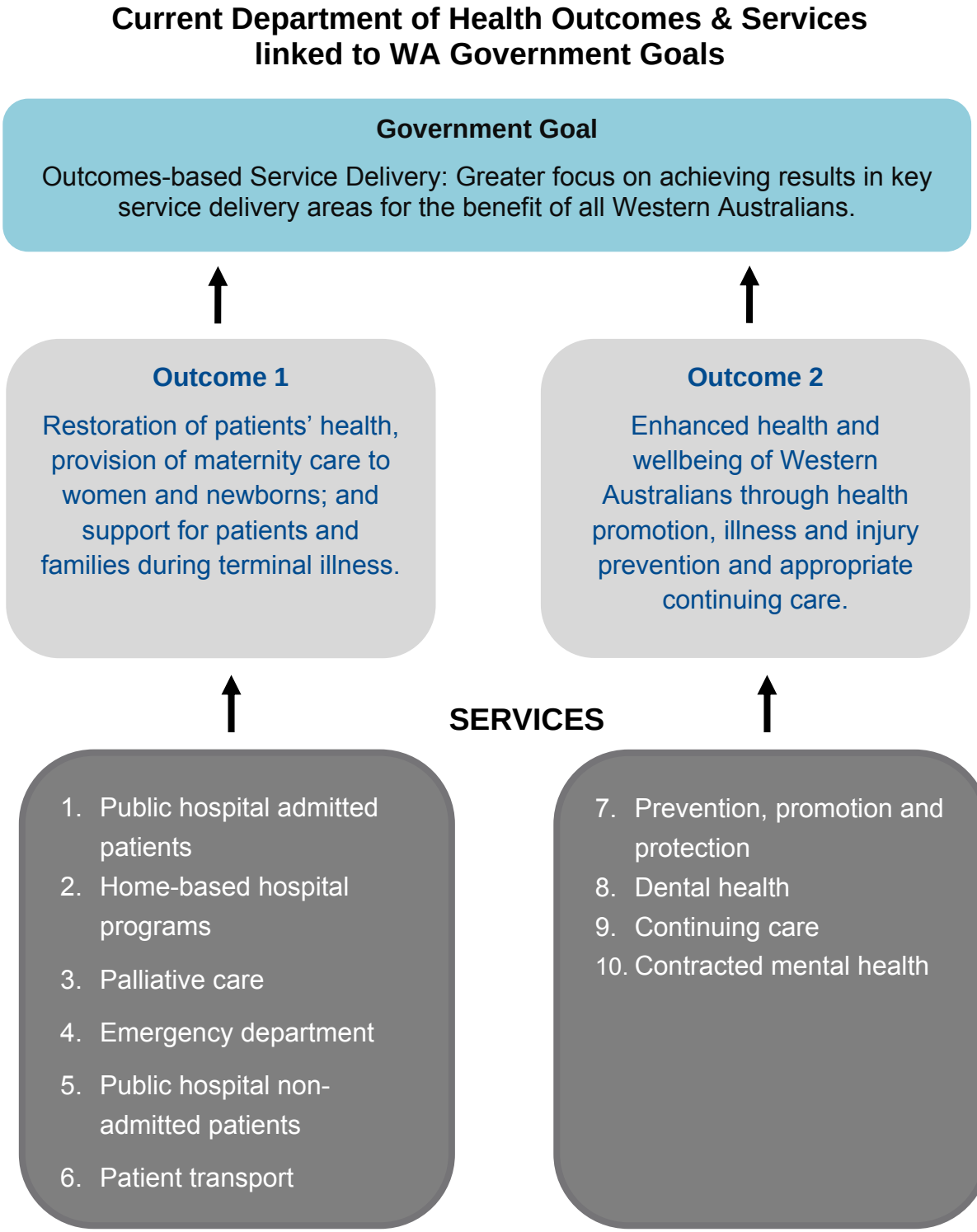
The Whole of Government goal to which the Department of Health contributes is "Outcomes-Based Service Delivery".

WA Health, as the whole public health system in Western Australia is known, endeavours to achieve two agency specific outcomes to meet this goal. They are:

- Restoration of patients' health, provision of maternity care to women and newborns and support for patients and families during terminal illness; and
- Enhanced health and wellbeing of Western Australians through health promotion, illness and injury prevention and appropriate continuing care.

Health care delivered by WA Health is categorised into 10 service groups that support the achievement of above two outcomes. A diagrammatic representation of the WA Health outcome structure follows.

Figure 15: Department of Health Outcome Structure



Key Performance Indicators

The WA Country Health Service (WACHS) is required under an Act of Parliament as well as the Treasurer's Instructions, to present annual indicators of effectiveness and efficiency to Parliament. There are a range of Key Effectiveness Indicators measuring progress towards meeting WA Health's two Outcomes, as well as Key Efficiency Indicators that measure the cost effectiveness of delivery of these services over time and combined they report the extent to which the strategies and activities of the health services contribute to the improvement of the health of the Western Australian community.

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

Outcome 1:
Restoration of patients' health; provision of maternity care to women and newborns and support for patients and families during terminal illness.

Outcome 2:
Enhanced health and wellbeing of Western Australians through health promotion, illness and injury prevention and appropriate continuing care.

All health entities contribute to the achievement of these outcomes, with the health service divisions and Area Health Services taking responsibility for specific areas. While the largest proportion of health service activity is directed to Outcome 1 (particularly within the Metropolitan Health Service), some health services within WACHS have proportionally more activity directed to delivering Outcome 2. Therefore, to ascertain the overall performance of the health system the following annual reports must be read in conjunction:

- Department of Health
- Metropolitan Health Service
- WA Country Health Service

Table 4: Service activities in relation to the health outcomes

Outcome 1	
Service 1 *	Public hospital admitted patients
Service 2	Home-based hospital programs
Service 3	Palliative care
Service 4 *	Emergency department
Service 5 *	Public hospital non-admitted patients
Service 6 *	Patient transport
Outcome 2	
Service 7 *	Prevention, promotion and protection
Service 8	Dental health
Service 9 *	Aged and continuing care
Service 10 *	Contracted mental health

* These services are reported by WACHS.

Comparative Results

Where possible, comparative results of prior years, are provided.

Performance Targets

Performance targets have been developed for the Effectiveness and Efficiency Key Performance Indicators wherever possible. Effectiveness indicator targets have been based on published national averages for the indicators, where available, or from the analysis of previous performance results. Aspirational targets are based on the best result achieved across the reported period. However, where there is a perfect result, generally not a likely outcome and often a function of small numbers (e.g. zero or 100%), the next best result has been adopted as the target.

Efficiency indicator targets are those contributing to the State-wide targets published in the 2012-13 Government Budget Statements (GBS) for the estimated 2011-12 budget expenditure. Targets are not CPI adjusted.

Consumer Price Index Deflator Series

The Consumer Price Index (CPI) Deflator Series is calculated on a five year cycle. 2008-09 was the base year for the current five year cycle. The deflator information is required to calculate the CPI-adjusted results for 2011-12.

Efficiency Indicators

The efficient use of resources and monitoring the unit cost of the various components of hospital care and health care services ensures overall quality and cost effectiveness and maximises the provision of health care. However ongoing enhancement in service activity cost modelling, especially in conjunction with the introduction of activity based funding, and variations in patient characteristics and clinic service types between sites and across time, can result in differences in service delivery costs. The efficiency indicators included in the WACHS Annual Report describe the rural health service's expenditure against a selected number of activity outputs representative of the provision of health care.

Mental Health

The Mental Health Commission of Western Australia (MHC) has assumed the policy control and management for the provision of mental health services in Western Australia. The mental health efficiency indicators reported in the WA Country Health Service Annual Report represent services provided under agreement with the MHC.

Outcome 1:

Restoration of patients' health, provision of maternity care to women and newborns and support for patients and families during terminal illness

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

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

Outcome 1: Effectiveness KPI

Percentage of patients discharged to home after admitted hospital treatment

Rationale

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

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

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

Target

The 2011 target is an aspirational target set for the 'all ages' cohort and is based on the best result achieved over the past four years: ≥97.4%.

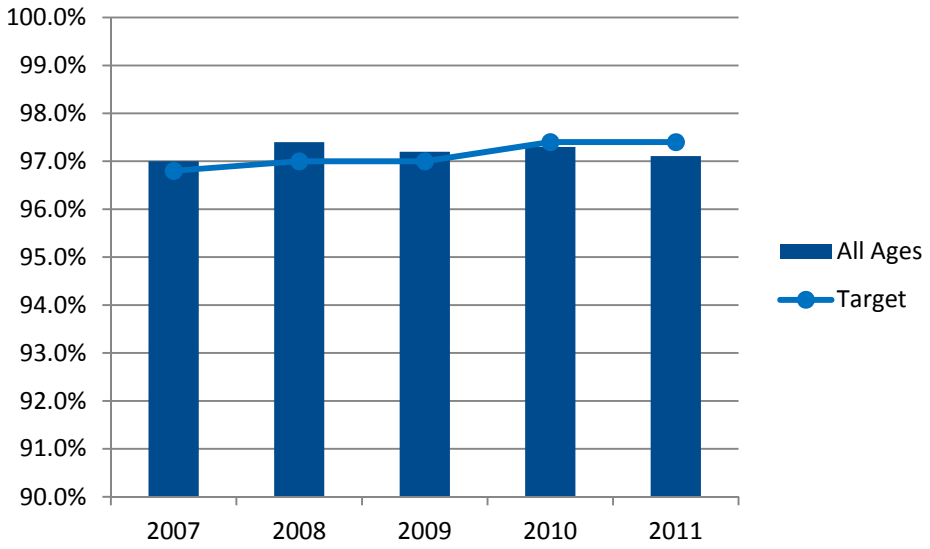
A result equal to or higher than the target indicates the Area Health Service has improved or maintained their performance level.

Results

Although comparable with prior years the result for 2011 of 97.1% of WACHS patients in the 'all age' cohort discharged safely is a result marginally below the target. During the year there were over 84,000 discharges from WACHS public hospitals across all age groups.

The consistently high age group discharge results achieved by the WACHS demonstrate the Area Health Service is providing high quality admitted hospital care. The results generally show the probability of being restored to health (discharged home after hospitalisation) reduces with age especially in the later years.

Figure 16: Percentage of patients discharged to home after admitted hospital treatment



Data source:
Hospital Morbidity Data System

Outcome 1: Effectiveness KPI

Survival rates for sentinel conditions

Rationale

The ongoing assessment and review of the health care provided in a hospital can inform clinical care and practice improvement. Monitoring the occurrence of sentinel events (for example, hospital acquired infections, medication errors or a fall), and the patient health outcome for selected sentinel conditions in a particular location, can provide valuable information for health care providers to improve clinical care.

This indicator measures the hospitals' performance in relation to restoring the health of people who have suffered a sentinel condition - namely a stroke, acute myocardial infarction (AMI) or fractured neck of femur (FNOF). For each of these conditions a good recovery is more likely when there is early intervention and appropriate care.

These three conditions have been chosen as they are particularly significant for the health care of the community and are leading causes of death and hospitalisation in Australia.

Survival rates can also be affected by many factors including the diagnosis, the treatment given or procedure performed and the age, sex and condition of each individual patient as well as patient co-morbid conditions at the time of admission or developed complications while in hospital.

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

Targets

For 2011 the target set for each condition and age group is an aspirational target based on the best result achieved in the past four years. However, where there is a perfect result, (e.g. 100%) generally not a likely outcome and often a function of small numbers, the next best result has been adopted as the target.

Improved or maintained performance will be demonstrated by a result above or equal to the target.

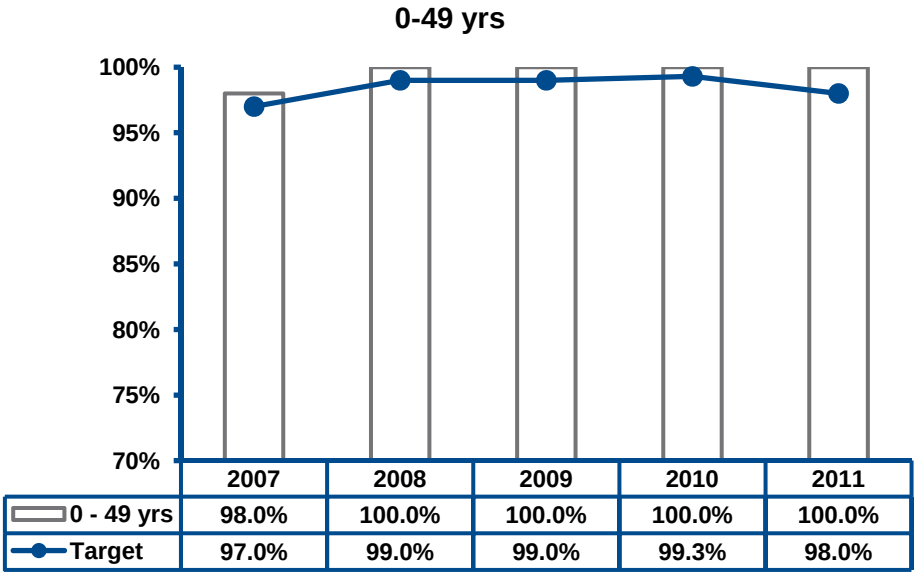
Results

The performance results for the sentinel conditions across the conditions and groups, while not meeting the aspirational targets is some instances, generally continue to demonstrate WACHS hospital adoption of appropriate clinical practices in providing health care.

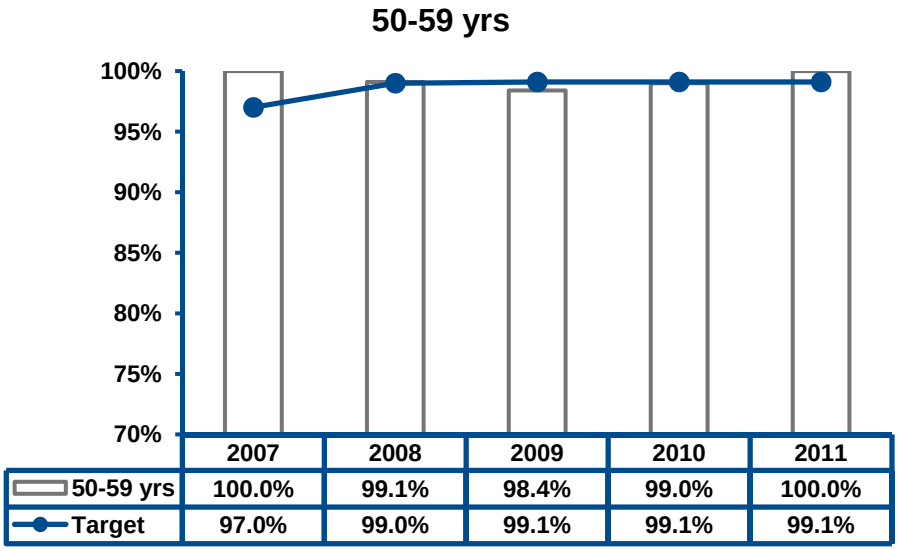
Survival rate for acute myocardial infarction (AMI)

Across WACHS, the results recorded for survival rate for AMI are above the set aspirational targets except for the 70-79 years and 80+ years age groups. Results are comparable or better than results recorded in prior years for all age groups.

Figure 17: Survival rate for acute myocardial infarction (AMI)

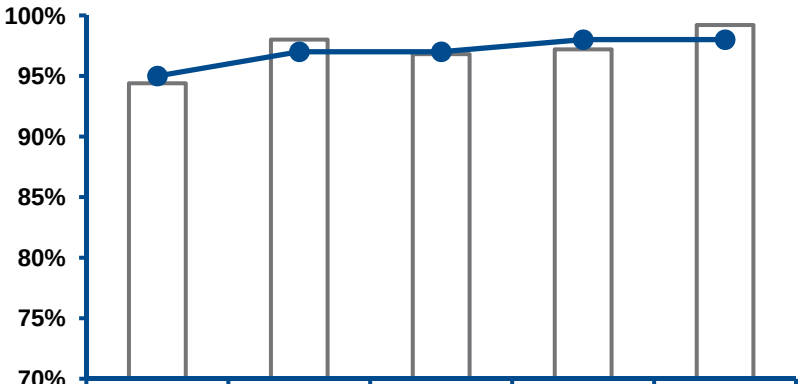


	2007	2008	2009	2010	2011
0 - 49 yrs	98.0%	100.0%	100.0%	100.0%	100.0%
Target	97.0%	99.0%	99.0%	99.3%	98.0%



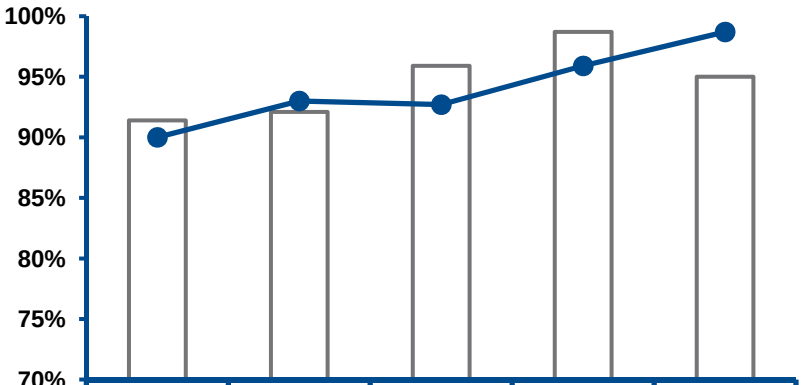
	2007	2008	2009	2010	2011
50-59 yrs	100.0%	99.1%	98.4%	99.0%	100.0%
Target	97.0%	99.0%	99.1%	99.1%	99.1%

60-69 yrs



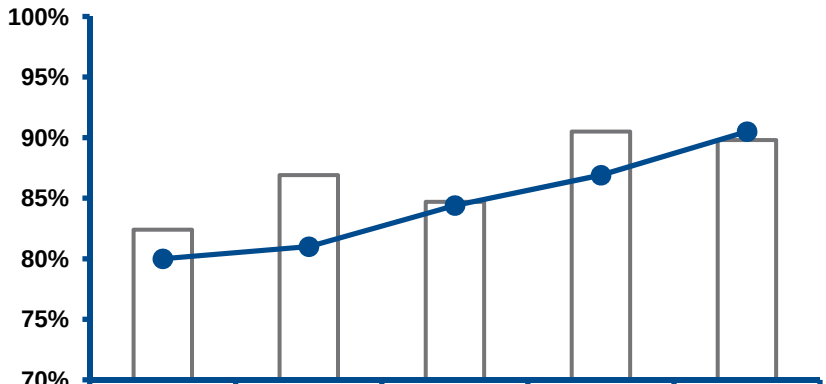
	2007	2008	2009	2010	2011
60-69 yrs	94.4%	98.0%	96.8%	97.2%	99.2%
Target	95.0%	97.0%	97.0%	98.0%	98.0%

70-79 yrs



	2007	2008	2009	2010	2011
70-79 yrs	91.4%	92.1%	95.9%	98.7%	95.0%
Target	90.0%	93.0%	92.7%	95.9%	98.7%

80+ yrs

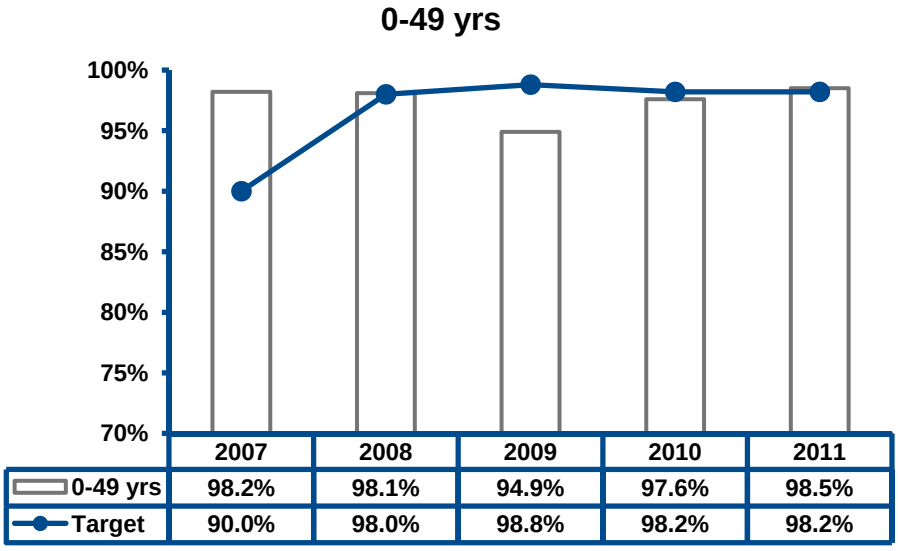


	2007	2008	2009	2010	2011
80+ yrs	82.4%	86.9%	84.7%	90.5%	89.8%
Target	80.0%	81.0%	84.4%	86.9%	90.5%

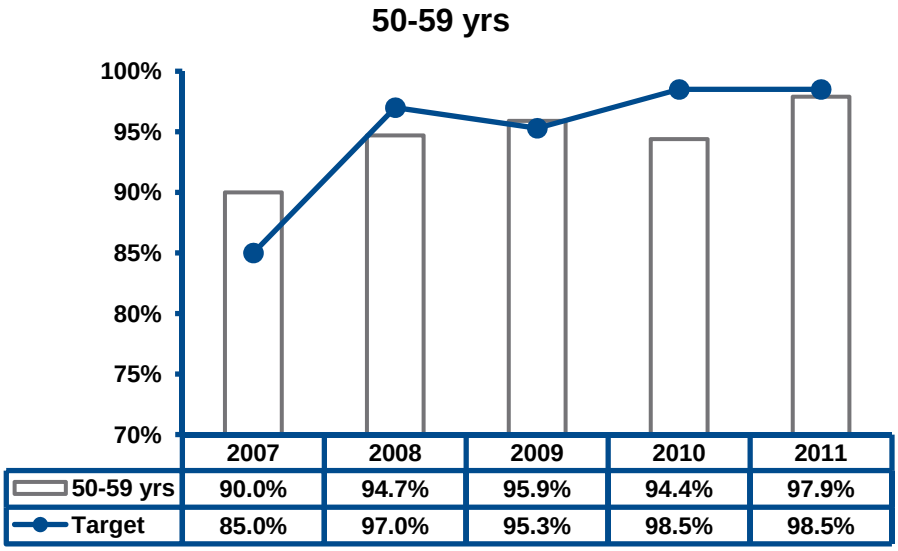
Survival rate for stroke

Generally the results recorded by WACHS for 2011 were better than results achieved in 2010 continuing an improving trend across the reported period except for the 80+ year age group. Results were above the aspirational target for age groups 0-49 years and 60-69 years, however below the targets for 50-59 year, 70-79 year and 80+ year age groups.

Figure 18: Survival rates for sentinel conditions – Stroke

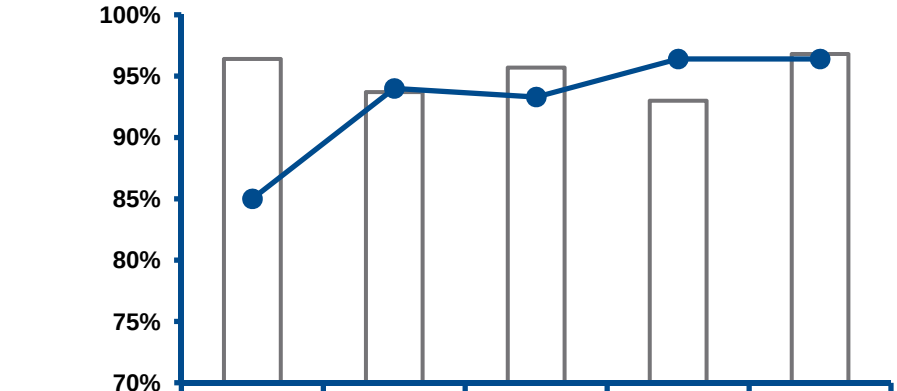


	2007	2008	2009	2010	2011
0-49 yrs	98.2%	98.1%	94.9%	97.6%	98.5%
Target	90.0%	98.0%	98.8%	98.2%	98.2%



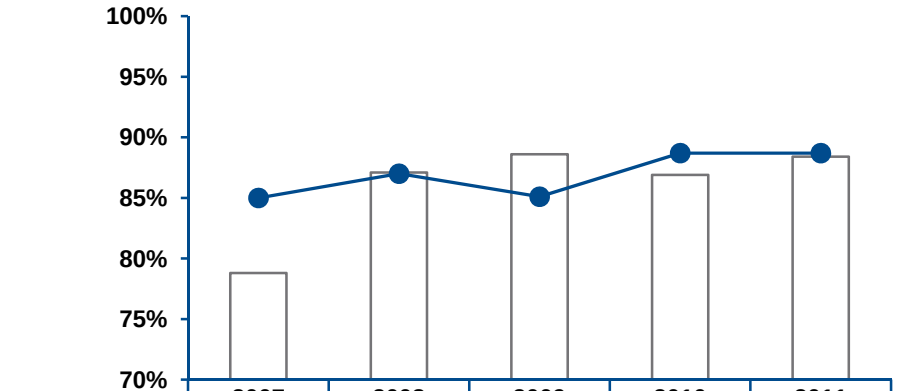
	2007	2008	2009	2010	2011
50-59 yrs	90.0%	94.7%	95.9%	94.4%	97.9%
Target	85.0%	97.0%	95.3%	98.5%	98.5%

60-69 yrs



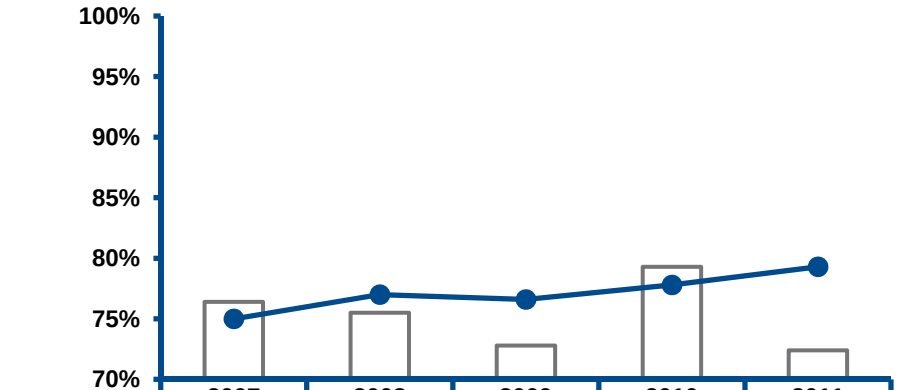
	2007	2008	2009	2010	2011
60-69 yrs	96.4%	93.7%	95.7%	93.0%	96.8%
Target	85.0%	94.0%	93.3%	96.4%	96.4%

70-79 years



	2007	2008	2009	2010	2011
70 -79 yrs	78.8%	87.1%	88.6%	86.9%	88.4%
Target	85.0%	87.0%	85.1%	88.7%	88.7%

80+ years

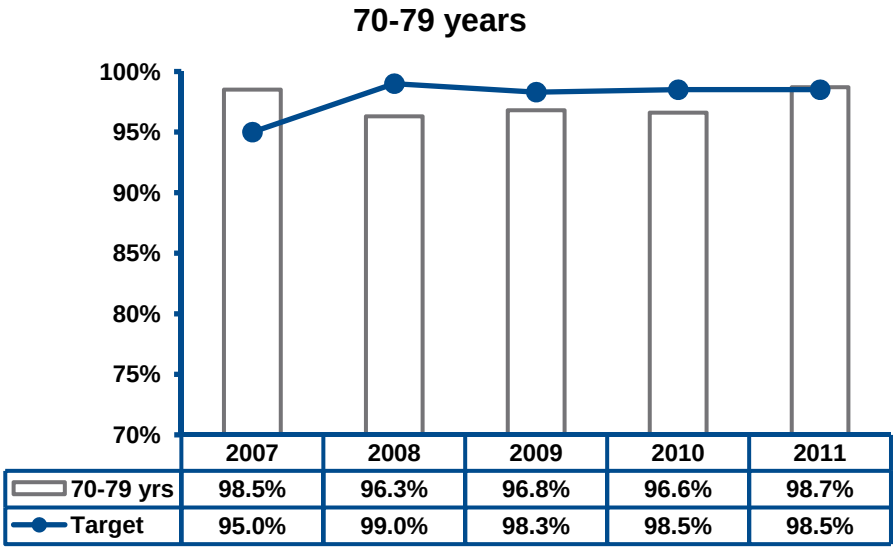


	2007	2008	2009	2010	2011
80+ yrs	76.4%	75.5%	72.8%	79.3%	72.4%
Target	75.0%	77.0%	76.6%	77.8%	79.3%

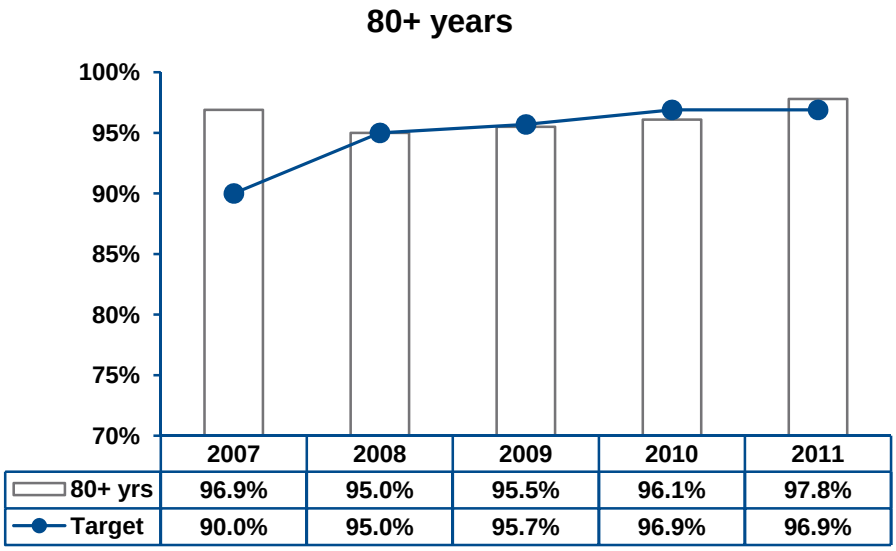
Survival rate for fractured neck of femur

WACHS in 2011 recorded survival rate results for FNOF, better than that achieved in 2010 and above the aspirational targets for both age groups.

Figure 19: Survival rates of fractured neck of femur



	2007	2008	2009	2010	2011
70-79 yrs	98.5%	96.3%	96.8%	96.6%	98.7%
Target	95.0%	99.0%	98.3%	98.5%	98.5%



	2007	2008	2009	2010	2011
80+ yrs	96.9%	95.0%	95.5%	96.1%	97.8%
Target	90.0%	95.0%	95.7%	96.9%	96.9%

Note:
For the WA Country Health Service, patient numbers for these conditions are generally low and therefore any variations in patient outcomes for these conditions can cause large variations to the annual crude survival rate percentages.

Data source:
Hospital Morbidity Data System – Data Integrity

Outcome 1: Effectiveness KPI

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 the same hospital as an admitted patient for the same or a related condition as one for which the patient has previously been discharged within 28 days. Unplanned readmissions necessitate patients spending additional periods of time in hospital as well as utilising additional hospital resources.

Although there are some conditions that may require numerous admissions to enable the best level of care to be given, in most of these cases readmission to hospital would be planned. A low unplanned readmission rate suggests that good clinical practice is in operation. This indicator should be considered in conjunction with the indicator “safely discharged home’.

Sample Period

For this indicator a representative period is used and relevant data is subjected to review to ensure the accuracy of the readmission status – unplanned or other. The representative period selected endeavours to reflect the busiest period in the preceding calendar year. For 2011 this period is September - November while in prior years periods July to September and April to June have been used.

Target

An aspirational target has been set for 2011 for WACHS at the best result achieved for the three month sample period in the past four calendar years, ≤ 2.2 per cent.

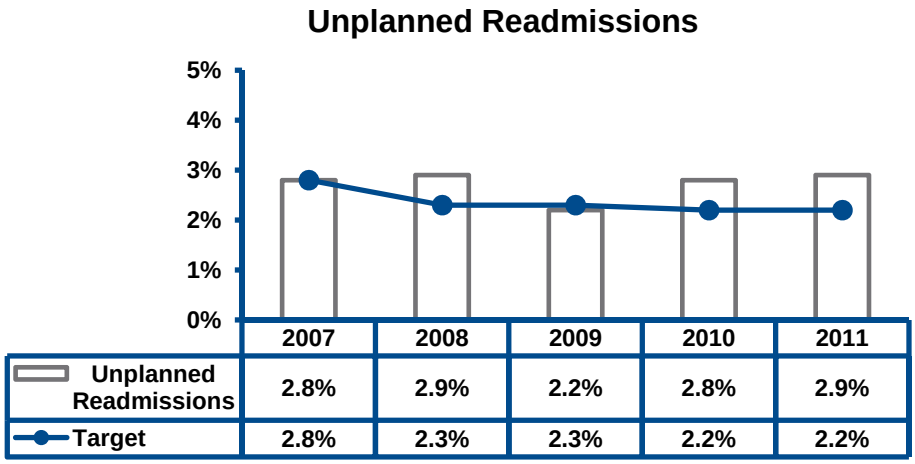
Improved or maintained performance will be demonstrated by a result below or equal to the target.

Results

The reported unplanned readmission rate for WACHS for 2011 was 2.9 per cent. While this result was significantly above the aspirational target achieved in 2009, it is only marginally above the five year average of 2.7%.

WACHS is continuing to develop models of healthcare that will achieve safe, quality in-patient care in our hospitals. In this regard WACHS will continue to monitor readmission rates to ensure that the highest standards of clinical practice and discharge planning are adopted to deliver the best level of care to all patients

Figure 20: Unplanned Readmissions



	2007	2008	2009	2010	2011
Unplanned Readmissions	2.8%	2.9%	2.2%	2.8%	2.9%
Target	2.8%	2.3%	2.3%	2.2%	2.2%

Note:
Results represent data for a three month period of each calendar year.

Data source:
Hospital Morbidity Data System – Data Integrity

Outcome 1: Effectiveness KPI

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

Rationale

Similar to the previous indicator for general readmissions, appropriate medical intervention together with good discharge planning will decrease the likelihood of unplanned hospital readmissions for a mental health condition. An unplanned readmission is an unplanned return to the same hospital as an admitted patient for a mental health condition as one for which the patient has previously been discharged within 28 days.

Unplanned readmissions necessitate patients spending additional periods of time in hospital as well as utilising additional hospital resources. A high percentage of readmissions may indicate that improvements could be made to discharge planning or to aspects of inpatient therapy protocols. Appropriate therapy, together with good discharge planning will decrease the likelihood of unplanned hospital readmissions.

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

Sample Period

For this indicator a representative period is used and relevant data is subjected to review to ensure the accuracy of the readmission status – unplanned or other. The representative period selected endeavours to reflect the busiest period in the preceding calendar year. For 2011 this period is September - November while in prior years periods July to September and April to June have been used.

Target

An aspirational target has been set for 2011 for WACHS at the best result achieved for the three month sample period, in the past four calendar years, ≤ 4.8 per cent.

Improved or maintained performance will be demonstrated by a result below or equal to the target.

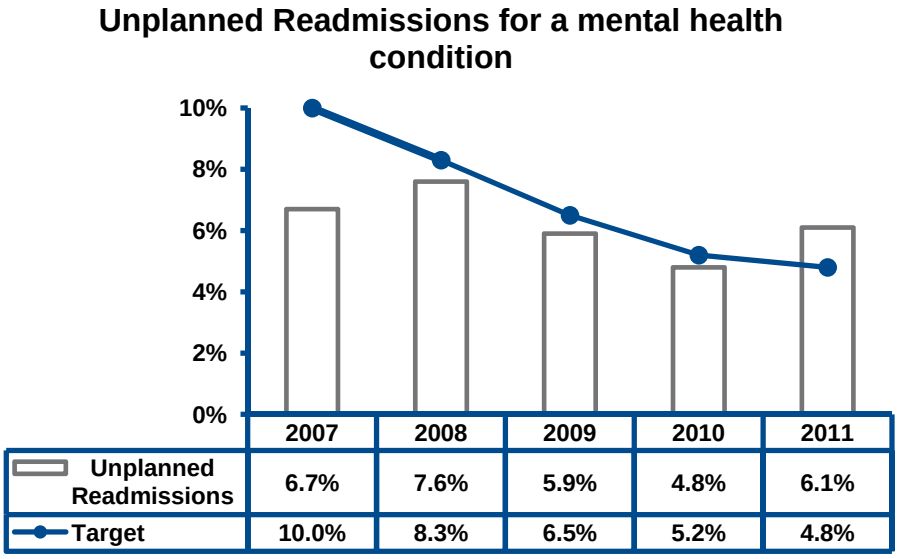
Results

The reported unplanned readmission rate for WACHS for 2011 was 6.1 per cent. Similar to the result for general unplanned readmissions, the result for unplanned readmissions for a related mental health condition was significantly above the aspirational target achieved in 2010, although it is below the five year average of 6.4%.

WACHS is committed to enhancing the mental health and well-being of all rural communities. Our aim is to provide a range of in-patient and community mental health

programs and establish support networks to deliver the appropriate treatment and support when required to prevent unplanned readmissions to hospital.

Figure 21: Unplanned Readmissions for a mental health condition



	2007	2008	2009	2010	2011
Unplanned Readmissions	6.7%	7.6%	5.9%	4.8%	6.1%
Target	10.0%	8.3%	6.5%	5.2%	4.8%

Note:
Results represent data for a three month period of each calendar year.

Data source:
Hospital Morbidity Data System – Data Integrity

Outcome 1: Effectiveness KPI

Percentage of live births with an APGAR score of three or less five minutes post delivery

Rationale

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

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

This indicator reports on the number and percentage of babies with a low APGAR score at birth (an APGAR score of three or less at five minutes post delivery). A baby with a low APGAR score is more likely to be premature with immature lungs, or the low APGAR score will indicate that the baby's mother had a more difficult delivery than one with a higher score.

Target

Aspirational targets for WACHS have been set at the best results achieved in the last four years. However, where there is a perfect result, (e.g. 0%) generally not a likely outcome and often a function of small numbers, the next best result has been adopted as the target.

Improved or maintained performance will be demonstrated by a result below or equal to the target.

Results

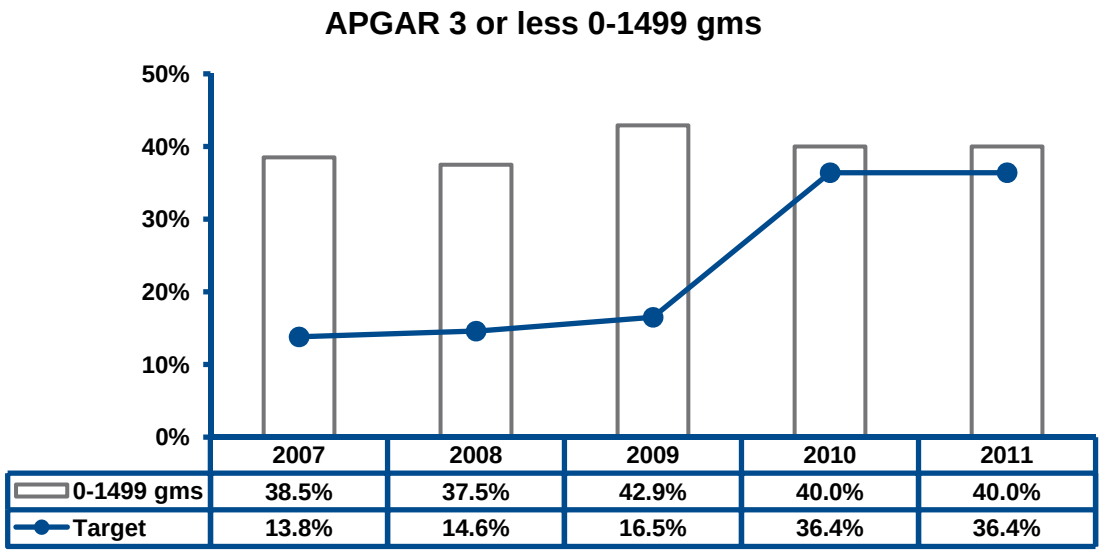
Please note that there are small numbers of babies born in the birthweight 0-1499 gram and 2000-2499 gram divisions across WACHS and they will often record poor APGAR score where the low birthweight is a significant contributor. These small numbers can result in large recorded results and variations across years.

The results recorded for 2011 for WACHS across all weight categories except 1500-1999 grams exceeded the aspirational targets. The result for babies with an APGAR score of 3 or less for all birthweights was 0.2 per cent, the same as recorded in 2010.

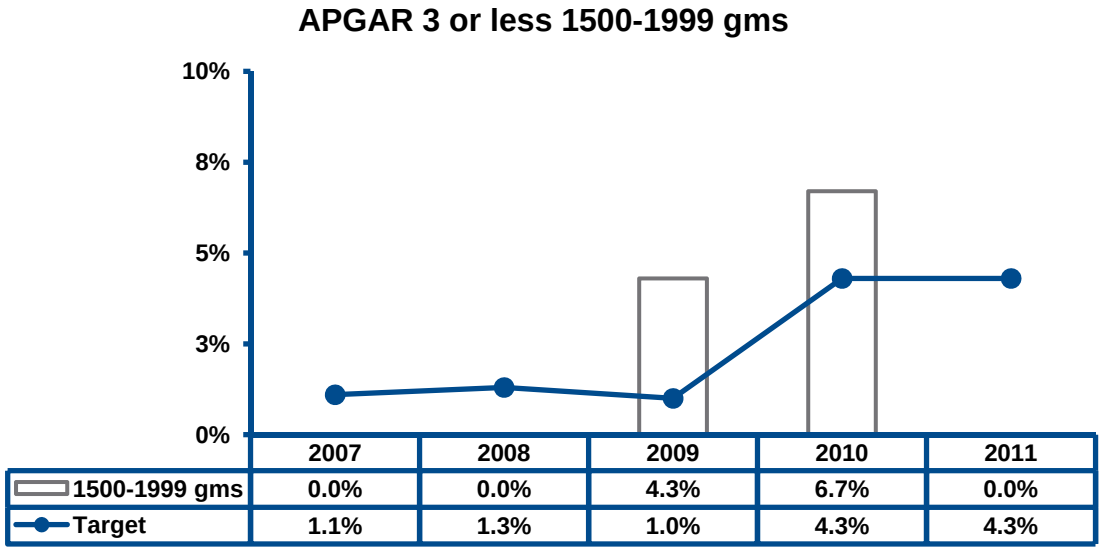
During the year 4,525 live babies were born in WACHS hospitals where 10 babies were born with an APGAR score of three or less five minutes post delivery.

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

Figure 22: AGPAR Score – graphs in birth weights

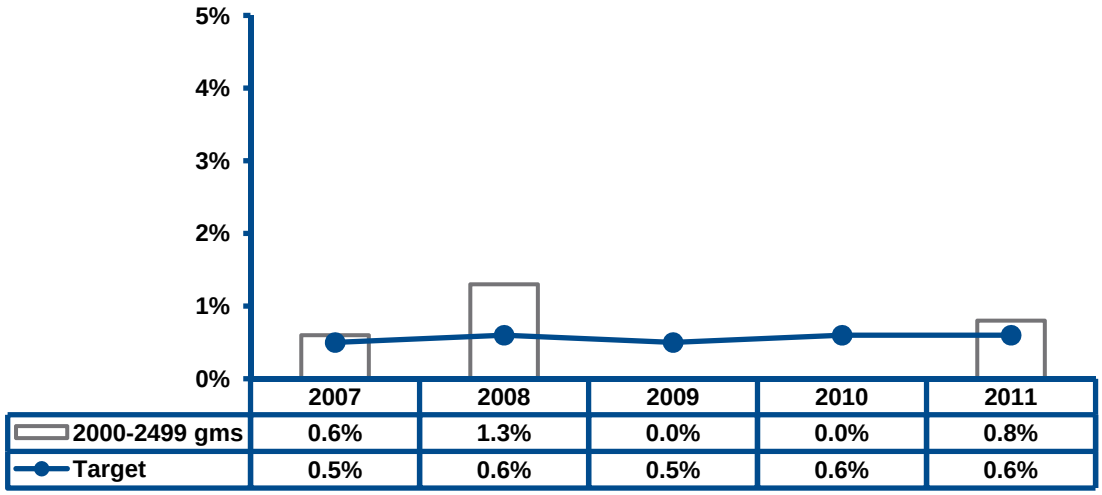


	2007	2008	2009	2010	2011
0-1499 gms	38.5%	37.5%	42.9%	40.0%	40.0%
Target	13.8%	14.6%	16.5%	36.4%	36.4%



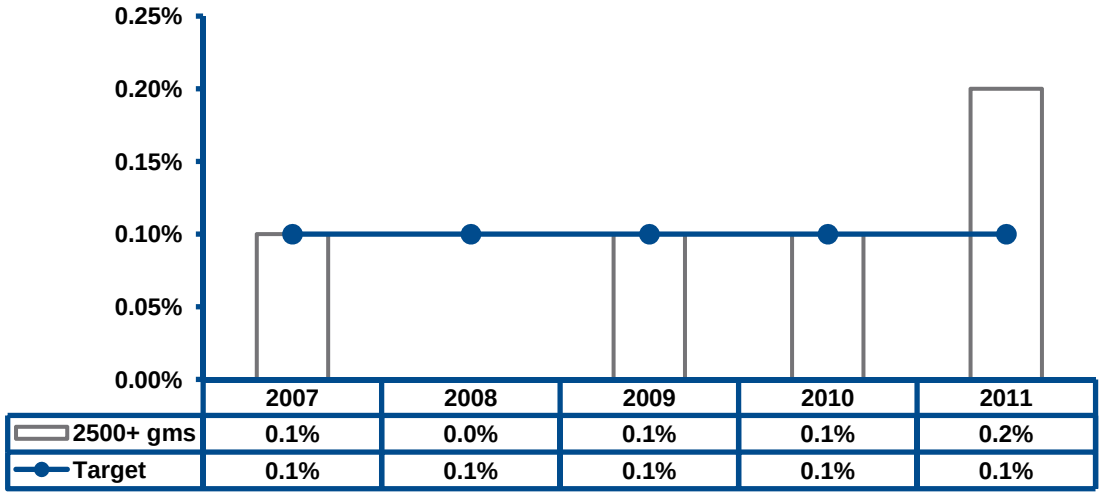
	2007	2008	2009	2010	2011
1500-1999 gms	0.0%	0.0%	4.3%	6.7%	0.0%
Target	1.1%	1.3%	1.0%	4.3%	4.3%

APGAR 3 or less 2000-2499 gms



	2007	2008	2009	2010	2011
2000-2499 gms	0.6%	1.3%	0.0%	0.0%	0.8%
Target	0.5%	0.6%	0.5%	0.6%	0.6%

APGAR 3 or less 2500+ gms



	2007	2008	2009	2010	2011
2500+ gms	0.1%	0.0%	0.1%	0.1%	0.2%
Target	0.1%	0.1%	0.1%	0.1%	0.1%

Data source:
Midwives Notification System

KPI

Outcome 1: Effectiveness KPI

Percentage of emergency service patients seen within recommended times (major rural hospitals)

Rationale

When patients first enter an Emergency Department or Service, they are assessed by specially trained nursing staff who assess how urgently treatment should be provided. The aim of this process, known as triage, is to ensure treatment is given in the appropriate time and 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 that indicates their urgency (see below). This code provides an indication of how quickly patients should be reviewed by medical staff.

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

This indicator measures the percentage of patient attendances in each triage category whose treatment commenced within the time periods recommended by the Australasian College for Emergency Medicine (ACEM) for each Triage category. This indicator reports for selected WACHS sites, measuring the time for medical treatment to commence by either a doctor or nurse. 'Waiting to be seen time' is the earlier of date/time seen by doctor or date/time seen by nurse (treatment commences) less the date/time of presentation (which is the earlier of arrival date/time and triage date/time). Also see note below.

Targets

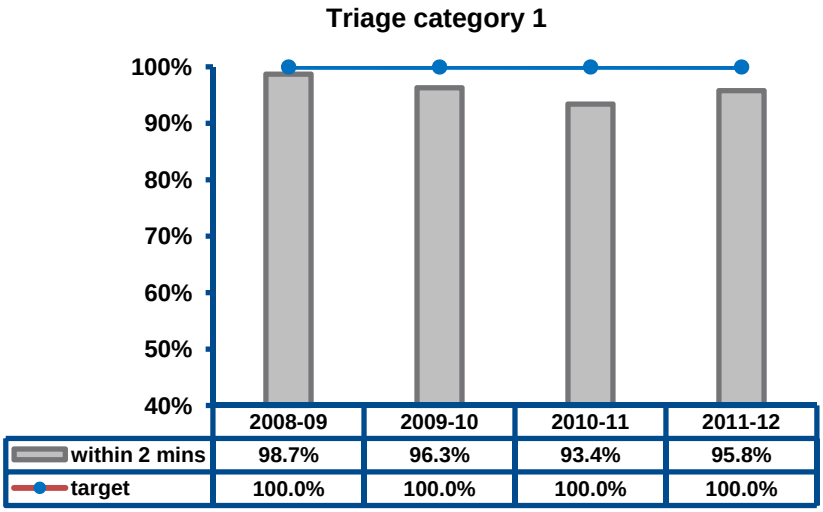
Set for each Triage Category. Improved performance is demonstrated by results equal to or higher than the target.

Results

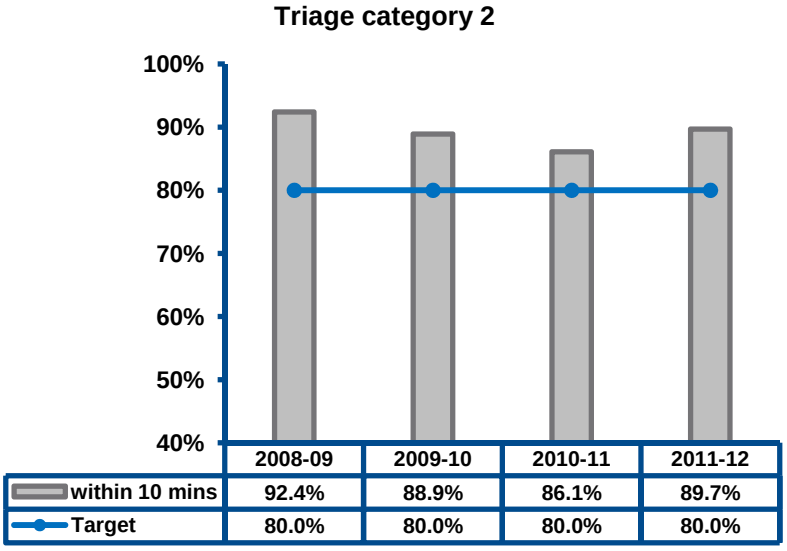
In 2011-12 the proportion of WA country patients in ED seen within the recommended time was above the minimum benchmarks for all Triage categories except Triage 1. For Triage 1 patients, the result of 95.8% while below the target, is comparable across the prior years and shows improvement compared to 2010-11. In 2011-12 37 triage one patients were not seen within the required time compared to 58 in the previous year.

Please note that in some cases treatment may be delayed due to the aggressive or violent behaviour of the patient.

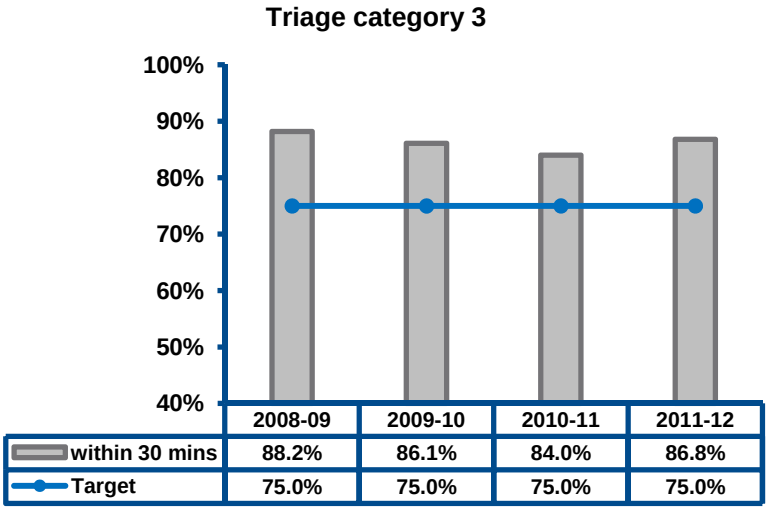
Figure 23: Proportion of emergency department attendances seen within recommended time by triage category



	2008-09	2009-10	2010-11	2011-12
within 2 mins	98.7%	96.3%	93.4%	95.8%
target	100.0%	100.0%	100.0%	100.0%

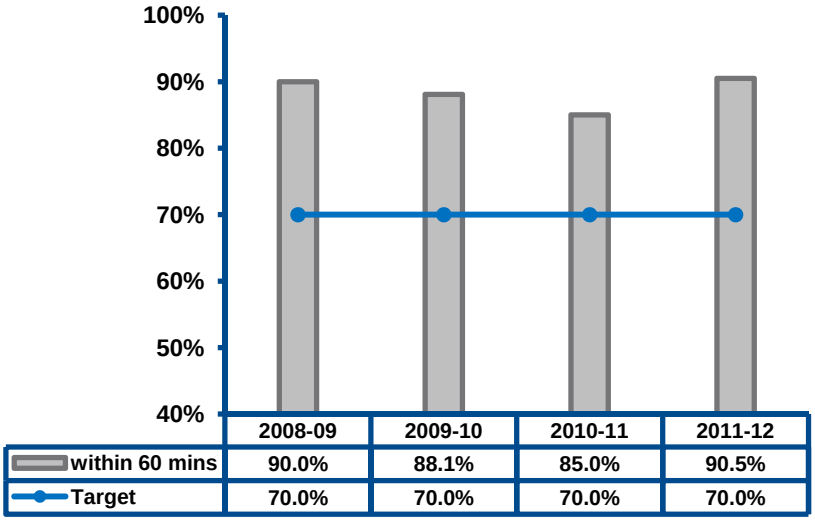


	2008-09	2009-10	2010-11	2011-12
within 10 mins	92.4%	88.9%	86.1%	89.7%
Target	80.0%	80.0%	80.0%	80.0%



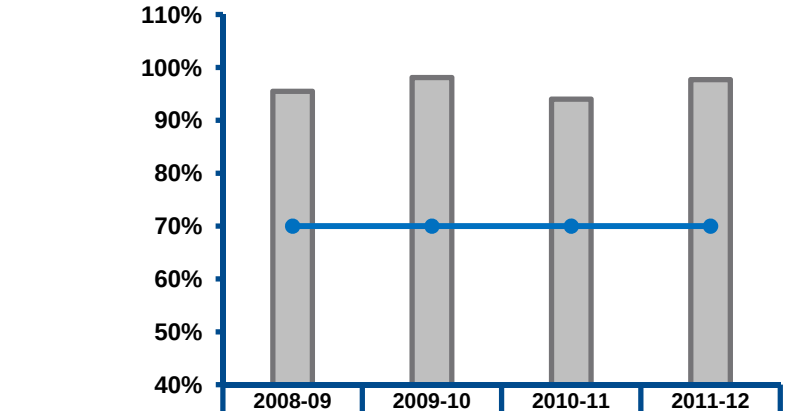
	2008-09	2009-10	2010-11	2011-12
within 30 mins	88.2%	86.1%	84.0%	86.8%
Target	75.0%	75.0%	75.0%	75.0%

Triage category 4



	2008-09	2009-10	2010-11	2011-12
within 60 mins	90.0%	88.1%	85.0%	90.5%
Target	70.0%	70.0%	70.0%	70.0%

Triage category 5



	2008-09	2009-10	2010-11	2011-12
within 2 hours	95.5%	98.1%	94.0%	97.7%
Target	70.0%	70.0%	70.0%	70.0%

Note:
WACHS sites that provide a significant volume of WACHS' emergency service activity report this indicator, historically being the same sites that provide high level complex care and report casemix adjusted separations. Bunbury and Kalgoorlie report 'doctor seen'; other sites report 'doctor or nurse seen' results.

Data source:
Emergency Department Data Collection – Data Integrity

Outcome 1: Effectiveness KPI

Rate of emergency attendances with a triage score of four and five not admitted

Rationale

The hospital emergency department or service will assess a patient, initiate treatment and decide whether to admit the patient for further care. As described in the previous indicator, the triaging of patients attending an emergency service ensures 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.

For a large number of country hospitals, information regarding non-admission for emergency attendance triaged 4 and 5 may also indicate the availability of primary care services and out-of-hours general practice options in that community. In such instances, community members must attend a rural hospital emergency department or service, as access to primary care services is not available to them. This information may therefore also help country health services to plan service provision care models for different locations and assess the likely workload an emergency department or service may receive attributed to those with less severe clinical needs.

This indicator reports the number of triage four and five emergency attendances at a WACHS hospital where the patient is not subsequently admitted.

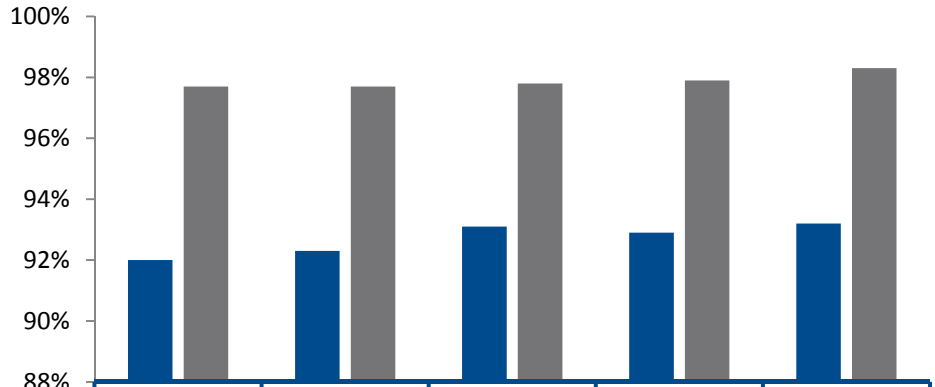
Target

A target has not been set as a patient attending a rural emergency department or service will be admitted or not admitted in accordance with clinical need.

Results

The percentages of Triage 4 and 5 emergency service attendances not admitted to WACHS hospitals were 93.2 per cent and 98.3 per cent respectively, comparable to prior years.

Figure 24: WACHS Triage 4 and 5 Non-Admitted



	2007-08	2008-09	2009-10	2010-11	2011-12
Triage 4 Not-Admitted	92.0%	92.3%	93.1%	92.9%	93.2%
Triage 5 Not-Admitted	97.7%	97.7%	97.8%	97.9%	98.3%

Data source:
Emergency Department Data Collection – Data Integrity

Service 1: Public hospital admitted patients
Efficiency KPI

Average cost per casemix adjusted separation for non-tertiary hospitals

Rationale

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

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

This indicator measures the average cost of a casemix-adjusted separation in non-tertiary hospitals. Separate results are reported for tertiary and non-tertiary sites as it is expected that the level of case acuity will be higher at tertiary sites than that at non-tertiary sites. WACHS does not have any tertiary category hospitals.

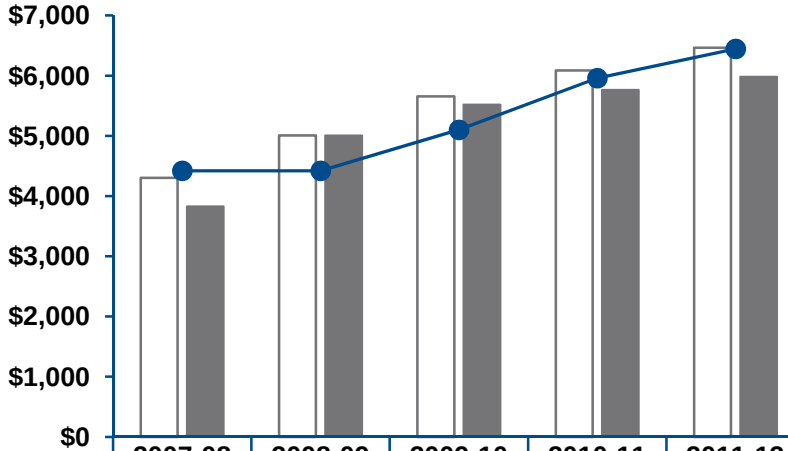
Target

$6,446 per weighted separation. A result below the target is desirable.

Result

The WACHS recorded a cost per casemix adjusted separation of $6,465, marginally above the target.

Figure 25: Average cost per casemix adjusted separation for non-tertiary hospitals



	2007-08	2008-09	2009-10	2010-11	2011-12
Actual cost	$4,302	$5,006	$5,657	$6,086	$6,465
CPI adjusted	$3,829	$5,006	$5,519	$5,765	$5,984
Target	$4,421	$4,421	$5,102	$5,960	$6,446

Data source:
Hospital Morbidity Data System (HMDS) – Data Integrity
WACHS Financial Systems

Service 1: Public hospital admitted patients Efficiency KPI

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 procedures delivered to patients, it is not the accepted method of costing admitted activity 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 or long stay patients with limited separations on which to calculate a representative casemix value.

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

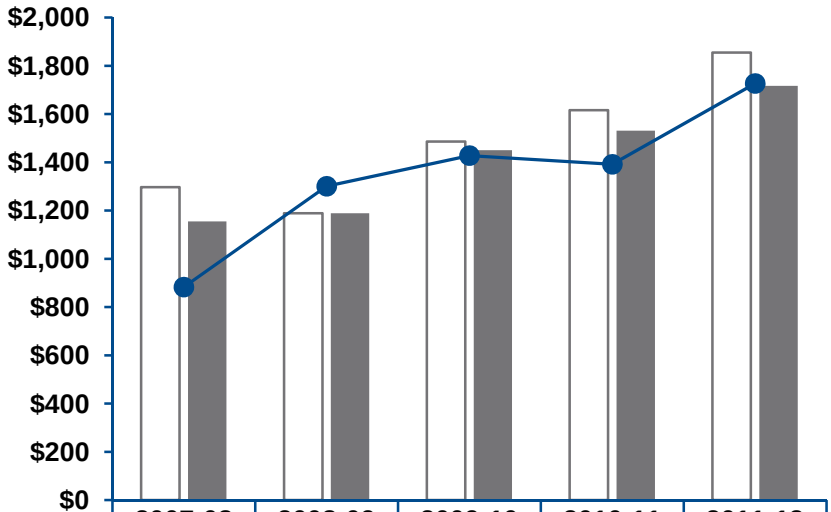
Target

$1,727 per bed-day. A result below the target is desirable.

Result

The WACHS recorded a cost per small hospital bed-day of $1,855, above the target. The significant increase compared to 2010-11 is the result of a combination of lower activity volume and higher service costs.

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



	2007-08	2008-09	2009-10	2010-11	2011-12
Actual cost	$1,297	$1,189	$1,486	$1,616	$1,855
CPI adjusted	$1,155	$1,189	$1,450	$1,531	$1,717
Target	$883	$1,301	$1,428	$1,392	$1,727

Note:
WACHS sites reporting beddays rather than weighted separations do so based on a historically lower level of separation activity and complexity compared to a larger casemix separation site.

Data source: HCARe and WACHS Financial Systems

KPI

Service 4: Emergency departments Efficiency KPI

Average cost per emergency department attendance

Rationale

Emergency departments provide treatment in a hospital to those people with sudden onset of illness or injury of such severity and urgency that they need immediate medical help which is either not available from their general practitioner, or for which their general practitioner has referred them for treatment. Emergency departments provide a range of services, from immediate resuscitation to urgent medical advice. An emergency department attendance may result in an admission to hospital or in treatment without admission.

Providing emergency department services to meet the needs of these patients requires a significant allocation of hospital resources to deliver the necessary health care and the efficient use of these resources can improve the patient's health outcome and their journey through the public hospital system, especially as this part of the acute health service is often the first point of contact with hospitals for residents in a community.

This is a new indicator commencing 2010-11 and measures the average cost per attendance at 13 major rural emergency departments.

Target

$383 per emergency department attendance. A result below the target is desirable.

Result

In 2011-12 average cost per emergency department attendance was $429, above the target. There was a 7% increase in activity with a 16% increase in expenditure for WACHS emergency departments and services in the larger country hospitals compared to 2010-11. The variance between 2011-12 and the target resulted from an over-estimate in activity than was realised.

Table 5: Average cost per emergency department attendance

	2010-11	2011-12
Target	$312	$383
Actual cost	$396	$429
CPI adjusted	$375	$397

Note:
This indicator reports for the 13 sites reporting under the emergency department triage effectiveness indicator.

Data source:
Emergency Department Data Collection – Data Integrity
WACHS Financial Systems

Service 5: Public patients non-admitted Efficiency KPI

Average cost per non-admitted hospital based occasion of service for rural hospitals

Rationale

In rural hospitals, medical officers, nurses and allied health staff provide non-admitted (out-patient) patient services. These include clinics for pre and post surgical care, allied health care and medical care as well as emergency services provided in the smaller rural hospitals not included under the Emergency Department cost indicator.

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

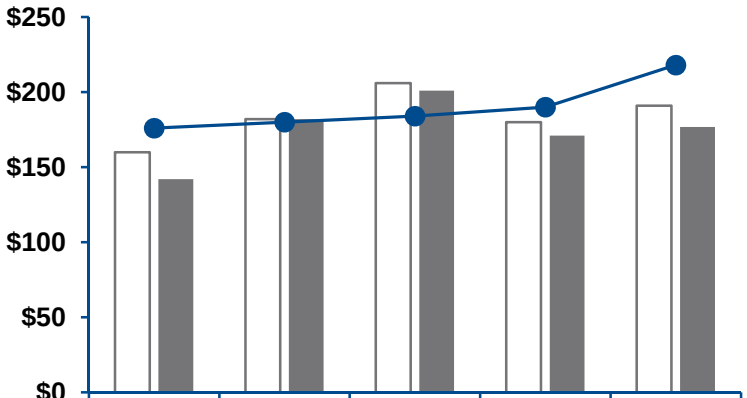
Target

$218 per non-admitted occasion. A result below the target is desirable.

Result

In 2011-12 WACHS recorded a cost per non-admitted hospital based occasion of service of $191, below target.

Figure 27: Average cost per non-admitted hospital based occasion of service for rural hospitals



	2007-08	2008-09	2009-10	2010-11	2011-12
Actual cost	$160	$182	$206	$180	$191
CPI adjusted	$142	$182	$201	$171	$177
Target	$176	$180	$184	$190	$218

Data source:
HCARe and site non-admitted activity data systems
WACHS Financial Systems

Service 5: Public patients non-admitted Efficiency KPI

Average cost per non-admitted occasion of service in a nursing post

Rationale

In addition to non-admitted occasions of service provided in a rural hospital, in some rural locations these services are also provided by nurses and allied health staff in rural nursing posts. These include clinics for post-surgical care, allied health care and medical care as well as small volumes of emergency care services.

It is important to monitor the unit cost of this type of non-admitted activity provided at these small specialised service units, which often provide the only health care service in a rural or remote locality. Nursing posts do not have the advantage of applying economies of scale, where minimum service capacity and access must be provided, at times for very few patients.

This indicator measures the average cost per non-admitted occasion of service provided in a nursing post.

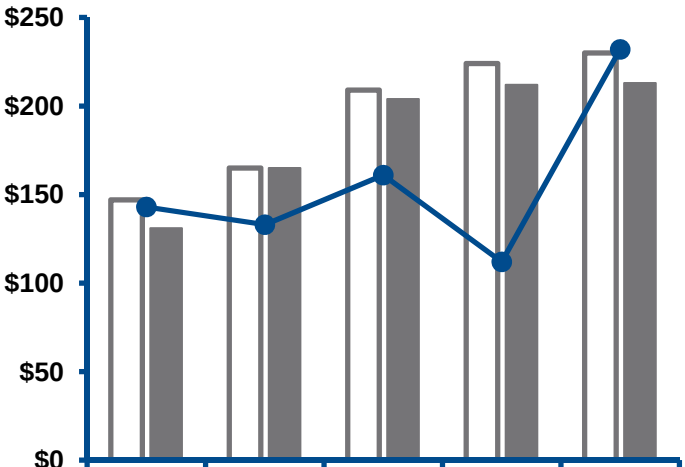
Target

$232 per non-admitted occasion in a nursing post. A result below the target is desirable.

Result

In 2011-12 WACHS recorded a cost per non-admitted occasion of service in a nursing post of $230, below target.

Figure 28: Average cost per non-admitted occasion of service in a nursing post



	2007-08	2008-09	2009-10	2010-11	2011-12
Actual cost	$147	$165	$209	$224	$230
CPI adjusted	$131	$165	$204	$212	$213
Target	$143	$133	$161	$112	$232

Data source:
HCARe and site non-admitted activity data systems
WACHS Financial Systems

Service 6: Public patient transport Efficiency KPI

Average cost per trip of Patient Assisted Travel Scheme

Rationale

The aim of the Patient Assisted Travel Scheme (PATS) is to allow permanent country residents to access the nearest medical specialist and specialist medical services. A subsidy is provided towards the cost of travel and accommodation for patients and, where necessary, an escort for the patient. Without travel assistance many people would be unable to access the services needed to diagnose or treat some conditions.

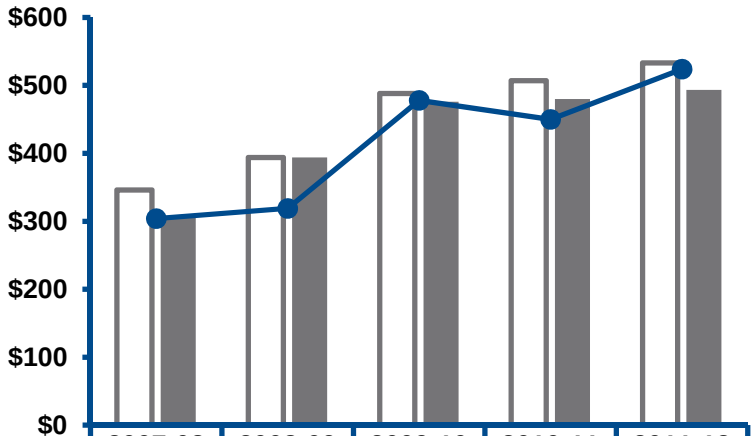
Target

$524 per PATS trip. A result below the target is desirable.

Result

Average cost per PATS trip in 2011-12 was $533, slightly above target. While in line with projections made for the budget target, the variance to 2010-11 reflects the Government support for the patient transport scheme with the number of PATS supported trips increasing by 14% and expenditure by 20%.

Figure 29: Average cost per trip of Patient Assisted Travel



	2007-08	2008-09	2009-10	2010-11	2011-12
Actual cost	$346	$394	$488	$507	$533
CPI adjusted cost	$308	$394	$476	$480	$493
Target	$304	$319	$478	$450	$524

Data source:
PATS activity web based data system
WACHS Financial Systems

Outcome 2:

Enhanced health and wellbeing of Western Australians through health promotion, illness and injury prevention and appropriate continuing care

The achievement of this health objective involves activities which:

1. Increase the likelihood of optimal health and wellbeing by:
    - Providing programs which support the optimal physical, social and emotional development of infants and children.
    - Encouraging healthy lifestyles including good diet and increased exercise.
2. Reduce the likelihood of onset of disease or injury by:
    - Delivering immunisation programs.
    - Providing safety programs.
    - Encouraging healthy lifestyles including good diet and increased exercise.
3. Reduce the risk of long-term disability or premature death from injury or illness through prevention, early identification and intervention, such as:
    - Programs for early detection of developmental issues in children and appropriate referral for intervention.
    - Early identification of disease and disabling conditions (breast and cervical cancer screening, screening of newborns) with appropriate intervention referrals.
    - Programs which support self-management by people with diagnosed conditions and disease (diabetic education).
4. Monitor the incidence of disease in the population to determine the effectiveness of primary health measures.
5. Provide continuing care services and programs that improve and enhance the wellbeing and the environment for people with chronic illness or disability enabling them to maintain as much independence in their everyday life as their illness permits, supporting people in their homes for as long as possible and providing extra care when long term residential care is required. These services:
    - 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.
    - 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.

Note:
WACHS population health units deliver both illness prevention and health promotion services as well as health protection services.

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

Outcome 2: Effectiveness KPI

Rate of hospitalisation for gastroenteritis in children

Rationale

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

Reduction in the number of children who are admitted to hospital per 1,000 (children) for treatment of gastroenteritis may be an indication of improved primary care or community health strategies - for example, health education. It is important to note, however, that other factors such as environmental issues will also have an impact on the prevalence of transmissible diseases like gastroenteritis.

Health promotion and illness prevention programs are delivered to ensure there is an understanding of hygiene within homes and in the community to promote the prevention of gastroenteritis. WACHS also supports a number of Environmental Health Workers who work in Aboriginal communities and with Aboriginal Medical Services.

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.

Target

The gastroenteritis rate of hospitalisation target is an aspirational target based on the best result achieved in the past four years for either population group. Generally this has been the result recorded for the non-Aboriginal population. Generally results for the Aboriginal population exceed this target and demonstrates the underlying premise supporting the “Closing the Gap” health initiatives implemented by the State and Australian Governments.

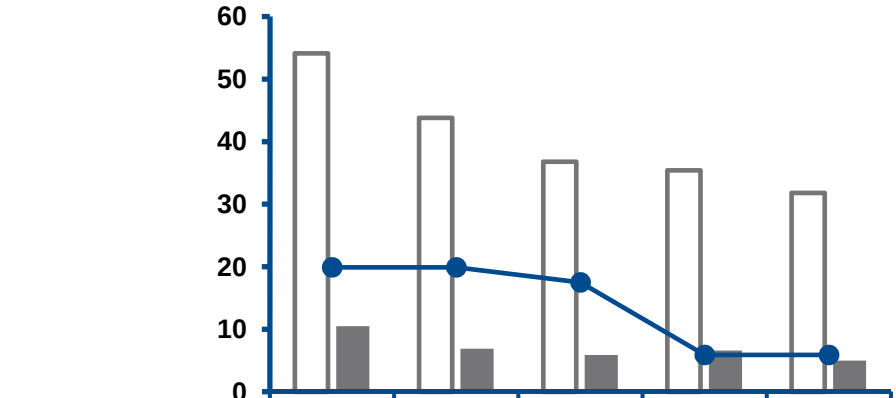
Improved or maintained performance will be demonstrated by a result lower than or equal to the target of 5.9 hospitalisations per 1000.

Results

In 2011 the WACHS hospitalisation rate for gastroenteritis in Aboriginal children was 31.8 per 1000, lower than that recorded in 2010 and continuing an improving trend shown across prior years. For non-Aboriginal children the hospitalisation rate was 5.0 per 1000, below the result for 2010, and reflective of an improving trend across the reporting period. The Aboriginal result exceeded the aspirational target.

WACHS population health programs in conjunction with other agency initiatives such as community infrastructure projects, aim to prevent the occurrence of gastroenteritis and similar conditions in rural and remote locations, particularly amongst Aboriginal populations.

Figure 30: Rate of hospitalisation for gastroenteritis in children (0-4 years)



	2007	2008	2009	2010	2011
Aboriginal	54.1	43.8	36.8	35.4	31.8
Non-Aboriginal	10.5	6.9	5.9	6.6	5.0
Target	19.9	19.9	17.5	5.9	5.9

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.

Data source:
Hospital Morbidity Data System – Data Integrity
Australian Bureau of Statistics

Outcome 2: Effectiveness KPI

Rate of hospitalisation for selected respiratory conditions

Rationale

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

Asthma is a chronic inflammatory condition of the airways with attacks occurring at varying levels of severity. In Australia, asthma is a major health, social and economic burden for the individual, the community and the State and Commonwealth healthcare sectors. The development of asthma is generally not preventable and therefore the health interventions are aimed at disease management. Where management is the principal focus of health strategies, the crude hospitalisation rate is an effective measure.

Croup is a respiratory condition that is usually triggered by an acute viral infection of the upper airway. The infection leads to swelling inside the throat, which interferes with normal breathing and produces the classical symptoms of a "barking" cough and loss of voice. It may produce mild, moderate, or severe symptoms, which often worsen at night.

Bronchiolitis is the inflammation of the bronchioles, the smallest air passages of the lungs and usually refers to acute viral bronchiolitis. It is a common disease in infancy, especially in children less than two years of age, and presents with coughing, wheezing, and shortness of breath. This inflammation is usually caused by a virus. An infant may be breathless for several days and, after an acute illness, it is common for the airways to remain sensitive for several weeks, leading to recurrent cough and wheeze.

Acute Bronchitis is most often caused by a virus that infects the epithelium of the bronchi, resulting in inflammation and increased secretion of mucus. A cough is a common symptom of acute bronchitis and develops in an attempt to expel the excess mucus from the lungs. Other common symptoms include sore throat, runny nose and nasal congestion, low-grade fever, pleurisy and malaise.

For these conditions the number of patients treated in hospital would be expected to decrease as the impact of condition prevention, health education and management programs increases.

Targets

Aspirational targets have been set for these conditions for the relevant age groups, based on the best result achieved in the past four years irrespective of population group.

Improved or maintained performance will be demonstrated by results lower than or equal to the targets.

Generally this is the result recorded for the non-Aboriginal population and currently most results for the Aboriginal population exceed these targets reflecting the underlying premise supporting the “Closing the Gap” health initiatives implemented by the State and Australian Governments.

The performance aims to achieve a result equal to or less than the target.

Results

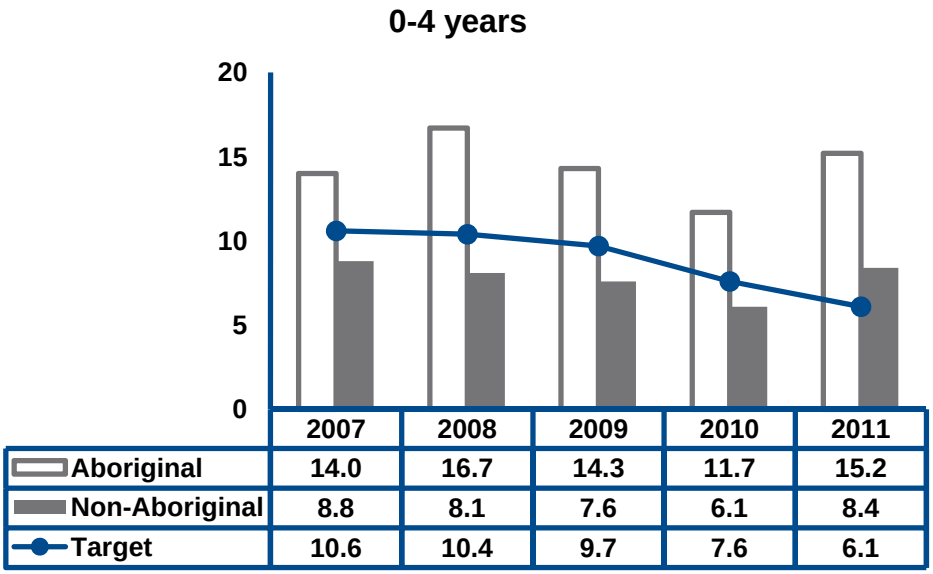
Specific programs developed and implemented by WACHS in conjunction primary care providers and representative organisations (e.g. Asthma Foundation), target the prevention, management and treatment of respiratory conditions especially in Aboriginal populations. Programs target individuals, families, groups and communities and focus on the determinants of poor health.

Acute Asthma

The rate of hospitalisation for acute asthma has remained relatively stable for WACHS non-Aboriginal populations. Results were above the aspirational targets for each age group except for the 19-34 year and 35+ year age groups.

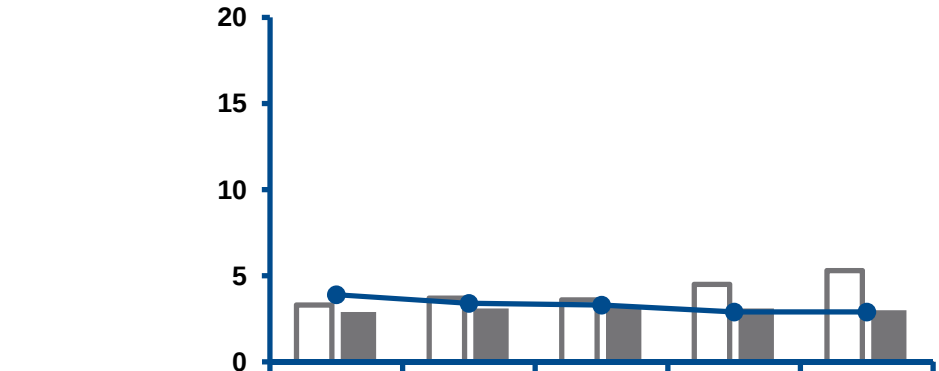
The rate of hospitalisation for acute asthma has increased in all age groups for WACHS Aboriginal populations except the 19-34 year age group. Recorded rates exceed the aspirational targets for each age group.

Figure 31: Rate of hospitalisation per 1,000 population for acute asthma



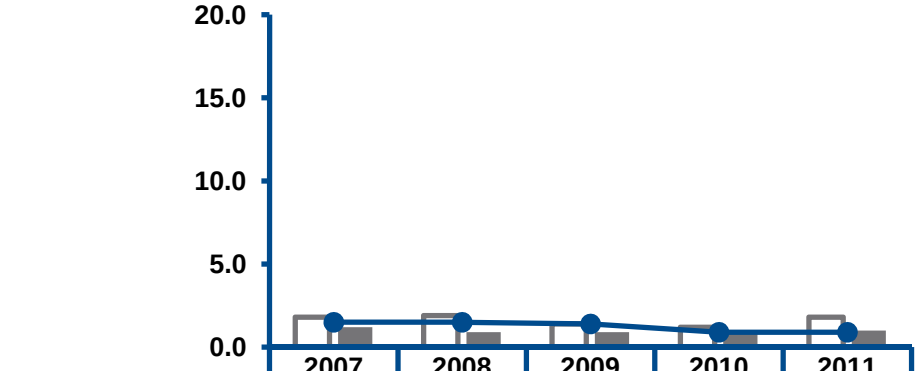
	2007	2008	2009	2010	2011
Aboriginal	14.0	16.7	14.3	11.7	15.2
Non-Aboriginal	8.8	8.1	7.6	6.1	8.4
Target	10.6	10.4	9.7	7.6	6.1

5-12 years



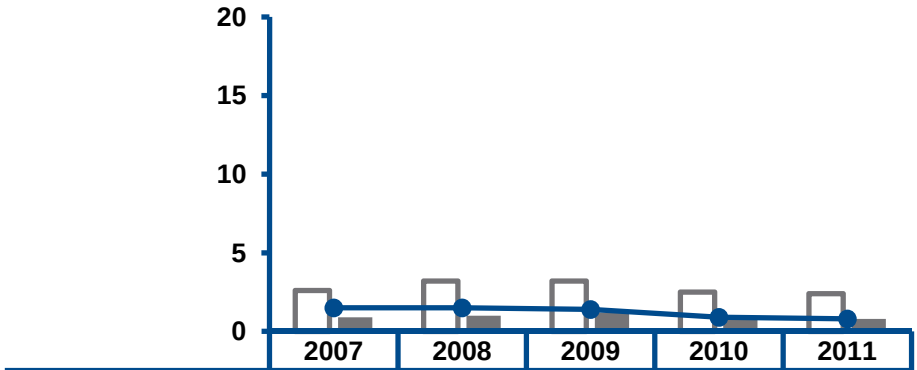
	2007	2008	2009	2010	2011
Aboriginal	3.3	3.7	3.6	4.5	5.3
Non-Aboriginal	2.9	3.1	3.2	3.1	3.0
Target	3.9	3.4	3.3	2.9	2.9

13-18 years

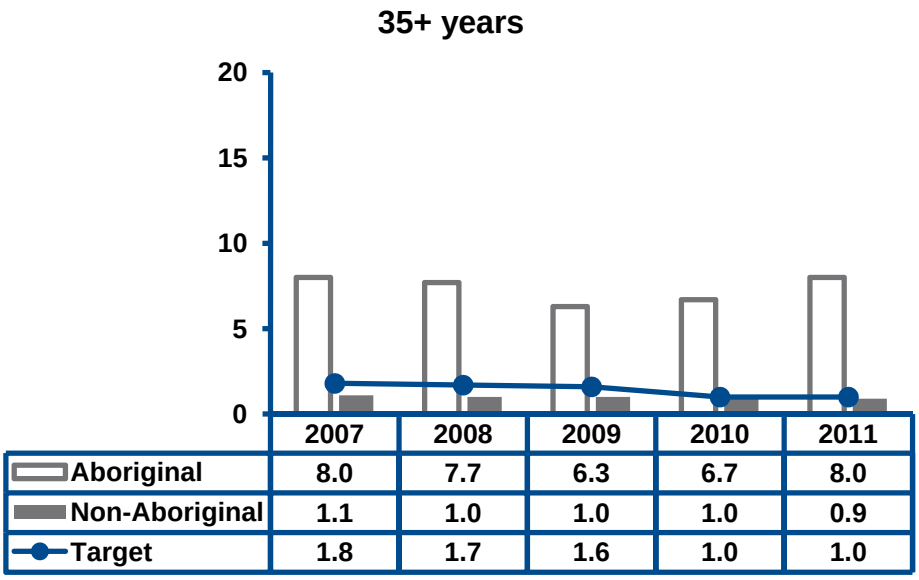


	2007	2008	2009	2010	2011
Aboriginal	1.8	1.9	1.4	1.2	1.8
Non-Aboriginal	1.2	0.9	0.9	1.0	1.0
Target	1.5	1.5	1.4	0.9	0.9

19-34 years



	2007	2008	2009	2010	2011
Aboriginal	2.6	3.2	3.2	2.5	2.4
Non-Aboriginal	0.9	1.0	1.2	0.8	0.8
Target	1.5	1.5	1.4	0.9	0.8

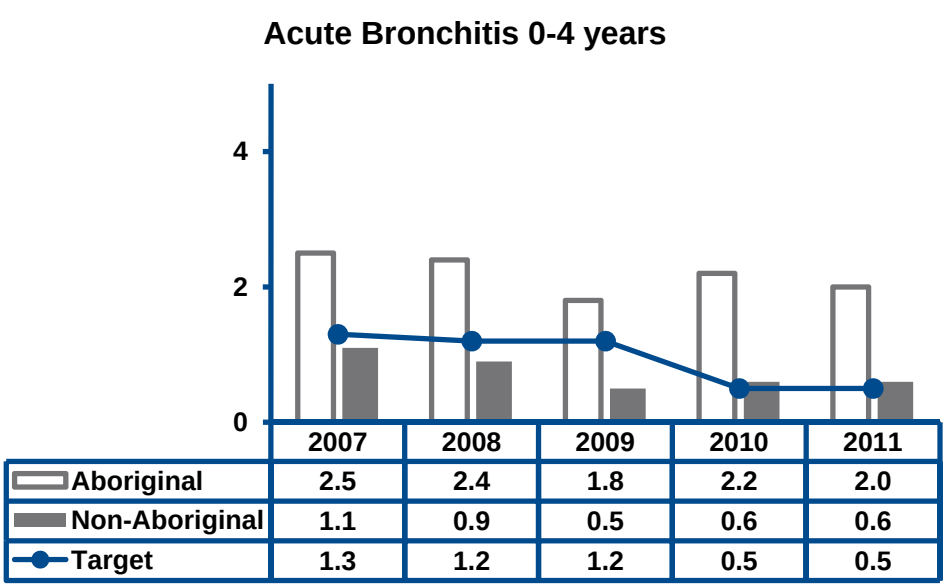


	2007	2008	2009	2010	2011
Aboriginal	8.0	7.7	6.3	6.7	8.0
Non-Aboriginal	1.1	1.0	1.0	1.0	0.9
Target	1.8	1.7	1.6	1.0	1.0

Acute Bronchitis

The rate of hospitalisation for acute bronchitis has remained stable with recent years for the WACHS non-Aboriginal population result and is marginally above the aspirational target. Although the rate of hospitalisation for acute bronchitis has decreased for the Aboriginal population compared to last year, it remains above the aspirational target.

Figure 32: Rate of hospitalisation per 1,000 children for Acute Bronchitis

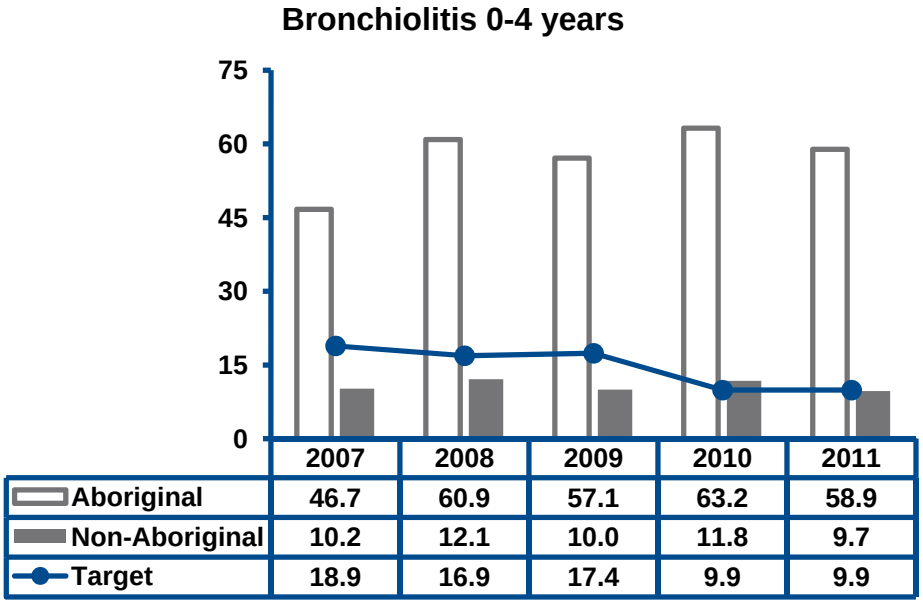


	2007	2008	2009	2010	2011
Aboriginal	2.5	2.4	1.8	2.2	2.0
Non-Aboriginal	1.1	0.9	0.5	0.6	0.6
Target	1.3	1.2	1.2	0.5	0.5

Bronchiolitis

The rates of hospitalisation for bronchiolitis in WACHS Aboriginal and non-Aboriginal populations decreased compared to 2010 however exceeded the aspirational target in the Aboriginal population.

Figure 33: Rate of hospitalisation per 1,000 children for Bronchiolitis

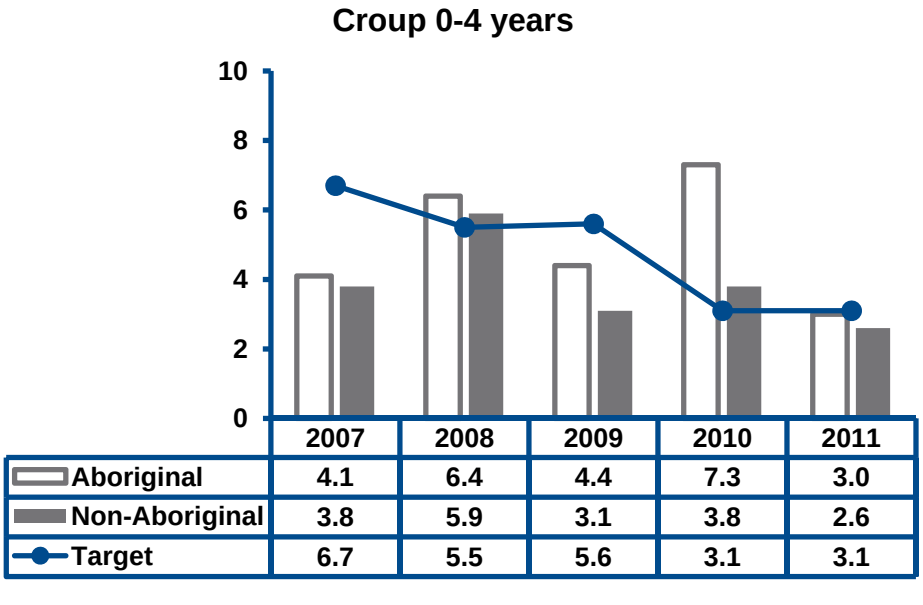


	2007	2008	2009	2010	2011
Aboriginal	46.7	60.9	57.1	63.2	58.9
Non-Aboriginal	10.2	12.1	10.0	11.8	9.7
Target	18.9	16.9	17.4	9.9	9.9

Croup

The rates of hospitalisation for croup improved materially in both non-Aboriginal and Aboriginal populations, and were below the aspirational target.

Figure 34: Rate of hospitalisation per 1,000 children for Croup



	2007	2008	2009	2010	2011
Aboriginal	4.1	6.4	4.4	7.3	3.0
Non-Aboriginal	3.8	5.9	3.1	3.8	2.6
Target	6.7	5.5	5.6	3.1	3.1

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.

Data source:
Hospital Morbidity Data System – Data Integrity
Australian Bureau of Statistics

Outcome 2: Effectiveness KPI

Rate of hospitalisation for falls in older persons

Rationale

There are a number of illness prevention, and health promotion and protection initiatives delivered by Area Health Service Population Health Units supported by similar initiatives provided by Department of Health Divisions, aimed at community safety and well being and injury prevention.

Some of these, such as the 'Stay on Your Feet'™ program, are designed to reduce the incidence and severity of fall-related injuries and hospitalisations of older persons. The number of older persons admitted to hospital per 1,000 population of a specific age group for treatment as a result of a fall in a domestic or community setting may be an indication of the impact of these strategies.

It would be expected that hospital admissions for these conditions would decrease as performance and quality of service increases.

The hospitalisations for falls by older persons demonstrates a relationship between falls events and an older person's possible diminished mobility. A fall in the home or in a community setting can affect an older person's quality of life. Targeting older persons with community and public health programs to prevent falls occurring can reduce injury and hospitalisation and support their ability to live safely at home.

Targets

Aspirational target: a 0.5% per annum reduction, for a sustained period for both Aboriginal and non-Aboriginal populations by 2020.

Results

Generally the hospitalisation rates recorded for 2011 demonstrate a higher rate of hospitalisation across both populations and age groups compared to prior years. As expected hospitalisation rates for a fall increases with age. Both population groups have yet to demonstrate sustained progress against the long term aspirational target although this trend may continue in the immediate years until the implemented falls prevention and injury mitigation strategies begin to take affect in the community.

Table 6: Rate of hospitalisation per 1,000 for falls in older persons

	2008		2009		2010		2011	
Age Cohorts	**Aboriginal**	**Non-Aboriginal**	**Aboriginal**	**Non-Aboriginal**	**Aboriginal**	**Non-Aboriginal**	**Aboriginal**	**Non-Aboriginal**
55-64 years	32.4	4.3	22.0	5.3	29.1	4.6	40.1	5.9
65-79 years	45.3	16.5	34.8	17.5	44.1	16.7	51.0	18.7
80+ years	81.6	91.6	115.3	85.5	70.2	83.7	58.8	97.3

Note:
This indicator measures hospitalisations 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. Individuals may experience repeat hospitalisations from the same cause.
Falls in hospitals and health facilities are not included in this KPI measurement, nor are falls occurring in settings not primarily targeted by the health promotion programs.

Data source:
Hospital Morbidity Data System
Australian Bureau of Statistics

Outcome 2: Effectiveness KPI

Percent of contacts with community-based public mental health non-admitted services within seven days prior to admission to a public mental health inpatient unit

Rationale

A large proportion of people with a mental health problem may have a chronic or recurrent illness that results in only partial recovery between acute episodes and deterioration in function that can lead to challenges in living an independent life. As a result, hospitalisation may be required on more than one occasion each year with the need for ongoing community-based support.

Access to communit- based mental health services may assist with improving the management of, or alleviate the need for admissions to, in-patient care. Many consumers admitted to public sector mental health acute inpatient units are known to public sector community mental health services and it is reasonable to expect that community services should be involved in pre-admission care.

The time period of seven days was recommended nationally as an indicative measure for contact with public community-based non-admitted services prior to admission to public mental health inpatient units.

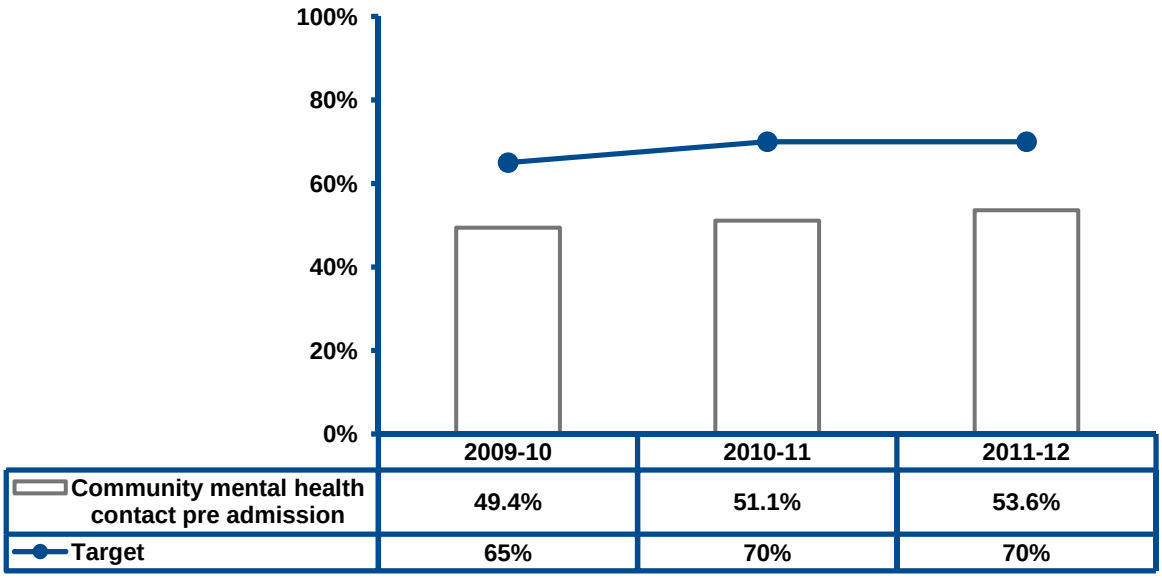
Target

Greater than or equal to 70%. (National target).

Results

In 2011-12, 53.6 per cent of the people who were to be admitted to a country public mental health inpatient unit were in contact with a community-based public mental health non-admitted service within seven days prior to their admission, which while continuing the improving trend of the prior years, is below the target. The National target is an aspirational benchmark which may not reflect mental health service delivery challenges in rural and remote areas.

Figure 35: Community mental health contact pre admission



	2009-10	2010-11	2011-12
Community mental health contact pre admission	49.4%	51.1%	53.6%
Target	65%	70%	70%

Note:
A data extraction error led to an incorrect result for 2009-10 published in the 2009-10 Annual Report. The 2009-10 result has been adjusted to the correct contact percentage.

Data source:
Mental Health Information Systems – Data Integrity

Outcome 2: Effectiveness KPI

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

Rationale

A large proportion of people with a mental health problem may have a chronic or recurrent illness that results in only partial recovery between acute episodes and deterioration in function that can lead to challenges in living an independent life. As a result, hospitalisation may be required on more than one occasion each year with the need for ongoing community-based support.

A responsive community support system for persons who have experienced an acute psychiatric episode requiring hospitalisation is essential to maintain clinical and functional stability and to minimise the need for hospital readmissions. Patients leaving hospital after a psychiatric admission with a formal discharge plan, involving linkages with public community-based services and support, are less likely to need inappropriate readmission. These community services provide ongoing clinical treatment and access to a range of programs that maximise an individual's independent functioning and quality of life.

The time period of seven days was recommended nationally as an indicative measure for contact with community based non-admitted services following hospital discharge.

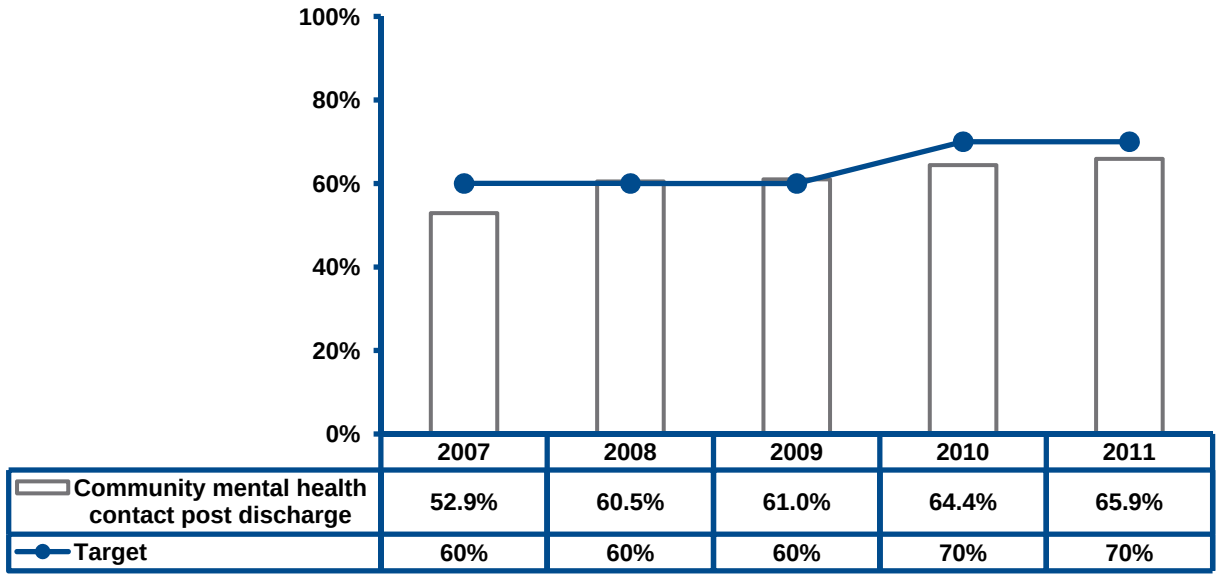
Target

Greater than or equal to 70% (National target).

Results

In 2011, 65.9 per cent of patients with a mental illness discharged from public mental health inpatient units had contact with a community-based public mental health non-admitted service within seven days of discharge. This result continues the improving trend of prior years although is below the National target.

Figure 36: Community mental health contact post discharge



	2007	2008	2009	2010	2011
Community mental health contact post discharge	52.9%	60.5%	61.0%	64.4%	65.9%
Target	60%	60%	60%	70%	70%

Data source:
Mental Health Information Systems – Data Integrity

Service 7: Promotion, protect and prevention Efficiency KPI

Cost per capita of Population Health Units

Rationale

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

Population health units support individuals, families and communities to increase control over and improve their health. In rural locations Population Health units provide both illness prevention and health promotion, and health protection services and programs including:

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

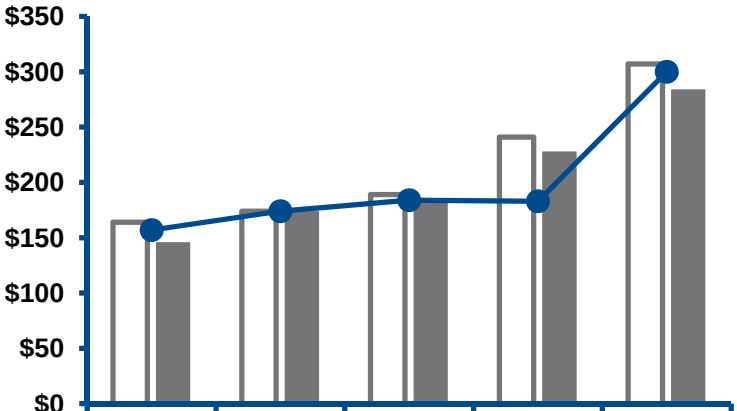
Target

$300 per capita. A result below the target is desirable.

Result

In 2011-12 WACHS cost per capita for population health was $307. The significant increase compared to 2010-11 reflects the increased expenditure made by WACHS for country population health units including additional funding for 'Closing the Gap' and child health intiatives as well as Southern Inland Health Initiative funding.

Figure 37: Cost per capita of Population Health Units



	2007-08	2008-09	2009-10	2010-11	2011-12
Actual cost	$164	$174	$189	$241	$307
CPI adjusted cost	$146	$174	$184	$228	$284
Target	$157	$174	$184	$183	$300

Data source:
Australian Bureau of Statistics
WACHS Finance Systems

Service 9: Continuing care Efficiency KPI

Average cost per bed-day for specified residential care facilities, flexible care (hostels) and nursing home type residents

Rationale

The WA Country Health Service provides residential care for patients who require long term care involving 24 hour nursing and support care.

The provision of non-acute permanent residential care is a significant activity provided to rural clients across the WA Country Health Service where access to local alternative private or non-government providers may be limited.

WACHS residential care services include permanent high dependency, high dependency respite, permanent low dependency and low dependency respite, nursing home type care in hospital, and hostel and flexible care.

This indicator reports the cost per residential aged care bed-day for residents of the specified residential aged care facilities in the Kimberley at Kununurra, and in the Pilbara at Karlarra in Port Hedland, and for all other WACHS residential aged care services.

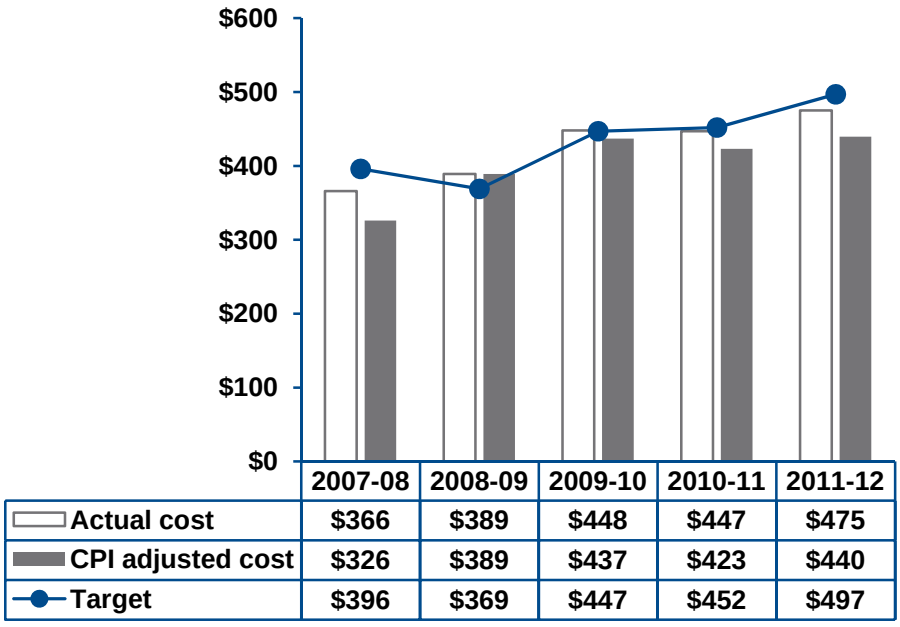
Target

$497 per residential care bedday. A result below the target is desirable.

Result

For 2011-12 average cost per residential care bed day was $475, below target.

Figure 38: Average cost per bed-day for specified residential care facilities, flexible care (hostels) and nursing home type residents



	2007-08	2008-09	2009-10	2010-11	2011-12
Actual cost	$366	$389	$448	$447	$475
CPI adjusted cost	$326	$389	$437	$423	$440
Target	$396	$369	$447	$452	$497

Data source:
WACHS HCARe data warehouse
WACHS Financial System

Service 10: Contracted mental health Efficiency KPI

Average cost per three month period of community care provided by public community mental health services

Rationale

Public community mental health services provided include assessment, treatment and continuing care.

The efficient use of public community-based resources can help minimise the overall costs of providing mental health care. It is therefore important to monitor the unit cost of community-based patient care in specialised public mental health community services.

This indicator gives a measure of the cost effectiveness of treatment for patients (non-admitted / ambulatory patients) receiving care from public community based mental health services.

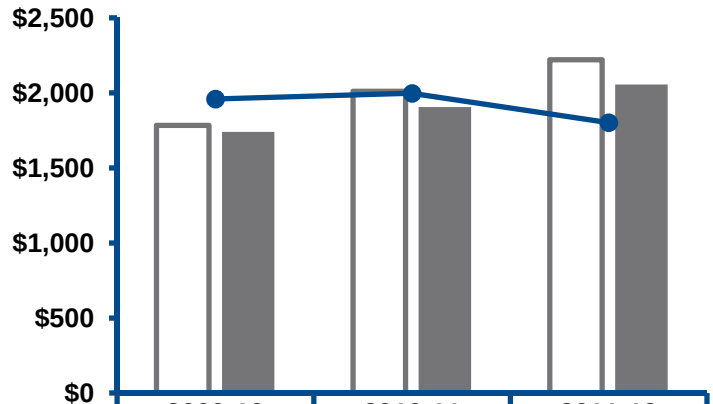
Target

$1,802 per three month period of care. A result below the target is desirable.

Result

In 2011-12 the cost per community mental health period of care was $2,221, above the target where the activity projections were greater than that realised and the corresponding expenditure significantly under-estimated. Compared to 2010-11 activity was nearly 7% higher and expenditure 18% greater than made in 2010-11.

Figure 39: Average cost per three month period of community mental health care



	2009-10	2010-11	2011-12
Actual cost	$1,783	$2,011	$2,221
CPI adjusted cost	$1,740	$1,905	$2,056
Target	$1,959	$1,997	$1,802

Note:
The community mental health efficiency indicator target and result includes statewide corporate overheads. While these costs are borne by WA Health, and are not included in the MHC service provision agreement, they have been included in the reported result as they contributed to the total unit cost for this health service product.

Data source:
Mental Health Information Systems
WACH Financial Systems

KPI

Service 10: Contracted mental health Efficiency KPI

Average cost per bed-day in specialised mental health units

Rationale

Specialised mental health inpatient units provide admitted patient care in specific hospitals or hospital wards for the treatment and care of patients with mental or behavioural disorders.

To ensure quality care and cost effectiveness, it is important to monitor the unit cost of admitted patient care in specialised mental health inpatient units. The efficient use of hospital resources can help minimise the overall costs of providing mental health care and enable the reallocation of funds to appropriate alternative non admitted care. In the context of the services provided, admitted mental health activity is better reported separately to other admitted activity, and as bed-days provided rather than by weighted separations.

This indicator measures the average cost per bed day in specialised mental health units. WACHS has specialised mental health units in Albany, Kalgoorlie, Broome and Bunbury.

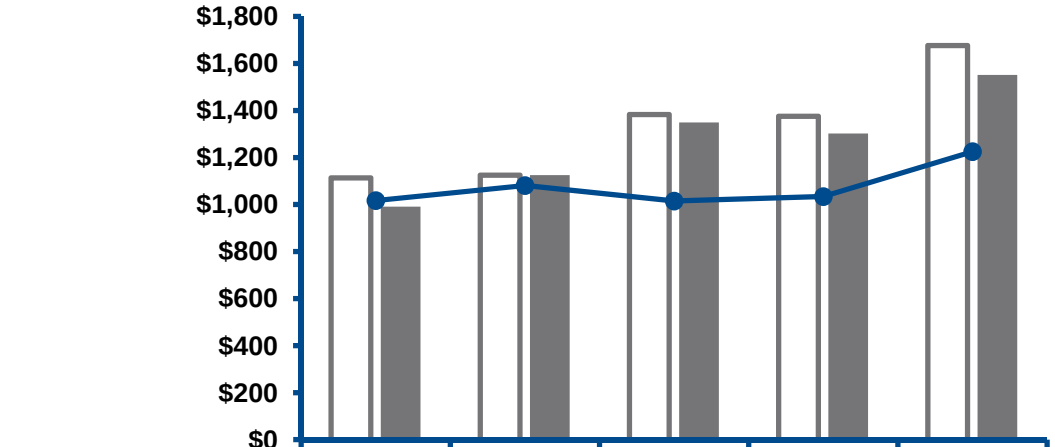
Target

$1,225 per specialised mental health bed-day. A result below the target is desirable.

Result

The average cost per bed-day in WACHS specialised mental health units was $1,676, above the target. This result when compared to 2010-11 and the target is largely due to the full start up costs associated with the newly opened Broome Specialised Mental Health Inpatient Unit which did not provide admitted care for the full year as well as higher expenditure than that projected in the budget and that was made in 2010-11 for the existing WACHS specialised mental health units.

Figure 40: Average cost per bed day in specialised mental health units



	2007-08	2008-09	2009-10	2010-11	2011-12
Actual cost	$1,113	$1,125	$1,383	$1,375	$1,676
CPI adjusted cost	$991	$1,125	$1,349	$1,302	$1,551
Target	$1,017	$1,081	$1,015	$1,034	$1,225

Note:
The community mental health efficiency indicator target and result includes statewide corporate overheads. While these costs are borne by WA Health, and are not included in the MHC service provision agreement, they have been included in the reported result as they contributed to the total unit cost for this health service product.

Data source:
Mental Health Information System / Bedstate – Data Integrity
HCARe
WACHS Financial Systems

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Delivering a **Healthy WA**

Disclosure & Compliance Reports

Enabling Legislation

The WA Country Health Service is established under sections 15 and 16 of the *Hospitals and Health Services Act 1927.* The Minister for Health is incorporated as the WA Country Health Service under section 7 of the *Hospitals and Health Services Act 1927,* and has delegated all of the powers and duties as such to the Director General of Health.

Public Sector Standards & Ethical Codes Compliance

Please refer to the 2011-12 Department of Health Annual Report for details of the WA Health compliance with the Western Australia Public Sector Code of Ethics, Public Sector Standards in Human Resource Management and the WA Health Code of Conduct.

Employee Profile

Agencies are required to report a summary of the number of employees by category, in comparison with the preceding financial year. The table below shows the average number of full-time equivalent staff employed by WACHS for 2011-12 by category.

Table 7: WACHS Total FTE by Category

Category	Definition	2010-11	2011-12
Administration and clerical	Includes all clerical-based occupations – ward and clerical support staff, finance managers and officers.	1,321	1,413
Agency	Includes contract staff in occupational categories: administration and clerical, medical support, hotel and site services, medical.	46	82
Agency nursing	Includes nurses engaged on a “contract for service” basis.	101	117
Assistants in nursing	Support registered nurses and enrolled nurses in delivery of general patient care.	11	29
Dental nursing	Includes dental clinic assistants.	0	0
Hotel services	Includes catering, cleaning, stores/supply laundry and transport occupations.	1,262	1,258
Medical salaried	Includes all salary-based medical occupations including interns, registrars and specialist medical practitioners.	255	298
Medical sessional	Includes sessional based medical occupations.	7	8
Medical support	Includes all Allied Health and scientific/technical related occupations.	675	763
Nursing	Includes all nursing occupations. Does not include agency nurses.	2,581	2,684
Site services	Includes engineering, garden and security-based occupations.	178	177
Other categories	Includes Aboriginal and ethnic health worker related occupations.	98	121
Total		**6,534**	**6,950**

Totals may not add due to rounding.

1. FTE is calculated as the monthly Average FTE and is the average hours worked during a period of time divided by the Award Full Time Hours for the same period. Hours include ordinary time; overtime; all leave categories; public holidays, Time Off in Lieu, Workers Compensation.
2. FTE figures provided are based on Actual (Paid) month to date FTE.
3. Data excludes the Drug and Alcohol Office.
4. Data Source: HR Data Warehouse, extracted 20 July 2012.

Capital Works

Figure 41: Busselton Health Campus

Please refer to the 2011-12 Department of Health Annual Report for financial details of the full WACHS capital works program.

Table 8: Major Capital Works in WACHS – *completed* in 2011-12

Project Title	Year project began	Approved cost 2011-12 budget ($000)	Final cost * ($000)
Bayulu Remote Clinic	2011	$880	$851
Broome Paediatric Ward	2010	$7,900	$7,900
Kalumburu Staff Housing EKDP	2010	$1,000	$1,000
Kununurra Renal Clinic	2011	$5,800	TBD*
Kununurra Health Provider Housing EKDP	2010	$6,800	$6,800

* Explain any significant difference between the approved cost and the final cost reported in the preceding financial year.
* Final cost still to be determined by BMW awaiting outstanding consultant fees.

Table 9: Capital Works in WACHS - in *progress* ($50m plus)

Project Title	Expected year of completion	Approved cost 2011-12 budget ($000)	Estimated * total cost ($000)
Southern Inland Health Initiative	2016	$325,000	$325,000
New Karratha Health Campus	2017	$207,100	$207,100
New Albany Health Campus	2013	$170,400	$170,400
New Busselton Health Campus	2014	$120,400	$120,400
Kalgoorlie Health Campus Redevelopment	2014	$55,800	$55,800
East Kimberley Development Package	2013	$50,000	$50,000

* Explain any significant variation between this year's and last year's estimated total cost.

Advertising

The following table lists expenditure on advertising, market research, polling, direct mail and media advertising made by the WA Country Health Service and published in accordance with the requirements of Section 175ZE of the *Electoral Act 1907*. The total expenditure for Advertising for the WACHS in 2011-12 was $504,449.

Table 10: 2011-12 WACHS advertising expenditure

Summary of Advertising	Amount ($)
Advertising Agencies	418,105
Media Advertising Organisations	86,344
Polling	0
Direct Mail Organisations	0
Media Advertising Organisations	0
Total Advertising Expenditure	**504,449**

Recipient / Organisations	Amount ($)
Advertising Agencies	
Adcorp Australia Limited	122,817
Adstream Australia	33
Albany Advertiser	4,043
Assorted Signs	1,148
Aust Sonographers	241
Austel Australia Pty Ltd	790
Australasian Medical Publishing Co Proprietary Limited	2,088
Australasian Society of Career Medical Officers Incorporated	600
Avon Valley Advocate	229
Blackwell Publishing Asia Pty Ltd	1,940
Boddington Community Newsletter	68
Boyup Brook Telecentre Inc	64
Broome Shire Council	282
Bruce Rock Telecentre Inc	29
Bunbury South Western Times	453
Chittering Times	140
Commerce & Trade Index	814
Countrywide Austral Pty Limited	450
Dalfour Pty Ltd	1,607
Dalwallinu Telecentre Incorporated	91
Denmark Bulletin	56
Dept of Mines & Petroleum	192
Express Print	455
First National Real Estate Broome	50
Geraldton Guardian	723
Geraldton Mid-West Times	246
Geraldton Newspapers Pty Ltd	894
Great Southern Advocate	120
Great Southern Herald	155
Healthway Foundation	1,334
HND Enterprises Pty Ltd	2,170
Hyden Resource & Telecentre	220
Industrial News	950
Kalannie Community Resource Centre Inc	64
Kalgoorlie Miner	732
Kids Safety News	498

Recipient / Organisations	Amount ($)
Kununurra Visitor	268
Lake Grace Community Resource Centre Inc	41
Macquarie Southern Cross	3,880
Market Creations Pty Ltd	780
Merredin Wheatbelt Mercury	31
Minnis Journals Pty Ltd	1,350
Mitchell And Partners Australia Pty Ltd	170,958
Narrogin Observer	212
Nationwide News Pty Limited	4,753
Northcliffe Community Development Inc	36
Nursing Careers (Allied Health)	726
Nursing Post	532
Nursing Review	8,810
Orana Cinemas Geraldton Pty Ltd	3,309
Palliative Care Australia Incorporated	68
Pemberton Telecentre Management Committee (Incorporated)	36
Picton Press	419
Pilbara News	206
Pindan Printing	360
Pingelly Times	26
Plantagenet News	106
Port Headland North West Telegraph	563
Presscom Pty Ltd	395
Royal Australian	545
SHPA International Publication	300
Seabreeze Comms Nursing Careers Allied Health	1,395
Sensis Pty Ltd	97
Services for Australian Rural & Remote Allied Health Inc	182
Shire of Three Springs	20
Shire of Trayning	17
Shire of West Arthur	32
Smith & Brown Design (WA)	650
South West Printing & Publishing Company Limited	1,432
Speech Pathology Australia	90
Spotlight Cinema Advertising	2,080
St George Books	4,990
The Australian	8,194
The Australasian College for Emergency Medicine	3,067
The Fence Post Newspaper Inc	45
The Gimlet Newspaper Inc	32
The Muddy Waters	120
The Nursing Post Pty Ltd	16,500
The Royal Australasian College of Medical Administrators	3,655
The Royal Australasian College of Physicians	250
The West Australian	12,951
The Williams Community Newspaper	25
The Windmill Community Newspaper Incorporated	30
UBM Medica (NZ) Ltd	1,401
WA Government Modules	634
Yamaji Languages Aboriginal Corporation	14,233
Youth & Community Welfare News	487
Total	**418,105**

Recipient / Organisations	Amount ($)
Media Advertising Organisations	
Aged Care Channel Pty Limited	2,522
Brookton Telegraph (Inc)	50
Countrywide Media	2,692
Denmark Bulletin	319
Dragonfly Media	480
Faircount Media Asia Pty Ltd	2,950
Geraldton Trophy & Engraving Centre	225
Green Man Media Productions	545
Jacaranda Photography	7,154
Keating Photography	509
Last Say Communications	60,633
Lizart Productions	64
Magpie Squawk	20
Quality Press WA	46
Redwave Media Pty Ltd	3,764
Rural Press Regional Media (WA) Pty Limited	747
Tremain Media	880
Uptempo Design & Screen Printers	661
Vertical Media Pty Ltd	1,439
Watershed News Incorporated	24
Whistling Moose Graphics	620
Total	**86,344**

Pricing Policy

The National Healthcare Agreement (NHA) sets the macro pricing framework for the charging of public hospital fees and charges.

Please see the Department of Health's Annual Report 2011-12.

Industrial Relations

Please see the Department of Health's Annual Report 2011-12 for the full report of Industrial Relations.

Substantive Equality

The WA Health Substantive Equality Implementation Committee is guiding the development and implementation of substantive equality within WA Health 2008-2013. Members of the Implementation Committee represent all areas of WA Health and are senior officers from a clinical or operational area who are in a position to be able to influence how services are delivered.

Please see the Department of Health Annual Report 2011-12 for the full report on Substantive Equality.

Recordkeeping

The *State Records Act 2000* was established to mandate the standardisation of statutory record keeping practices for every Government agency including records creation policy, record security and the responsibilities of all staff. Government agency practice is subject to the provisions of the Act and the standards and policies, and Government agencies are subject to scrutiny by the State Records Commission.

The WA Country Health Service (WACHS) must comply with the Department of Health's (DOH) Record Keeping Plan (RKP). WA Country Health Service (WACHS) has been developing a Recordkeeping Plan and supporting framework to replace the existing plan which will expire during 2012. The revised plan will be submitted to the State Records Office in the latter half of 2012.

A corporate recordkeeping strategy has been developed and approved by WACHS Executive and is currently being implemented in its Central Office. To ensure WACHS progresses towards compliance, the Records and TRIM Services team have completed recordkeeping surveys and site visit reviews to develop a sustainable and transferrable framework across the service.

Recordkeeping Strategies

The Records and TRIM services team have made significant progress in raising recordkeeping awareness within WACHS through the implementation of the corporate recordkeeping strategy.

WACHS is implementing an electronic record and document management solution for managing corporate records compliant with the State Records Act 2000 framework. WACHS has invested in developing, and has begun implementing, best practice and contemporary recordkeeping solutions and processes to assist in the success of this strategy.

During 2011-12 the major part of this strategy, the development of effective and measurable training programs to ensure staff are aware of their recordkeeping obligations, and have the skills to manage corporate records effectively, has continued. These programs address recordkeeping awareness across WACHS. Electronic Document and Records Management Systems eDRMS training is included for the induction of new starters, and is available to existing staff for refresher courses and as a information resource. The program has been developed as an online training and assessment solution with Records and TRIM Services providing helpdesk assistance and support.

Regular reporting on the success of the recordkeeping and training program is provided to senior management. These reports include training assessments, follow-up training, monitoring the number of eDRMS users, statistics on records created, data integrity evaluation and 'help-desk' support requests.

As a measure of the success of the program there has been an increase of over 460% in documents and folders saved within the TRIM eDRMS this financial year compared to the previous year.

WACHS has a Health Information Management (HIM) Network that regularly meets to discuss key components of health and patient records through the record management framework and also through the six key principles:

1. Proper and Adequate Records

- The WACHS Intranet cross references with DOH Record Services, Legislative and Legal Services Intranet sites, State-wide Data Collection Standards and the DOH Forms Design and Documentation Standards for Health Records.
- WACHS, through the development of data entry standards for health information systems and monitoring of performance indicators, ensures data quality consistency.

2. Policy and Procedures

- WACHS complies with the DOH WA Patient Information Retention and Disposal Schedule Version 3, 2008, as approved by the State Records Commission.
- The WACHS HIM Network have developed an Audit Checklist and a Hospital Inpatient General Health Records Audit framework.
- A WACHS Health Record Standard is being finalised which will provide a framework for consistent policies and procedures.

3. Language Control

- All sites create client records under their patient administration system with a unique registration which is monitored for duplicates based on the client/patient name, date of birth and other demographics.
- WACHS is currently working with the DOH Health Information Network to establish a statewide unique client/patient master index.

4. Preservation

- Work is complete on the centralisation of HCARe databases along with data recovery back-up and work is progressing on standardised downtime procedures.
- The HIM Network has drafted a Physical Records Audit Tool for all sites covering:
- Organisational Commitment: policies, procedures, training
- Storage: building construction, physical components - security, shelving, equipment
- Environmental Conditions, and Fire Prevention and Suppression
- Regions are working on hard copy health record retention compliance with many either using or considering off-site storage.

5. Retention and Disposal

- WACHS complies with the DOH WA Patient Information Retention and Disposal Schedule Version 3, 2008 and there is a link to the schedule on the WACHS Intranet.

6. Compliance

- In conjunction with the training needs analysis, a HCARe Client Management System (CMS) Standard Training Plan has been endorsed by the HCARe Business User Group, and is available via the WACHS Intranet along with all current manuals',

cheat sheets and business rules.
- Regional audits of health records identify areas for improvement in regard to support and training for staff.
- Regions provide presentations and orientation/induction programs on health records management.

Freedom of Information

For the year ending 30 June 2012, the WA Country Health Service considered 2,620 applications for access to information in accordance with the *Freedom of Information Act 1992*.

Table 11: Freedom of information applications 2011-12

Applications	Number
Carried over from 2010-11	73
Received in 2011-12	2,547
Total applications received in the 2011-12	2,620
Granted full access	1,336
Granted partial or edited access [1]	1,088
Withdrawn	20
Refused	49
In progress	64
Other [2]	63
Total	**2,620**

[1] Includes the number accessed in accordance with section s 28 of the *Freedom of Information Act 1992 (WA).*
[2] Includes exemptions, deferments or transfers to other departments/agencies.

The types of documents held by WACHS include:
- patient medical and dental records;
- medical test and pathology results;
- social work and child protection agency notes;
- patient information brochures and instruction sheets;
- policy development documents, and policy and procedures manuals;
- engineering records, such as hospital plans and occupational safety and heath information;
- human resource records;
- financial and accounting records;
- administrative records, for example, committee meeting minutes and business correspondence;
- psychological medicine notes;
- Child Protection Agency notes;
- evidentiary documents;
- building plans and tender documents;
- complaint files; and
- occupational health and safety information.

Applications for access to WACHS patient records and other health service related documents must be made in writing, detailing the material required. Applications can be made by parents, legal guardians or representatives, and members of the public (non-personal) and are acknowledged in writing. Applications are assessed by appointed Freedom of Information (FOI) coordinators in each region for validity and release appropriateness depending on the material being sought, and where approved for release, materials may be de-identified. Requests for general information are dealt with under a less formalised process.

Requests for information can be granted, partially granted, granted edited access or refused. Applicants are advised of the reasons for access decisions including their rights of review and the procedures to be followed.

Each region and, in some cases, healthcare facility has a FOI coordinator who can receive access requests and assist the applicant in how to prepare and process a request for information access. These officers can generally be contacted via the WACHS regional office.

All personal FOI applications are dealt with in accordance with the *Freedom of Information Act*. All applications are assessed for validity, recorded on the relevant departmental databases and allocated a FOI number. All applications are acknowledged and the 45 day deadline is advised. Records may need to be copied and authorised for release. All notes are assessed by the FOI Co-ordinator as to their relevance to the application before being released. All relevant documents are then scanned and de-identified prior to being released (unless under legal subpoena). Patient medical records, which are copied, are sent to the applicant by registered mail. However, applicants may request to view their records instead and can make an appointment with the FOI Coordinator.

The written application must comply with the legislation and include sufficient information for the patient or information to be identified, provide an Australian address for the correspondence, include the patient's consent if applicable. The identification of the applicant must be established for personal information.

Non-personal applications are also dealt with under the *Freedom of Information Act*. The process for dealing with non-personal applications is the same as above and may involve liaising with clinical staff and the hospital executive with regards to the appropriateness of the requested information being released.

Disability Access & Inclusion Plan

Disability Access and Inclusion Plan

Disability Access and Inclusion Plans (DAIP) have been implemented in the WA Country Health Service (WACHS) in line with the WA Health DAIP.

The DAIP identifies strategies, actions, timelines and responsibilities, to ensure people with disabilities living in country WA have the same opportunities as other people to access health facilities at the same level and quality of services. DAIP committees in each WACHS region work to ensure that the Outcomes detailed in the legislation are addressed in the activities undertaken by WACHS' hospitals, health care facilities and within the various health programs implemented by the Area Health Service.

The *Disabilities Services Act 1993* requires public authorities to develop and implement a Disability Access and Inclusion Plan and undertake a continuous process of review to ensure the organisation meets the outcomes outlined in the Act.

The following is a selection of the specific actions undertaken during 2011-12 across WACHS in relation to the outcomes of the DAIP.

Outcome 1

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

- Throughout 2011-12 WACHS continued to progress the implementation of the Area Health Service Disability Access Plans at both a regional and network level, to ensure compliance with this Outcome and relevance to current issues pertaining to people with a disability.

Outcome 2

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

- Disability Access and Inclusion planning is reviewed for all WACHS capital works projects to incorporate disability and inclusion access as per the Australian Building Code. These considerations are evident at the Albany Health Campus, where the needs of people with disabilities have been incorporated in design features such as easy wheelchair access, and wide corridors and doorways. Adequate disabled parking has been provided for both the staff and public with the parking sites located close to the main entrances. Ward areas have non slip surfaces for those persons requiring walking aids.
- WACHS continually reviews its operations to ensure they meet the requirements of the DAIP.

Outcome 3

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

- Stipulations under the Department of Health Communications Style Guide have been adopted in the preparation of all information developed for public distribution and all

information is available in alternative formats including the health service's 'Rights and Responsibilities' information provided on a Patient First DVD enabling visually impaired clients to listen to the information.
- WACHS displays its own information posters as well as those provided by the Disability Services Commission promoting Disability Access and Inclusion. WACHS has also developed a self directed learning package for staff.

Outcome 4

People with disabilities receive the same level and quality of service from the staff of a public authority as other people receive from the staff of that authority:
- Disability awareness is included in mandatory training days, induction sessions and self directed learning packages to ensure all staff can deliver consistent services and healthcare to people with a disability.
- WACHS facilitates regular education sessions using e-learning packages, DSC training packages and DVD's, to assist staff to achieve competencies (certificate level) in appropriate training courses such as health service staff working with clients with a disability in residential care.

Outcome 5

People with disabilities have the same opportunities as other people to make complaints to a public authority:
- WACHS conducts regular regional and area-wide audits of its complaints processes especially in relation to ensuring that people with a disability have the same opportunities as others in the community.
- Regions have patient and customer liaison officers who can assist people to register a complaint.
- Regions review complaint forms and lodgement processes to ensure these provide the appropriate platform for initiating a complaint. WACHS regions provide information on the complaint process for the hearing impaired and can facilitate access to translating and interpreting services.
- Information on how to access Advocare support services is available across WACHS enabling community members, including those with a disability to state their concerns to an external body if required. Many WACHS areas have routine annual visits by Advocare to alert the community, especially people with a disability in the hospital and community, to the services relating to advocacy.

Outcome 6

People with disabilities have the same opportunities as other people to participate in any public consultation by a public authority:
- People with disabilities are encouraged to participate in and have been appointed to WACHS District Health Advisory Councils. Information and advice from the District Health Advisory Councils informs the Area Health Service as to the appropriate healthcare services to meet the needs of all community members, including those with a disability.

Internal Audit

Completed audits are considered by the relevant executive (generally through local audit liaison meetings), and are also considered at the WA Health Audit Committee. The Audit Committee has external and internal representation, and has an external Chair and Deputy Chair. The Audit Committee, which also has oversight over the Strategic Audit Plan, meets on at least a quarterly basis.

Audits undertaken were generally planned audits; however, on occasion, management initiated audits or special audits were also carried out. Audits target numerous subject areas including financial and operational compliance, service performance or information system efficiency or integrity. In addition, external consultants were utilised to complete some audits either independently or in a co-sourced arrangement. The audit process assists senior management to achieve sound managerial control.

The following are specific audits in relation to WACHS. Please refer to the 2011-12 Department of Health Annual Report for the full list of 29 audits undertaken by the corporate Governance Directorate, some of which have also impacted on the WA Country Health Service.

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

Table 12: Completed Audits

Audit	Area audited
Credentialing	WACHS
Capital & Infrastructure	WACHS
Privately Referred Non-Inpatient	WACHS
Ambulatory Surgery Initiative	WACHS

Recruitment

The WA Country Health Service recruitment processes are undertaken in accordance with the *Public Sector Standards in Human Resource Management* policies and aim to recruit suitably skilled persons to positions promptly to ensure continuation of service.

As in recent years, the workforce recruitment priority during the year for WACHS focused on the medical, nursing and allied health.

Strategies feature recruitment promotions in prominent print media and professional journals, at career expos, target graduate programs and recruitment articles in rural health. There was also an emphasis to recruit locally where possible, and to increase the level of employment of Aboriginal people.

Medical Recruitment

The Clinical Workforce and Reform Unit (CW&RU) provide a centralised coordinated approach for the recruitment and appointment of medical practitioners to permanent vacancies within WACHS. The Unit provides employment contracts for hospital salaried medical practitioners employed under the Department of Health Medical Practitioners AMA Industrial Agreement 2011. Recruitment for locum positions is the responsibility of the individual regions. Medical Practitioners employed on Medical Services Agreements (MSA) are also managed in the regions.

Regional vacancies are advertised on the WACHS website, a focal point for medical practitioners considering a permanent position within country WA and for recruitment agencies. Applications are also received directly by the regions and through the CW&RU team. Medical Recruitment Pools are advertised on the WA Health jobs board managed by Health Corporate Network (HCN).

Advertising in 2011 via medical journals, specialist colleges and online websites resulted in a total of 1,531 applicants. Of these applicants 146 were considered for interview. In 2011 there were 93 ‘new starters’ to country health services in WA. 49.5% of these new employees completed their original medical qualifications overseas. The majority of these were from the UK (26), with three each from New Zealand and Myanmar, two each from India, Pakistan and the Philippines, with one each from the following countries: USA; Canada; South Africa; Poland; Nigeria; Nepal; Japan; and Germany.

The 2011 salaried medical practitioner recruitment data for WACHS reflect the overall percentage of International Medical Graduates (IMGs) working in rural and remote WA (both public and private sector) which is reported at greater than 53% by Rural Health West (Minimum Data Set, November 2011). This compares to 2002 data where only 38% of the rural workforce were classified as IMGs.

The Rural Generalist Pathway offers a career pathway for junior doctors wishing to train in rural area with a growing number of diverse placements in supported rural locations available in 2012. This is a collaboration with Rural Health West, WA General Practice Education and Training and the Postgraduate Medical Council of WA, the Rural Clinical School and Australian Medical Association Doctors in Training . The Postgraduate

Medical Education Unit opened in 2011 to support the 27 Interns, 56 Resident Medical Officers and 20 Registrars working in our country hospitals.

As well as assisting with industrial and payroll queries from medical practitioners employed on a salaried contract, and the contractors employed, the CW&RU coordinates the credentialing of doctors. It has also been integral to the set up and progression of the Southern Inland Health Initiative (SIHI).

The CW&RU has resumed responsibility for the orientation and assessment of all International Medical Graduates who are commencing with WACHS and have not had previous working experience in Australia. This individualised and comprehensive orientation is scheduled prior to their commencing in the region and assists to improve patient safety and quality, and deliver greater satisfaction and retention of staff.

Nursing Recruitment

Nursing recruitment across WACHS has continued to be managed both at a regional level and centrally in 2011-12. Regions continue to have dedicated nursing resources to coordinate the recruitment of registered nurses, enrolled nurses and midwives at a local level. Central recruitment is coordinated for areas of need including nurse practitioners and other identified areas of shortage.

The 'Ocean to Outback' and 'Country to Coast' rotational programs for nurses and midwives continue to generate significant interest. Presently both programs are under review to ensure they meet the needs of health services and participants. Active recruitment into these programs will recommence in early 2013. Promotion of these programs is conducted via the website and through a number of expos targeting graduate nurses from metropolitan hospitals.

WACHS attended the annual Royal College of Nurses Expo (April 2012). This expo is an excellent opportunity for regions to promote rural and remote nursing with the WACHS regions and recruit to all areas of nursing including, registered and enrolled nurses, midwives and nurse practitioners.

WACHS continues to participate in the Graduate Connect Program to recruit graduate registered and enrolled nurses across a number of WACHS sites. Recruitment into these programs is conducted through participation in a number of expos held at the universities, targeting final year students. In 2012 WACHS joined the graduate nurse connect recruitment system for graduate midwives (in addition to the recruitment of graduate registered and enrolled nurses). Ten graduate midwife positions have been made available in 2012. This process will continue in 2013.

Recruitment of Nurse Practitioners as part of the SIHI continues, together with areas where nurse practitioner roles are designated and service needs are identified.

Aboriginal employment

Increasing and retaining our Aboriginal workforce is a major priority for WACHS and is supported through the:

- Development of the WACHS Aboriginal Employment Strategy 2010-2014 to support an increase in our Aboriginal health workforce;
- Indigenous Employment Program (IEP) to support the recruitment and retention of 70 new Aboriginal employees across country WA. The IEP funds will subsidise mentoring and support programs for new Aboriginal employees, as well as help to fund other priority Aboriginal workforce initiatives, such as career and professional development, leadership and cultural learning;
- Establishment of three Aboriginal Regional Coordinators/Consultants in three regions;
- Development of an Introductory Aboriginal Cultural e-Learning Package available online to all WACHS employees; and
- Establishment of the WACHS Aboriginal Workforce Taskforce.

Allied Health Recruitment

All allied health recruitment is coordinated locally at the point of vacancy and is facilitated via Health Corporate Network (HCN). At a health service level, WACHS proactively markets rural and remote careers to university students through a variety of strategies such as career expos, lectures and support for rural health student clubs. General allied health careers marketing is also undertaken at expos, conferences and via the internet. WACHS Area Office provides a centralised contact for expressions of interest and referral to relevant regions. Coordinated information is provided to regional WACHS managers regarding targeted advertising strategies, recruitment agencies and locum processes/supports.

Recruitment Training

WA Health released the Recruitment, Selection and Appointment (RSA) policy and procedures in August 2011. Training sessions have been made available to assist potential and current panel members based on the policy and procedures.

This training includes information regarding short listing, interviewing, conducting referee checks and completing the selection report. HCN representatives visited WACHS sites offering short training sessions on their processes and the relevant forms for RSA.

Training was available to all managers on the merit selection process in accordance with policy and the Public Sector Standards and training was available to staff in the methods for addressing selection criteria and preparing resumes.

The Commissioner's Instructions (instruments issued by the Public Sector Commissioner under s22A of the Public Sector Management Act 1994) were released in February 2011. These are:

- No. 1 – Employment Standards, and;
- No. 2 – Filing a Public Sector Vacancy

WACHS undertook a coordinated approach to the implementation of these instructions to increase awareness. WA Country Health Service also released an e-Learning package on RSA for use across the State.

Visa Management

WACHS has taken a greater role in visa management to ensure better compliance with Department of Immigration and Citizenship (DIAC) requirements and in 2011 processed: 135 long stay business 457 visas; 10 Employer Nominations (EN) for Permanent Residency for Doctors; and 28 Regional Sponsored Migration Scheme (RSMS) applications for Permanent Residency for Nurses and Allied Health staff.

Staff Development

The WACHS Learning and Development (L&D) network continues to:

- Operate within the framework of the operational plan and report on progress of the Essential Training Program (ETP) and staff development activities as required;
- Develop and implement training packages (self directed online training and face to face); and
- Coordinate and work with educators across WACHS, both internally and externally to provide robust and sustainable development opportunities for all staff.

Excellence in healthcare relies on continuous development of the skill and expertise of the healthcare workforce. WACHS is committed to providing opportunities for training and professional development to facilitate the personal growth, and enhance the confidence and competence of its staff.

The L&D programs target employees in the following categories:

- Nursing Midwifery;
- Population Health;
- Medical Services;
- Corporate Services;
- Aged Care;
- Mental Health; and
- Operators / Supply

The implementation of the Essential Skills Program (ESP) for staff provides a consistent set of training programs that staff must complete as a baseline for legislative, regulatory and operational standards.

Reporting

Reporting against the ESP has improved compliance. A report containing relevant data about new employees is soon to be released, which will inform managers on the status of recruitment, induction, and orientation in the organisation.

The L&D network have developed a single web site for WACHS to simplify access to training programs. The introduction of minimum training packages has improved compliance against the core essential training requirements. A suite of e-learning programs has been developed with approximately 50 programs now available.

A L&D monthly program report is available on the web site, which informs both Executive and regional members of key initiatives that are taking place.

Allied Health Education and Training

WACHS has established and piloted an Allied Health Graduate Transition to Practice (New Graduate) Program. There are currently 16 graduates participating in the program across multiple WACHS sites.

Allied Health Student Training

Funding from Health Workforce Australia has significantly enhanced WACHS' capacity to provide student clinical training. This includes the establishment of the first ever dedicated student training sites for allied health professionals, as well as enhancing support for supplementary training sites.

Initiatives have resulted in the creation of an additional 150-180 allied health student clinical training places in Country WA at the following sites:

- Broome Physiotherapy;
- Geraldton Speech Pathology
- Geraldton Sub-Acute Care (Inter-professional);
- Northam Physiotherapy;
- Bunbury Physiotherapy;
- Bunbury Disability;
- Albany Dietetic; and
- Albany Mental Health (Inter-professional).

Fire Safety Model

A new Fire Safety Model, recommended by independent fire safety consultants 'Metro Fire', was endorsed and implemented in the South West. Training for emergency controllers and area wardens was declared mandatory for identified personnel. Training commenced in 2012 and is due for completion in September 2012, by which time all identified staff will have been trained. In line with this model and the WACHS Essential Training policy, staff will be required to participate in annual fire and evacuation drills and online training across all emergency codes.

Links to Patient Safety and Quality

In 2011-12 the L&D network worked closely with the Kimberley Clinical Governance and Patient Safety Committee to develop educational programs to reduce incidence of identified risks through up-skilling and educating the workforce.

This close partnership has enabled work to progress on a range of initiatives to address identified clinical risks. These include:

- Development of e-learning educational resources which support, Febrile Child Procedure, Paediatrics Education and Brief Risk Assessment;
- Establishing a license agreement with the Australian College of Critical Care Nurses which has provided the opportunity to train and certify employees in Advanced Life Support. Twelve staff were selected to undertake Instructor Training, with plans to extend this to paediatric life support.
- To complement the Resuscitation suite, a Neonatal Resuscitation Train the Trainer program was conducted in Broome, with 16 staff successfully completing the program.

Workers' Compensation & Rehabilitation

The WACHS is committed to providing its staff with a safe and healthy work environment and recognises this as pivotal in attracting and maintaining the workforce necessary to deliver effective and efficient health care services.

Table 13: Workers' compensation claims

Employee Category	Number of claims in 2011-12
Nursing Services / Dental Care Assistant	111
Administration and Clerical	23
Medical Support	16
Hotel Services	128
Maintenance	11
Medical (salaried)	4
Total	**293**

Occupational injury and illness prevention

In 2012 the existing Country Health Service safety management system (SMS), was revised and included in draft Country Health Service Strategic Safety Frameworks. The draft 2012 Country Health Service Strategic Safety Frameworks aligns with updated requirements of the WA Code of Practice for occupational safety and health (OSH) in the Public Sector, and Public Sector Commission circular 11/2009. As required in this circular, the draft frameworks include:

- A statement of Executive commitment;
- Known safety risk profile; and
- Strategic goals

The revised safety management system (SMS) within each draft framework continues to align with WorkSafe Plan indicators and is modelled on an AS4801:2001 continuous improvement framework. The improved draft SMS policy framework supports the SMS and utilises WorkSafe Plan Standards to ensure that performance data can be collected and reported to enable evaluation of the system's effectiveness. The current status of WACHS performance is as follows:

- **Management commitment** – The Whole of Health OSH policy 2007 has been adopted by WACHS;
- **Planning** – A range of safety performance indicators are provided to management. A draft WACHS safety improvement action plan supports program initiatives and strategic risk. A comprehensive safety review was completed in June 2009 and 2012;
- **Hazard Management** – All safety risk identification and risk control procedures are arranged under this heading. The WA Health risk management system is incorporated into injury prevention procedures to assist supervisors to identify and control safety risks using the hierarchy of control with corrective actions applied through risk analysis, and control measures based on priority of risk;
- **Consultation** – All regions have established safety committees. A safety issue resolution procedure provides a clear pathway to escalate unresolved safety issues

to senior staff; and
- **Training** – Employee safety training needs have been identified, training codes allocated to safety training, and performance data is available monthly to leaders.

Employee rehabilitation

WACHS has implemented a workers compensation and injury management system as required by the *Workers Compensation and Injury Management Act 1981*. The system uses a case management approach ensuring injured workers return to work options are individual and the best outcome for each worker. Regional worker's compensation staff process compensation claims and ensure that injured employees receive their correct entitlements. Injured workers are referred to injury management intervention programs where appropriate.

WACHS has three injury management coordinators to coordinate return to work programs, including preparing and monitoring, in consultation with the case management team, written return to work plans.

Occupational Safety, Health & Injury Management Performance

Commitment to OSH injury management

'All areas of WA Health will comply with or exceed, Occupational Safety and Health (OSH) legal requirements, and will develop and implement safe systems and work practices that reflect its commitment to safety and health'. (Source: WA Health OSH Policy 2007)

WACHS maintains and enhances it's commitment to assisting injured workers to return to work as soon as medically appropriate and adheres to the requirements of the *Workers Compensation and Injury Management Act 1981* in the event of a work related injury or illness.

WACHS has an integrated risk management approach to occupational safety and health underpinned by policies in accordance with the *Occupational Safety and Health Act 1984*.

WACHS has implemented an Injury Management System (IMS) which meets the requirements of the *Worker's Compensation and Injury Management Act 1981.* Supporting policies and procedures are available to all employees online or from management, and are provided to new employees at orientation training.
Where appropriate, WACHS will engage appropriately qualified and WorkCover accredited rehabilitation providers to assist in the process of facilitating employees who are injured at work to return to gainful employment. 'An appointed accredited rehabilitation provider will liaise with all involved parties to establish and monitor an injury management program as soon as practicable in consultation with the treating doctor, supervisory staff and the injured employee to match capabilities with available duties.' (Source: WACHS Injury Management Policy and procedure, 2010)

Employee consultation

WACHS has established Occupational Safety and Health Committees in each region as part of a formal consultative process. The membership is stipulated in an agreed terms of reference and is consistent with the *Occupational Safety and Health Act 1984*. Supporting policies and procedures exist to further support the WACHS SMS, including a formal OSH issue resolution procedure.

OSH assessment

WA Country Health Service commenced a procurement process to engage consultants to undertake a Worksafe Plan Self Assessment of its safety system. The procurement process was in progress at 30 June 2012.

Table 14: Occupational safety and health and injury management performance

Fatalities	Lost time injury / disease incidence rate (per 100)	Lost time injury / disease incidence rate (per 100)	Injured workers returned to work within 26 weeks (%)	Managers trained in OSH and injury management responsibilities (%)
0	2.65%	29.35%	60.5%	73.8%

Delivering a **Healthy WA**

Financial Statements

Certification Statement

WA COUNTRY HEALTH SERVICE
CERTIFICATION OF FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2012

The accompanying financial statements of the WA Country Health Service have been prepared in compliance with the provisions of the *Financial Management Act 2006* from proper accounts and records to represent fairly the financial transactions for the financial year ending 30 June 2012 and financial position as at 30 June 2012.

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.

Rob Henry
ACTING CHIEF FINANCE OFFICER
DEPARTMENT OF HEALTH

Date: 20 September 2012

Kim Snowball
ACCOUNTABLE AUTHORITY
DEPARTMENT OF HEALTH

Date: 20 September 2012

Audit Opinion

Auditor General

INDEPENDENT AUDITOR'S REPORT

To the Parliament of Western Australia

WA COUNTRY HEALTH SERVICE

Report on the Financial Statements
I have audited the accounts and financial statements of the WA Country Health Service.

The financial statements comprise the Statement of Financial Position as at 30 June 2012, the Statement of Comprehensive Income, Statement of Changes in Equity and Statement of Cash Flows for the year then ended, and Notes comprising a summary of significant accounting policies and other explanatory information.

Director General's Responsibility for the Financial Statements
The Director General is responsible for keeping proper accounts, and the preparation and fair presentation of the financial statements in accordance with Australian Accounting Standards and the Treasurer's Instructions, and for such internal control as the Director General determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility
As required by the Auditor General Act 2006, my responsibility is to express an opinion on the financial statements based on my audit. The audit was conducted in accordance with Australian Auditing Standards. Those Standards require compliance with relevant ethical requirements relating to audit engagements and that the audit be planned and performed to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Health Service's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances. An audit also includes evaluating the appropriateness of the accounting policies used and the reasonableness of accounting estimates made by the Director General, as well as evaluating the overall presentation of the financial statements.

I believe that the audit evidence obtained is sufficient and appropriate to provide a basis for my audit opinion.

Opinion
In my opinion, the financial statements are based on proper accounts and present fairly, in all material respects, the financial position of the WA Country Health Service at 30 June 2012 and its financial performance and cash flows for the year then ended. They are in accordance with Australian Accounting Standards and the Treasurer's Instructions.

Report on Controls
I have audited the controls exercised by the WA Country Health Service during the year ended 30 June 2012.

Controls exercised by the WA Country Health Service are those policies and procedures established by the Director General to ensure that the receipt, expenditure and investment of money, the acquisition and disposal of property, and the incurring of liabilities have been in accordance with legislative provisions.

7th Floor Albert Facey House 469 Wellington Street Perth MAIL TO: Perth BC PO Box 8489 Perth WA 6849 TEL: 08 6557 7500 FAX: 08 6557 7600

Audit Opinion

Director General's Responsibility for Controls
The Director General is responsible for maintaining an adequate system of internal control to ensure that the receipt, expenditure and investment of money, the acquisition and disposal of public and other property, and the incurring of liabilities are in accordance with the Financial Management Act 2006 and the Treasurer's Instructions, and other relevant written law.

Auditor's Responsibility
As required by the Auditor General Act 2006, my responsibility is to express an opinion on the controls exercised by the WA Country Health Service based on my audit conducted in accordance with Australian Auditing and Assurance Standards.

An audit involves performing procedures to obtain audit evidence about the adequacy of controls to ensure that the Health Service complies with the legislative provisions. The procedures selected depend on the auditor's judgement and include an evaluation of the design and implementation of relevant controls.

I believe that the audit evidence obtained is sufficient and appropriate to provide a basis for my audit opinion.

Opinion
In my opinion, the controls exercised by the WA Country Health Service are sufficiently adequate to provide reasonable assurance that the receipt, expenditure and investment of money, the acquisition and disposal of property, and the incurring of liabilities have been in accordance with legislative provisions during the year ended 30 June 2012.

Report on the Key Performance Indicators
I have audited the key performance indicators of the WA Country Health Service for the year ended 30 June 2012.

The key performance indicators are the key effectiveness indicators and the key efficiency indicators that provide information on outcome achievement and service provision.

Director General's Responsibility for the Key Performance Indicators
The Director General is responsible for the preparation and fair presentation of the key performance indicators in accordance with the Financial Management Act 2006 and the Treasurer's Instructions and for such controls as the Director General determines necessary to ensure that the key performance indicators fairly represent indicated performance.

Auditor's Responsibility
As required by the Auditor General Act 2006, my responsibility is to express an opinion on the key performance indicators based on my audit conducted in accordance with Australian Auditing and Assurance Standards.

An audit involves performing procedures to obtain audit evidence about the key performance indicators. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the key performance indicators. In making these risk assessments the auditor considers internal control relevant to the Director General's preparation and fair presentation of the key performance indicators in order to design audit procedures that are appropriate in the circumstances. An audit also includes evaluating the relevance and appropriateness of the key performance indicators for measuring the extent of outcome achievement and service provision.

I believe that the audit evidence obtained is sufficient and appropriate to provide a basis for my qualified audit opinion.

Basis for Qualified Opinion
Controls over the initial recording of waiting time data used for the effectiveness indicators "Percentage of emergency service patients seen within recommended times (major rural hospitals)" were inadequate. Audit tests of a sample of attendance and treatment times identified a significant number of differences between source records and the database. Consequently, I was unable to determine whether this effective indicator was fairly presented.

Qualified Opinion
In my opinion, except for the possible effects of the matter described in the Basis for Qualified Opinion paragraph, the key performance indicators of the WA Country Health Service are relevant and appropriate to assist users to assess the Health Service's performance and fairly represent indicated performance for the year ended 30 June 2012.

Emphasis of Matter
As reported by the Health Service in the key performance indicators, the effectiveness indicators for "Rate of unplanned hospital readmissions within 28 days to the same hospital for a related condition" and "Rate of unplanned hospital readmissions within 28 days to the same hospital for a mental health condition" are based on the sample period September to November 2011. My opinion is not modified in respect of this matter.

Matter of Significance
WA Country Health Service has received approval from the Under Treasurer to remove the "Elective Surgery Waiting Times" Key Performance Indicator (KPI) from the audited KPIs for the year ended 30 June 2012. The approval is conditional on the inclusion of unaudited performance indicators measuring elective surgery waiting times in the agency's 2011-12 Annual Report and that elective surgery waiting times be reinstated as an audited KPI following the successful definition of national elective surgery waiting time indicators. My opinion is not modified in respect of this matter.

Independence
In conducting this audit, I have complied with the independence requirements of the Auditor General Act 2006 and Australian Auditing and Assurance Standards, and other relevant ethical requirements.

Matters Relating to the Electronic Publication of the Audited Financial Statements and Key Performance Indicators
This auditor's report relates to the financial statements and key performance indicators of the WA Country Health Service for the year ended 30 June 2012 included on the Health Service's website. The Health Service's management are responsible for the integrity of the Health Service's website. This audit does not provide assurance on the integrity of the Health Service's website. The auditor's report refers only to the financial statements and key performance indicators described above. It does not provide an opinion on any other information which may have been hyperlinked to/from these financial statements or key performance indicators. If users of the financial statements and key performance indicators are concerned with the inherent risks arising from publication on a website, they are advised to refer to the hard copy of the audited financial statements and key performance indicators to confirm the information contained in this website version of the financial statements and key performance indicators.

COLIN MURPHY
AUDITOR GENERAL
FOR WESTERN AUSTRALIA
Perth, Western Australia
20 September 2012

Financial Statements

WA Country Health Service

Statement of Comprehensive Income

For the year ended 30th June 2012

	Note	2012 $000	2011 $000
COST OF SERVICES			
Expenses			
Employee benefits expense	7	723,879	632,704
Fees for visiting medical practitioners		69,803	59,512
Patient support costs	8	213,953	191,032
Finance costs	9	716	956
Depreciation and amortisation expense	10	42,860	39,947
Loss on disposal of non-current assets	11	608	3,955
Repairs, maintenance and consumable equipment	12	33,077	33,883
Other expenses	13	120,245	100,057
Total cost of services		**1,205,141**	**1,062,046**
INCOME			
Revenue			
Patient charges	14	41,542	33,227
Commonwealth grants and contributions	15a	69,905	35,008
Other grants and contributions	15b	65,892	61,433
Donation revenue	16	1,151	602
Interest revenue		16	129
Other revenue	17	22,241	18,537
Total revenue		200,747	148,936
Total income other than income from State Government		**200,747**	**148,936**
NET COST OF SERVICES		**1,004,394**	**913,110**
INCOME FROM STATE GOVERNMENT			
Service appropriations	18	1,010,914	907,624
Assets assumed / (transferred)	19	304	-
Resources received free of charge	20	12	68
Royalties for Regions Fund	21	44,468	13,280
Total income from State Government		**1,055,698**	**920,972**
SURPLUS FOR THE PERIOD		**51,304**	**7,862**
OTHER COMPREHENSIVE INCOME/(LOSS)			
Changes in asset revaluation reserve	36	12,244	41,931
TOTAL COMPREHENSIVE INCOME/(LOSS) FOR THE PERIOD		**63,548**	**49,793**

Refer also to note 52 'Schedule of Income and Expenses by Service'.
The Statement of Comprehensive Income should be read in conjunction with the accompanying notes.

WA Country Health Service

Statement of Financial Position

As at 30th June 2012

	Note	2012 $000	2011 $000
ASSETS			
Current Assets			
Cash and cash equivalents		13,450	6,326
Restricted cash and cash equivalents	22	41,564	24,686
Receivables	23	15,991	13,835
Inventories	25	4,974	4,794
Other current assets	26	4,044	2,856
Non-current assets classified as held for sale	27	-	79
Total Current Assets		80,023	52,576
Non-Current Assets			
Amounts receivable for services	24	303,974	253,328
Property, plant and equipment	28	1,515,271	1,365,656
Intangible assets	29	99	146
Total Non-Current Assets		1,819,344	1,619,130
Total Assets		**1,899,367**	**1,671,706**
LIABILITIES			
Current Liabilities			
Payables	31	72,909	57,567
Borrowings	32	1,373	1,192
Provisions	33	103,758	95,550
Other current liabilities	34	31	1,846
Total Current Liabilities		178,071	156,155
Non-Current Liabilities			
Borrowings	32	11,164	12,605
Provisions	33	18,578	16,546
Total Non-Current Liabilities		29,742	29,151
Total Liabilities		**207,813**	**185,306**
NET ASSETS		**1,691,554**	**1,486,400**
EQUITY			
Contributed equity	35	1,283,605	1,141,999
Reserves	36	354,318	342,074
Accumulated surplus/(deficit)	37	53,631	2,327
TOTAL EQUITY		**1,691,554**	**1,486,400**

The Statement of Financial Position should be read in conjunction with the accompanying notes.

WA Country Health Service

Statement of Cash Flows

For the year ended 30th June 2012

	Note	2012 $000 Inflows (Outflows)	2011 $000 Inflows (Outflows)
CASH FLOWS FROM STATE GOVERNMENT			
Service appropriation		959,532	860,768
Capital appropriation		97,612	74,719
Holding account drawdowns		-	1,782
Royalties for Regions Fund		86,990	41,514
Net cash provided by State Government	38	**1,144,134**	**978,783**
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Employee benefits		(708,216)	(621,347)
Supplies and services		(425,398)	(391,966)
Receipts			
Receipts from customers		41,464	31,975
Commonwealth grants and contributions		69,905	35,008
Other grants and contributions		64,046	63,083
Donations received		1,136	602
Interest received		16	129
Other receipts		20,166	17,321
Net cash provided by / (used in) operating activities	38	**(936,881)**	**(865,195)**
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments			
Payments for purchase of non-current physical assets		(183,548)	(114,371)
Receipts			
Proceeds from sale of non-current physical assets	11	297	565
Net cash provided by / (used in) investing activities		**(183,251)**	**(113,806)**
Net increase / (decrease) in cash and cash equivalents		24,002	(218)
Cash and cash equivalents at the beginning of the period		31,012	31,229
CASH AND CASH EQUIVALENTS AT THE END OF PERIOD	38	**55,014**	**31,012**

The Statement of Cash Flows should be read in conjunction with the accompanying notes.

WA Country Health Service

Statement of Changes in Equity

For the year ended 30th June 2012

	Note	2012 $000	2011 $000
CONTRIBUTED EQUITY	35		
Balance at start of period		1,141,999	1,038,833
Transactions with owners in their capacity as owners:			
Capital appropriations		98,873	75,856
Royalties for Regions Fund		42,522	28,234
Other contributions by owners		390	-
Distributions to owners		(179)	(924)
Balance at end of period		1,283,605	1,141,999
RESERVES	36		
Asset Revaluation Reserve			
Balance at start of period		342,074	300,143
Comprehensive income/(loss) for the period		12,244	41,931
Balance at end of period		354,318	342,074
ACCUMULATED SURPLUS/(DEFICIT)	37		
Balance at start of period		2,327	(5,535)
Surplus/(deficit) for the period		51,304	7,862
Balance at end of period		53,631	2,327
TOTAL EQUITY			
Balance at start of period		1,486,400	1,333,441
Total comprehensive income/(loss) for the period		63,548	49,793
Transactions with owners in their capacity as owners		141,606	103,166
Balance at end of period		**1,691,554**	**1,486,400**

The Statement of Changes in Equity should be read in conjunction with the accompanying notes.

WA Country Health Service

Notes to the Financial Statements

For the year ended 30th June 2012

Note 1 Australian Accounting Standards

General

The Health Service's financial statements for the year ended 30 June 2012 have been prepared in accordance with Australian Accounting Standards. The term 'Australian Accounting Standards' refers to Standards and Interpretations issued by the Australian Accounting Standards Board (AASB).

The Health Service has adopted any applicable, new and revised Australian Accounting Standards from their operative dates.

Early adoption of standards

The Health Service cannot early adopt an Australian Accounting Standard unless specifically permitted by Treasurer's Instruction 1101 '*Application of Australian Accounting Standards and Other Pronouncements*'. There has been no early adoption of Australian Accounting Standards that have been issued or amended (but not operative) by the Health Service for the annual reporting period ended 30 Jun 2012.

Note 2 Summary of significant accounting policies

(a) General Statement

The Health Service is a not-for-profit reporting entity that prepares general purpose financial statements in accordance with Australian Accounting Standards, the Framework, Statements of Accounting Concepts and other authoritative pronouncements of the Australian Accounting Standards Board as applied by the Treasurer's instructions. Several of these are modified by the Treasurer's instructions to vary application, disclosure, format and wording.

The Financial Management Act and the Treasurer's instructions impose legislative provisions that govern the preparation of financial statements and take precedence over the Australian Accounting Standards, the Framework, Statements of Accounting Concepts and other authoritative pronouncements of the Australian Accounting Standards Board.

Where modification is required and has had a material or significant financial effect upon the reported results, details of that modification and the resulting financial effect are disclosed in the notes to the financial statements.

(b) Basis of Preparation

The financial statements have been prepared on the accrual basis of accounting using the historical cost convention, except for land and buildings which have been measured at fair value .

The accounting policies adopted in the preparation of the financial statements have been consistently applied throughout all periods presented unless otherwise stated.

The financial statements are presented in Australian dollars and all values are rounded to the nearest thousand dollars ($'000).

Note 3 'Judgements made by management in applying accounting policies' discloses judgements that have been made in the process of applying the Health Service's accounting policies resulting in the most significant effect on amounts recognised in the financial statements.

Note 4 Key sources of estimation uncertainty' discloses key assumptions made concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

(c) Contributed Equity

AASB Interpretation 1038 '*Contributions by Owners Made to Wholly-Owned Public Sector Entities*' requires transfers in the nature of equity contributions, other than as a result of a restructure of administrative arrangements, to be designated by the Government (the owner) as contributions by owners (at the time of, or prior to transfer) before such transfers can be recognised as equity contributions. Capital appropriations have been designated as contributions by owners by Treasurer's Instruction 955 '*Contributions by Owners made to Wholly Owned Public Sector Entities*' and have been credited directly to Contributed equity.

The transfer of net assets to/from other agencies, other than as a result of a restructure of administrative arrangements, are designated as contributions by owners where the transfers are non-discretionary and non-reciprocal.
See also note 35 'Contributed equity'.

(d) Income

Revenue recognition

Revenue is recognised and measured at the fair value of consideration received or receivable. The following specific recognition criteria must also be met before revenue is recognised as follows:

Sale of goods
Revenue is recognised from the sale of goods and disposal of other assets when the significant risks and rewards of ownership are transferred to the purchaser and can be measured reliably.

Provision of services
Revenue is recognised on delivery of the service to the client.

WA Country Health Service

Notes to the Financial Statements

For the year ended 30th June 2012

(d) Income (continued)

Interest
Revenue is recognised as the interest accrues.

Service Appropriations
Service Appropriations are recognised as revenues at fair value in the period in which the Health Service gains control of the appropriated funds. The Health Service gains control of appropriated funds at the time those funds are deposited to the bank account or credited to the 'Amounts receivable for services' (holding account) held at Treasury.
See also note 18 'Service appropriations' for further information.

Grants, donations, gifts and other non-reciprocal contributions
Revenue is recognised at fair value when the Health Service obtains control over the assets comprising the contributions, usually when cash is received.

Other non-reciprocal contributions that are not contributions by owners are recognised at their fair value. Contributions of services are only recognised when a fair value can be reliably determined and the services would be purchased if not donated.

Royalties for Regions funds are recognised as revenue at fair value in the period in which the Health Service obtains control over the funds. The Health Service obtains control of the funds at the time the funds are deposited into the Health Service's bank account.

Gains

Realised and unrealised gains are usually recognised on a net basis. These include gains arising on the disposal of non-current assets and some revaluations of non-current assets.

(e) Borrowing Costs

Borrowing costs are expensed in the period in which they are incurred.

(f) Property, Plant and Equipment

Capitalisation/Expensing of assets
Items of property, plant and equipment costing $5,000 or more are recognised as assets and the cost of utilising assets is expensed (depreciated) over their useful lives. Items of property, plant and equipment costing less than $5,000 are immediately expensed direct to the Statement of Comprehensive Income (other than where they form part of a group of similar items which are significant in total).

Initial recognition and measurement
Property, plant and equipment are initially recognised at cost:

For items of property, plant and equipment acquired at no cost or for nominal cost, the cost is the fair value at the date of acquisition.

Subsequent measurement
Subsequent to initial recognition as an asset, the revaluation model is used for the measurement of land and buildings and historical cost for all other property, plant and equipment. Land and buildings are carried at fair value less accumulated depreciation (buildings) and accumulated impairment losses. All other items of property, plant and equipment are stated at historical cost less accumulated depreciation and accumulated impairment losses.

Where market-based evidence is available, the fair value of land and buildings (non-clinical sites) is determined on the basis of current market buying values determined by reference to recent market transactions.

In the absence of market-based evidence, fair value of land and buildings (clinical sites) is determined on the basis of existing use. This normally applies where buildings are specialised or where land use is restricted. Fair value for existing use assets is determined by reference to the cost of replacing the remaining future economic benefits embodied in the asset, i.e. the depreciated replacement cost.

When buildings are revalued, the accumulated depreciation is eliminated against the gross carrying amount of the asset and the net amount restated to the revalued amount.

Land and buildings are independently valued annually by the Western Australian Land Information Authority (Valuation Services) and recognised annually to ensure that the carrying amount does not differ materially from the asset's fair value at the end of the reporting period.

The most significant assumptions in estimating fair value are made in assessing whether to apply the existing use basis to assets and in determining estimated useful life. Professional judgement by the valuer is required where the evidence does not provide a clear distinction between market type assets and existing use assets.

See also note 28 'Property, plant and equipment' for further information on revaluation.

Derecognition
Upon disposal or derecognition of an item of property, plant and equipment, any revaluation surplus relating to that asset is retained in the asset revaluation surplus.

WA Country Health Service

Notes to the Financial Statements
For the year ended 30th June 2012

(f) Property, Plant and Equipment (continued)

Asset revaluation reserve
The asset revaluation reserve is used to record increments and decrements on the revaluation of non-current assets as described in note 28 'Property, plant and equipment'.

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

In order to apply this policy, the following methods are utilised :
* Land - not depreciated
* Buildings - diminishing value
* Plant and equipment - diminishing value with a straight line switch

Under the diminishing value with a straight line switch method, the cost amounts of the assets are allocated on average on a diminishing value basis over the first half of their useful lives and a straight line basis for the second half of their useful lives.

The assets' useful lives are reviewed annually. Expected useful lives for each class of depreciable asset are:

Buildings	50 years
Leasehold improvements	Term of the lease
Computer equipment	4 to 10 years
Furniture and fittings	10 to 50 years
Motor vehicles	2 to 10 years
Medical equipment	3 to 20 years
Other plant and equipment	4 to 50 years

Artworks controlled by the Health Service are classified as property, plant and equipment. These are anticipated to have indefinite useful lives. Their service potential has not, in any material sense, been consumed during the reporting period and consequently no depreciation has been recognised.

(g) Intangible Assets

Capitalisation/Expensing of assets
Acquisitions of intangible assets costing $5,000 or more and internally generated intangible assets costing $5,000 or more are capitalised. The cost of utilising the assets is expensed (amortised) over their useful life. Costs incurred below these thresholds are immediately expensed directly to the Statement of Comprehensive Income.

Intangible assets are initially recognised at cost. For assets acquired at no cost or for nominal cost, the cost is their fair value at the date of acquisition.

The cost model is applied for subsequent measurement requiring the asset to be carried at cost less any accumulated amortisation and accumulated impairment losses.

In order to apply this policy, the following methods are utilised :
* Computer software - diminishing value with a straight line switch method

Under the diminishing value with a straight line switch method, the cost amounts of the assets are allocated on average on a diminishing value basis over the first half of their useful lives and a straight line basis for the second half of their useful lives.

The assets' useful lives are reviewed annually. Expected useful lives for each class of intangible asset are:

Computer software	5 - 10 years

Computer software

Software that is an integral part of the related hardware is recognised as property, plant and equipment. Software that is not an integral part of the related hardware recognised as an intangible asset. Software costing less than $5,000 is expensed in the year of acquisition.

(h) Impairment of Assets

Property, plant and equipment and intangible assets are tested for any indication of impairment at the end of each reporting period. Where there is an indication of impairment, the recoverable amount is estimated. Where the recoverable amount is less than the carrying amount, the asset is considered impaired and is written down to the recoverable amount and an impairment loss is recognised. As the Health Service is a not-for-profit entity, unless an asset has been identified as a surplus asset, the recoverable amount is the higher of an asset's fair value less costs to sell and depreciated replacement cost.

The risk of impairment is generally limited to circumstances where an asset's depreciation is materially understated, where the replacement cost is falling or where there is a significant change in useful life. Each relevant class of assets is reviewed annually to verify that the accumulated depreciation/amortisation reflects the level of consumption or expiration of the asset's future economic benefits and to evaluate any impairment risk from falling replacement costs.

Intangible assets with an indefinite useful life and intangible assets not yet available for use are tested for impairment at the end of each reporting period irrespective of whether there is any indication of impairment.

WA Country Health Service

Notes to the Financial Statements

For the year ended 30th June 2012

(h) Impairment of Assets (continued)

The recoverable amount of assets identified as surplus assets is the higher of fair value less costs to sell and the present value of future cash flows expected to be derived from the asset. Surplus assets carried at fair value have no risk of material impairment where fair value is determined by reference to market-based evidence. Where fair value is determined by reference to depreciated replacement cost, surplus assets are at risk of impairment and the recoverable amount is measured. Surplus assets at cost are tested for indications of impairment at the end of each reporting period.

See also note 30 'Impairment of assets' for the outcome of impairment reviews and testing.
Refer also to note 2(p) 'Receivables' and note 23 'Receivables' for impairment of receivables.

(i) Non-current Assets (or disposal groups) Classified as Held for Sale

Non-current assets (or disposal groups) held for sale are recognised at the lower of carrying amount and fair value less costs to sell and are disclosed separately from other assets in the Statement of Financial Position. Assets classified as held for sale are not depreciated or amortised.

(j) Leases

Leases of property, plant and equipment, where the Health Service has substantially all of the risks and rewards of ownership, are classified as finance leases. The Health Service does not have any finance leases.

Leases in which the lessor retains significantly all of the risks and rewards of ownership are classified as operating leases.

Operating lease payments are expensed on a straight line basis over the lease term as this represents the pattern of benefits derived from the leased items.

(k) Financial Instruments

In addition to cash, the Health Service has two categories of financial instrument:
- Loans and receivables; and
- Financial liabilities measured at amortised cost.

Financial instruments have been disaggregated into the following classes:

Financial assets:
* Cash and cash equivalents
* Restricted cash and cash equivalents
* Receivables
* Amounts receivable for services

Financial liabilities:
* Payables
* Borrowings

Initial recognition and measurement of financial instruments is at fair value which normally equates to the transaction cost or the face value. Subsequent measurement is at amortised cost using the effective interest method.

The fair value of short-term receivables and payables is the transaction cost or the face value because there is no interest rate applicable and subsequent measurement is not required as the effect of discounting is not material.

(l) Cash and Cash Equivalents

For the purpose of the Statement of Cash Flows, cash and cash equivalent (and restricted cash and cash equivalent) assets comprise cash on hand and short-term deposits with original maturities of three months or less that are readily convertible to a known amount of cash and which are subject to insignificant risk of changes in value.

A change in banking arrangement effective from 1 July 2011 in accordance with the State Government's direction has resulted in the loss of interest earning capacity for all of the Health Service's bank accounts.

(m) Accrued Salaries

Accrued salaries (see note 31 'Payables') represent the amount due to employees but unpaid at the end of the financial year, as the pay date for the last pay period for that financial year does not coincide with the end of the financial year. Accrued salaries are settled within a fortnight of the financial year end. The Health Service considers the carrying amount of accrued salaries to be equivalent to its net fair value.

(n) Amounts Receivable for Services (holding account)

The Health Service receives income from the State Government partly in cash and partly as an asset (holding account receivable). The accrued amount appropriated is accessible on the emergence of the cash funding requirement to cover leave entitlements and asset replacement.
See also note 18 'Service appropriations' and note 24 'Amounts receivable for services'.

WA Country Health Service

Notes to the Financial Statements
For the year ended 30th June 2012

(o) Inventories

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

Inventories not held for resale are measured at cost unless they are no longer required, in which case they are measured at net realisable value. (See Note 25 ' Inventories'.)

(p) Receivables

Receivables are recognised at original invoice amounts less an allowance for any uncollectible amounts (i.e. impairment). The collectability of receivables is reviewed on an ongoing basis and any receivables identified as uncollectible are written-off against the allowance account. The allowance for uncollectible amounts (doubtful debts) is raised when there is objective evidence that the Health Service will not be able to collect the debts. The carrying amount is equivalent to fair value as it is due for settlement within 30 days.
See also note 2(k) 'Financial Instruments' and note 23 'Receivables'.

Change to accounting procedure for Goods and Services Tax
Rights to collect amounts receivable from the Australian Taxation Office and responsibilities to make payment for GST have been assigned to the 'Minister for Health in his Capacity as the Deemed Board of the Metropolitan Public Hospitals' (Metropolitan Health Services). This change in accounting procedure was a result of application of the grouping provisions of "A New Tax System (Goods and Service Tax) Act 1999" whereby the Minister for Health in his Capacity as the Deemed Board of the Metropolitan Public Hospitals became the representative member for Health entities as part of governments' shared services initiative. The Health entities include the Department of Health, Mental Health Commission, Metropolitan Health Services, Peel Health Service, WA Country Health Service, WA Alcohol and Drug Authority, QE II Medical Centre Trust, and Health and Disability Services Complaints Office.

(q) Payables

Payables are recognised when the Health Service becomes obliged to make future payments as a result of a purchase of assets or services. The carrying amount is equivalent to fair value, as they are generally settled within 30 days.

See also note 2(k) 'Financial instruments' and note 31 'Payables'.

(r) Borrowings

All loans payable are initially recognised at fair value, being the net proceeds received. Subsequent measurement is at amortised cost using the effective interest rate method.

See also note 2(k) 'Financial instruments' and note 32 'Borrowings'.

(s) Provisions

Provisions are liabilities of uncertain timing or amount and are recognised where there is a present legal or constructive obligation as a result of a past event and when the outflow of resources embodying economic benefits is probable and a reliable estimate can be made of the amount of the obligation. Provisions are reviewed at the end of each reporting period.

See also note 33 'Provisions'.

Provisions - employee benefits

All annual leave and long service leave provisions are in respect of employees' services up to the end of the reporting period.

Annual Leave

The liability for annual leave that is expected to be settled within 12 months after the end of the reporting period is recognised and measured at the undiscounted amounts expected to be paid when the liability is settled.

Annual leave that is not expected to be settled within 12 months after the end of the reporting period is recognised and measured at the present value of amounts expected to be paid when the liabilities are settled using the remuneration rate expected to apply at the time of settlement.

When assessing expected future payments consideration is given to expected future wage and salary levels including non-salary components such as employer superannuation contributions, as well as the experience of employee departures and periods of service. The expected future payments are discounted using market yields at the end of the reporting period on national government bonds with terms to maturity that match, as closely as possible, the estimated future cash outflows.

The provision for annual leave is classified as a current liability as the Health Service does not have an unconditional right to the defer settlement of the liability for at least 12 months after the end of the reporting period.

Long service leave

The liability for long service leave that is expected to be settled within 12 months after the end of the reporting period is recognised and measured at the undiscounted amounts expected to be paid when the liability is settled.

WA Country Health Service

Notes to the Financial Statements
For the year ended 30th June 2012

(s) Provisions (continued)

Long service leave that is not expected to be settled within 12 months after the end of the reporting period is recognised and measured at the present value of amounts expected to be paid when the liabilities are settled using the remuneration rate expected to apply at the time of settlement.

When assessing expected future payments, consideration is given to expected future wage and salary levels including non-salary components such as employer superannuation contributions, as well as the experience of employee departures and periods of service. The expected future payments are discounted using market yields at the end of the reporting period on national government bonds with terms to maturity that match, as closely as possible, the estimated future cash outflows.

Unconditional long service leave provisions are classified as current liabilities as the Health Service does not have an unconditional right to defer settlement of the liability for at least 12 months after the end of the reporting period. Pre-conditional and conditional long service leave provisions are classified as non-current liabilities because the Health Service has an unconditional right to defer the settlement of the liability until the employee has completed the requisite years of service.

Sick Leave

Liabilities for sick leave are recognised when it is probable that sick leave paid in the future will be greater than the entitlement that will accrue in the future.

Past history indicates that on average, sick leave taken each reporting period is less than the entitlement accrued. This is expected to continue in future periods. Accordingly, it is unlikely that existing accumulated entitlements will be used by employees and no liability for unused sick leave entitlements is recognised. As sick leave is non-vesting, an expense is recognised in the Statement of Comprehensive Income for this leave as it is taken.

Deferred Salary Scheme

The provision for the deferred salary scheme relates to Health Service's employees who have entered into an agreement to self-fund an additional twelve months leave to be taken in the fifth year of the agreement. The provision recognises the value of salary set aside for employees to be used in the fifth year. The liability has been calculated on current remuneration rates in respect of services provided by employees up to the reporting date and includes related on-costs. It is reported as a current provision since employees can leave the scheme at their discretion at any time.

Superannuation

The Government Employees Superannuation Board (GESB) administers public sector superannuation arrangements in Western Australia in accordance with legislative requirements . Eligibility criteria for membership in particular schemes for public sector employees varies according to commencement and implementation dates.

Eligible employees contribute to the Pension Scheme, a defined benefit pension scheme closed to new members since 1987, or the Gold State Superannuation Scheme (GSS), a defined benefit lump sum scheme closed to new members since 1995.

The GSS is a defined benefit scheme for the purposes of employees and whole-of-government reporting. However, it is a defined contribution plan for agency purposes because the concurrent contributions (defined contributions) made by the Health Service to GESB extinguises the Health Service's obligations to the related superannuation liability.

The Health Service has no liabilities under the Pension Scheme or the GSS. The liabilities for the unfunded Pension Scheme and the unfunded GSS transfer benefits attributable to members who transferred from the Pension Scheme, are assumed by the Treasurer. All other GSS obligations are funded by concurrent contributions made by the Health Service to the GESB.

Employees commencing employment prior to 16 April 2007 who were not members of either the Pension Scheme or the GSS became non-contributory members of the West State Superannuation Scheme (WSS). Employees commencing employment on or after 16 April 2007 became members of the GESB Super Scheme (GESBS). From 30 March 2012, exisiting members of WSS or GESBS and new employees became able to choose their preferred superannation fund. The Department makes concurrent contributions to GESB or other funds on behalf of employees in compliance with the *Commonwealth Government's Superannuation Guarantee (Administration) Act 1992.* Contributions to these accumulation schemes extinguish the Department's liability for superannuation charges in respect of employees who are not members of the Pension Scheme or GSS.

The GESB makes all benefit payments in respect of the Pension Scheme and GSS transfer benefits, and recoups the employer's share from the Treasurer.
See also note 2(t) 'Superannuation Expense'.

Gratuities

The Health Service is obliged to make gratuity payments to medical practitioners and nurses under their respective industrial agreements. These groups of employees are entitled to a gratuity payment for each year of continuous service in specified regions in Western Australia.

The liability for gratuity payments is measured as the present value of expected future payments to be made in respect of services provided by employees up to the reporting date. Consideration is given to expected future salary levels, experience of employee departures and periods of service. Expected future payments are discounted using market yields at the end of the reporting period on national government bonds with terms to maturity that match, as closely as possible, the estimated future cash flows.

WA Country Health Service

Notes to the Financial Statements
For the year ended 30th June 2012

(s) Provisions (continued)

Employment on-costs

Employment on-costs (workers' compensation insurance) are not employee benefits and are recognised separately as liabilities and expenses when the employment to which they relate has occurred. Employment on-costs are included as part of 'Other expenses' and are not included as part of the Health Service's 'Employee benefits expense'. Any related liability is included in 'Employment on-costs provision'.
See also note 13 'Other expenses' and note 33 'Provisions'.

(t) Superannuation Expense

The superannuation expense in the Statement of Comprehensive Income comprises employer contributions paid to the GSS (concurrent contributions), the West State Superannuation Scheme (WSS), and the GESB Super Scheme (GESBS). The employer contribution paid to the GESB in respect of the GSS in paid back into the Consolidated Account by GESB.

(u) Resources Received Free of Charge or for Nominal Cost

Resources received free of charge or for nominal cost that can be reliably measured are recognised as income at fair value. Where the resource received represents a service that the Health Service would otherwise pay for, a corresponding expense is recognised. Receipts of assets are recognised in the Statement of Financial Position.

Assets or services received from other State Government agencies are separately disclosed under Income from State Government in the Statement of Comprehensive Income.

(v) Comparative Figures

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

(w) Trust Accounts

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

Details of Trust Accounts are reported as a note to the financial statements (refer to note 49).

Note 3 Judgements made by management in applying accounting policies

The preparation of financial statements requires management to make judgements about the application of accounting policies that have a significant effect on the amounts recognised in the financial statements. The Health Service evaluates these judgements regularly.

The judgements that have been made in the process of applying accounting policies that have the most significant effect on the amounts recognised in the financial statements include:

Buildings

A number of buildings that are located on the land of local government agencies have been recognised in the financial statements. The Health Service believes that, based on past experience, its occupancy in these buildings will continue to the end of their useful lives.

Note 4 Key sources of estimation uncertainty

Key estimates and assumptions concerning the future are based on historical experience and various other factors that have a significant risk of causing a material adjustment to the carrying amount of assets and liabilities within the next financial year.

Buildings

In order to estimate fair value on the basis of existing use, the depreciated replacement costs are determined on the assumption that the buildings will be used for the same functions in the future. A major change in utilisation of the buildings may result in material adjustment to the carrying amounts.

Employee benefits provision

In estimating the non-current long service leave liabilities, employees are assumed to leave the Health Service each year on account of resignation or retirement at 13.9%. This assumption was based on an analysis of the turnover rates exhibited by employees over a five years period. Employees with leave benefits to which they are fully entitled are assumed to take all available leave uniformly over the following five years or to age 65 if earlier.

Other estimations and assumptions used in calculating the Health Service's long service leave provision include expected future salary rates, discount rates, employee retention rates and expected future payments. Changes in these estimations and assumptions may impact on the carrying amount of the long service leave provision.

WA Country Health Service

Notes to the Financial Statements
For the year ended 30th June 2012

Note 5 Disclosure of changes in accounting policy and estimates

Initial application of an Australian Accounting Standard

The Health Service has applied the following Australian Accounting Standards effective for annual reporting periods beginning on or after 1 July 2011 that impacted on the Health Service.

Title	
AASB 1054	*Australian Additional Disclosures* This Standard, in conjunction with AASB 2011-1 Amendments to Australian Accounting Standards arising from the Trans-Tasman Convergence Project, removes disclosure requirements from other Standards and incorporates them in a single Standard to achieve convergence between Australian and New Zealand Accounting Standards. There is no financial impact.
AASB 2009-12	*Amendments to Australian Accounting Standards [AASB 5, 8, 108, 110, 112, 119, 133, 137, 139, 1023 & 1031 and Int 2, 4, 16, 1039 & 1052]* This Standard makes editorial amendments to a range of Australian Accounting Standards and Interpretations. There is no financial impact.
AASB 2010-4	*Further Amendments to Australian Accounting Standards arising from the Annual Improvements Project [AASB 1, 7, 101 & 134 and Int 13]* The amendments to AASB 7 clarify financial instrument disclosures in relation to credit risk. The carrying amount of financial assets that would otherwise be past due or impaired whose terms have been renegotiated is no longer required to be disclosed. There is no financial impact. The amendments to AASB 101 clarify the presentation of the statement of changes in equity. The disaggregation of other comprehensive income reconciling the carrying amount at the beginning and the end of the period for each component of equity is no longer required. There is no financial impact.
AASB 2010-5	*Amendments to Australian Accounting Standards [AASB 1, 3, 4, 5, 101, 107, 112, 118, 119, 121, 132, 133, 134, 137, 139, 140, 1023 & 1038 and Int 112, 115, 127, 132 & 1042]* This Standard makes editorial amendments to a range of Australian Accounting Standards and Interpretations. There is no financial impact.
AASB 2010-6	*Amendments to Australian Accounting Standards – Disclosures on Transfers of Financial Assets [AASB 1 & 7]* This Standard introduces additional disclosure relating to transfers of financial assets in AASB 7. An entity shall disclose all transferred financial assets that are not derecognised and any continuing involvement in a transferred asset, existing at the reporting date, irrespective of when the related transfer transaction occurred. There is no financial impact.
AASB 2011-1	*Amendments to Australian Accounting Standards arising from the Trans-Tasman Convergence Project [AASB 1, 5, 101, 107, 108, 121, 128, 132 & 134 and Int 2, 112 & 113]* This Standard, in conjunction with AASB 1054, removes disclosure requirements from other Standards and incorporates them in a single Standard to achieve convergence between Australian and New Zealand Accounting Standards. There is no financial impact.
AASB 2011-5	*Amendments to Australian Accounting Standards – Extending Relief from Consolidation, the Equity Method and Proportionate Consolidation [AASB 127, 128 & 131]* This Standard extends the relief from consolidation, the equity method and proportionate consolidation by removing the requirement for the consolidated financial statements prepared by the ultimate or any intermediate parent entity to be IFRS compliant, provided that the parent entity, investor or venturer and the ultimate or intermediate parent entity are not-for-profit non-reporting entities that comply with Australian Accounting Standards. There is no financial impact.

Future impact of Australian Accounting Standards not yet operative

The Health Service cannot early adopt an Australian Accounting Standard unless specifically permitted by Treasurer's Instruction 1101 '*Application of Australian Accounting Standards and Other Pronouncements*'. Consequently, the Health Service has not applied early any of the following Australian Accounting Standards that have been issued that may impact the Health Service. Where applicable, the Health Service plans to apply these Australian Accounting Standards from their application date.

Title		Operative for reporting periods beginning on/after
AASB 9	*Financial Instruments* This Standard supersedes AASB 139 Financial Instruments: Recognition and Measurement, introducing a number of changes to accounting treatments. The Standard was reissued in December 2010. The Health Service has not yet determined the application or the potential impact of the Standard.	1 Jan 2013

WA Country Health Service

Notes to the Financial Statements

For the year ended 30th June 2012

AASB 10	*Consolidated Financial Statements* This Standard supersedes requirements under AASB 127 Consolidated and Separate Financial Statements and Int 112 Consolidation – Special Purpose Entities, introducing a number of changes to accounting treatments. The Standard was issued in August 2011. The Health Service has not yet determined the application or the potential impact of the Standard.	1 Jan 2013
AASB 11	*Joint Arrangements* This Standard supersedes AASB 131 Interests in Joint Ventures, introducing a number of changes to accounting treatments. The Standard was issued in August 2011. The Health Service has not yet determined the application or the potential impact of the Standard.	1 Jan 2013
AASB 12	*Disclosure of Interests in Other Entities* This Standard supersedes disclosure requirements under AASB 127 Consolidated and Separate Financial Statements and AASB 131 Interests in Joint Ventures. The Standard was issued in August 2011. The Health Service has not yet determined the application or the potential impact of the Standard.	1 Jan 2013
AASB 13	*Fair Value Measurement* This Standard defines fair value, sets out a framework for measuring fair value and requires disclosures about fair value measurements. There is no financial impact.	1 Jan 2013
AASB 119	*Employee Benefits* This Standard supersedes AASB 119 Employee Benefits, introducing a number of changes to accounting treatments. The Standard was issued in September 2011. The Health Service has not yet determined the application or the potential impact of the Standard.	1 Jan 2013
AASB 127	*Separate Financial Statements* This Standard supersedes requirements under AASB 127 Consolidated and Separate Financial Statements, introducing a number of changes to accounting treatments. The Standard was issued in August 2011. The Health Service has not yet determined the application or the potential impact of the Standard.	1 Jan 2013
AASB 128	*Investments in Associates and Joint Ventures* This Standard supersedes AASB 128 Investments in Associates, introducing a number of changes to accounting treatments. The Standard was issued in August 2011. The Health Service has not yet determined the application or the potential impact of the Standard.	1 Jan 2013
AASB 1053	*Application of Tiers of Australian Accounting Standards* This Standard establishes a differential financial reporting framework consisting of two tiers of reporting requirements for preparing general purpose financial statements. There is no financial impact.	1 Jul 2013
AASB 2009-11	*Amendments to Australian Accounting Standards arising from AASB 9 [AASB 1, 3, 4, 5, 7, 101, 102, 108, 112, 118, 121, 127, 128, 131, 132, 136, 139, 1023 & 1038 and Int 10 & 12]* [Modified by AASB 2010-7]	1 Jul 2013
AASB 2010-2	*Amendments to Australian Accounting Standards arising from Reduced Disclosure Requirements [AASB 1, 2, 3, 5, 7, 8, 101, 102, 107, 108, 110, 111, 112, 116, 117, 119, 121, 123, 124, 127, 128, 131, 133, 134, 136, 137, 138, 140, 141, 1050 & 1052 and Int 2, 4, 5, 15, 17, 127, 129 & 1052]* This Standard makes amendments to Australian Accounting Standards and Interpretations to introduce reduced disclosure requirements for certain types of entities. There is no financial impact.	1 Jul 2013

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AASB 2010-7	*Amendments to Australian Accounting Standards arising from AASB 9 (December 2010) [AASB 1, 3, 4, 5, 7, 101, 102, 108, 112, 118, 120, 121, 127, 128, 131, 132, 136, 137, 139, 1023 & 1038 and Int 2, 5, 10, 12, 19 & 127]* This Standard makes consequential amendments to other Australian Accounting Standards and Interpretations as a result of issuing AASB 9 in December 2010. The Health Service has not yet determined the application or the potential impact of the Standard.	1 Jan 2013
AASB 2011-2	*Amendments to Australian Accounting Standards arising from the Trans-Tasman Convergence Project – Reduced Disclosure Requirements [AASB 101 & 1054]* This Standard removes disclosure requirements from other Standards and incorporates them in a single Standard to achieve convergence between Australian and New Zealand Accounting Standards for reduced disclosure reporting. There is no financial impact.	1 Jul 2013
AASB 2011-6	*Amendments to Australian Accounting Standards – Extending Relief from Consolidation, the Equity Method and Proportionate Consolidation – Reduced Disclosure Requirements [AASB 127, 128 & 131]* This Standard extends the relief from consolidation, the equity method and proportionate consolidation by removing the requirement for the consolidated financial statements prepared by the ultimate or any intermediate parent entity to be IFRS compliant, provided that the parent entity, investor or venturer and the ultimate or intermediate parent entity comply with Australian Accounting Standards or Australian Accounting Standards – Reduced Disclosure Requirements. There is no financial impact.	1 Jul 2013
AASB 2011-7	*Amendments to Australian Accounting Standards arising from the Consolidation and Joint Arrangements Standards [AASB 1, 2, 3, 5, 7, 9, 2009-11, 101, 107, 112, 118, 121, 124, 132, 133, 136, 138, 139,1023 & 1038 and Int 5, 9, 16 & 17]* This Standard gives effect to consequential changes arising from the issuance of AASB 10, AASB 11, AASB 127 Separate Financial Statements and AASB 128 Investments in Associates and Joint Ventures. The Health Service has not yet determined the application or the potential impact of the Standard.	1 Jan 2013
AASB 2011-8	*Amendments to Australian Accounting Standards arising from AASB 13 [AASB 1, 2, 3, 4, 5, 7, 9, 2009-11, 2010-7, 101, 102, 108, 110, 116, 117, 118, 119, 120, 121, 128, 131, 132, 133, 134, 136, 138, 139, 140, 141, 1004, 1023 & 1038 and Int 2, 4, 12, 13, 14, 17, 19, 131 & 132]* This Standard replaces the existing definition and fair value guidance in other Australian Accounting Standards and Interpretations as the result of issuing AASB 13 in September 2011. There is no financial impact.	1 Jan 2013
AASB 2011-9	*Amendments to Australian Accounting Standards – Presentation of Items of Other Comprehensive Income [AASB 1, 5, 7, 101, 112, 120, 121, 132, 133, 134, 1039 & 1049]* This Standard requires to group items presented in other comprehensive income on the basis of whether they are potentially reclassifiable to profit or loss subsequently (reclassification adjustments). The Health Service has not yet determined the application or the potential impact of the Standard.	1 Jul 2012
AASB 2011-10	*Amendments to Australian Accounting Standards arising from AASB 119 (September 2011) [AASB 1, 8, 101, 124, 134, 1049 & 2011-8 and Int 14]* This Standard makes amendments to other Australian Accounting Standards and Interpretations as a result of issuing AASB 119 Employee Benefits in September 2011. The Health Service has not yet determined the application or the potential impact of the Standard.	1 Jan 2013
AASB 2011-11	Amendments to AASB 119 (September 2011) arising from Reduced Disclosure Requirements This Standard gives effect to Australian Accounting Standards – Reduced Disclosure Requirements for AASB 119 (September 2011). There is no financial impact.	1 Jul 2013
AASB 2012-1	*Amendments to Australian Accounting Standards - Fair Value Measurement - Reduced Disclosure Requirements [AASB 3, 7, 13, 140 & 141]* This Standard establishes and amends reduced disclosure requirements for additional and amended disclosure requirements for additional and amended disclosures arising from AASB 13 and the consequential amendments implemented through AASB 2011-8. There is no financial impact.	1 Jul 2013

WA Country Health Service

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Note 6 Services of the Health Service

Information about the Health Service's services and, the expenses and revenues which are reliably attributable to those services are set out in Note 52. The key services of the Health Service are:

Public Hospital Admitted Patients
Public hospital admitted patient services describe the care services provided to inpatients in public hospitals (excluding specialised mental health wards) and to public patients treated in private facilities under contract to WA Health. An admission to hospital can be for a period of one or more days and includes medical and surgical treatment, renal dialysis, oncology services, and obstetric care.

Palliative Care
Palliative care services describe inpatient and home-based multidisciplinary care and support for terminally ill people and their families and carers provided by contracted non-government providers. Education and advisory services are also available to assist professionals, particularly those in rural areas.

Emergency Department
Emergency department services describe the treatment provided in metropolitan and major rural hospitals to those people with sudden onset of illness or injury of such severity and urgency that they need immediate medical help which is either not available from their general practitioner (GP), or for which their GP has referred them for treatment. Emergency departments provide a range of services, from immediate resuscitation to urgent medical advice. An emergency department attendance may result in an admission to hospital or in treatment without admission. Not all metropolitan public hospitals provide emergency services. Privately provided contracted emergency services are included.

Public Hospital Non-admitted Patients
Medical officers, nurses and allied health staff provide non-admitted (outpatient) patient services. Services include clinics for pre and post surgical care, allied health care and medical care as well as emergency services provided in the remainder of rural hospitals not included under the emergency department service.

Patient Transport
Patient transport services are those services provided by St John Ambulance Australia, the Royal Flying Doctor Service Western Operations and the Patient Assisted Travel Scheme (PATS). These services assist people in need of urgent medical treatment to reach the nearest appropriate medical facility or assist people living in rural or remote locations to access specialist services.

Prevention, Promotion and Protection
Prevention, promotion and protection services describe programs implemented to increase optimal health and wellbeing, encourage healthy lifestyles, reduce the onset of disease and disability, reduce the risk of long-term illness and disability with early detection and developmental interventions, or monitor the incidence of disease in the population to determine the effectiveness of health measures and provide direction for new policies and programs. Specific areas of service include genomics, the management and development of health information, Indigenous health, breast screening services, child and community health, health promotion, communicable disease control, environmental health, disaster planning and management, statutory medical notifications and services provided by the Office of the Chief Medical Officer.

Continuing Care
Aged and continuing care services include:

- the Home and Community Care (HACC) program which provides services such as domestic assistance, social support, nursing care, respite care, food services and home maintenance that aims to support people who live at home and whose capacity for independent living is at risk of premature admission to long-term residential care;

- the Transition Care program, progressively replacing the Care Awaiting Placement program which aims is to help older people's independence and confidence at the end of a hospital stay by assisting them to maintain or improve their functional ability. This program provides the person with more time and support in a non-hospital environment to complete their restorative process, optimise their functional capacity and assists them and their family to access longer-term care arrangements;

- non-government continuing care programs that offer residential care type services for frail, aged or younger disabled persons who are unable to access a permanent care placement in a Commonwealth Government funded residential aged care facility, or where their care needs exceed what can be provided in a normal home environment;

- residential care in rural areas provided for people assessed as no longer being able to live at home and includes nursing home care provided by the State, nursing home type care provided in public hospitals and hostel care; and

- chronic illness support services providing people with a chronic condition with treatment and preventive care to enable them to remain healthy at home. Services include chronic disease support initiatives which aim to improve the life of those with chronic conditions, reduce avoidable hospital admissions and inpatient length-of-stay, emergency service presentations, and non-government organisation contracts that provide community members with services and support for a range of chronic conditions and illnesses.

Contracted Mental Health
Contracted mental health services describe the services provided by Area Health Services under agreement with the Mental Health Commission for specialised admitted and community mental health services.

WA Country Health Service

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	2012 $000	2011 $000
Note 7 Employee benefits expense		
Salaries and wages (a)	671,385	587,462
Superannuation - defined contribution plans (b)	52,494	45,242
	723,879	632,704

(a) Includes the value of the fringe benefits to employees plus the fringe benefits tax component and the value of superannuation contribution component for leave entitlements.

(b) Defined contribution plans include West State, Gold State and GESB Super Schemes (contributions paid).

Employment on-costs expenses (workers' compensation insurance) are included at Note 13 'Other expenses'.

Employment on-costs liability is included at note 33 'Provisions'.

Note 8 Patient support costs		
Medical supplies and services	55,513	51,042
Domestic charges	8,088	7,554
Fuel, light and power	20,398	18,484
Food supplies	9,779	9,151
Patient transport costs	43,588	36,057
Purchase of external services	76,587	68,744
	213,953	191,032
Note 9 Finance costs		
Interest expense	716	956
Note 10 Depreciation and amortisation expense		
Depreciation		
Buildings	31,848	31,237
Leasehold improvements	292	275
Computer equipment	215	188
Furniture and fittings	154	153
Motor vehicles	882	774
Medical equipment	8,348	6,159
Other plant and equipment	1,076	1,112
	42,815	39,898
Amortisation		
Intangible assets	45	49
	42,860	39,947
Note 11 Loss on disposal of non-current assets		
Cost of disposal of non-current assets		
Property, plant and equipment	905	4,520
Proceeds from disposal of non-current assets:		
Property, plant and equipment	(297)	(565)
Net loss	608	3,955
Note 12 Repairs, maintenance and consumable equipment		
Repairs and maintenance	20,822	22,451
Consumable equipment	12,255	11,432
	33,077	33,883

WA Country Health Service

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For the year ended 30th June 2012

	2012 $000	2011 $000
Note 13 Other expenses		
Communications	4,355	4,181
Computer services	2,550	1,774
Other employee related expenses	19,240	16,503
Workers compensation insurance (a)	8,651	8,316
Insurance	3,560	3,346
Legal expenses	1,012	164
Motor vehicle expenses	5,878	5,943
Operating lease expenses	41,010	31,344
Printing and stationery	4,287	3,755
Doubtful debts expense	709	584
Purchase of external services	15,518	12,970
Write-down of assets	3,068	268
Other	10,407	10,909
	120,245	100,057

(a) The employment on-costs include workers' compensation insurance only. The on-costs liability associated with the recognition of annual and long service leave liability is included at note 33 'Provisions'. Superannuation contributions accrued as part of the provision for leave are employee benefits and are not included in employment on-costs.

Note 14 Patient charges		
Inpatient bed charges	24,996	22,518
Inpatient other charges	238	224
Outpatient charges	16,308	10,485
	41,542	33,227
Note 15 Grants and contributions		
(a) Commonwealth grants and contributions		
Recurrent		
Nursing homes	2,594	2,319
Aboriginal Health and Cadetship Program	118	-
Aged Care Housing Assistance	126	-
Bringing Them Home	107	105
Communicable Disease Program	162	159
Customs	196	309
Ear Health	1,520	-
East Kimberley Development Program	-	3,719
Elective Waiting List Reduction Plan - Facility Development Albany Regional Hospital	-	2,580
Extended Aged Care in the Home	244	-
Grant for Aged Care Training Program	-	146
Grant for Carelink	297	438
Grant for Community Aged Care Program	784	816
Grant for Dept of Veterans Affairs - Home & Domiciliary Care	150	96
Grant for Medical Specialists Outreach Assistance Program	378	800
Grant for Primary Health Care Access Program - Kimberley	1,570	1,539
Grant for Regional Health Services	3,623	3,593
Grant from National Respite Carers Program	1,279	1,467
Healthy for Life	764	899
Health Kids Checks	237	-
Job Creation Packages	1,102	892
Kununurra Sobering up centre	-	330
Medicare Australia - Pharmaceutical Benefits Scheme	2,386	
Mobile Respite Program	215	165
New Directions Mothers & Babies	774	761
NRCP Carelink	268	-
OATSIH - Healthy for Life	391	-
OATSIH - Sexual Health	246	475
Office of Aboriginal and Torres Strait Islander Health - Wheatbelt - PHCAP	1,756	1,722
Office of Aboriginal and Torres Strait Islander Health - Wheatbelt - New Directions	213	-
RACP Specialist Training Program	-	206
Respite Carers Centre	142	193
Rheumatic Heart Disease Register	810	795
Rural Primary Health Service - Goldfields South East Coastal	468	-
Specialist Training Program	695	-
Substance Abuse	245	226
Trachoma & Healthy Kids Check	222	407
Wyndhan Sobering up centre	-	330
Other	559	-

WA Country Health Service

Notes to the Financial Statements
For the year ended 30th June 2012

Note 15 Grants and contributions (continued)	2012 $000	2011 $000
Capital		
Broome - Paediatrics capital grants	6,400	1,500
Bunbury Radiotherapy Facility capital grant	1,900	1,287
Bunbury Hospital Intensive Care Unit capital grant	13,597	749
Day Therapy Unit	395	-
East Kimberley Environmental Health	1,720	-
Kimberley Renal - Kununurra capital grant	3,490	280
Kimberley Renal - Derby capital grant	1,500	320
Kununurra Hospital expansion capital grant	4,000	4,000
Kununurra CT Scanner	1,900	-
Kununurra Service providers housing	2,000	-
NPA Bunbury Sub Acute Inpatient Beds	2,000	-
NPA Bunbury Sub Acute Day Therapy Unit	1,528	-
Other	4,834	1,385
	69,905	35,008
(b) Other grants and contributions		
Bowel Screening	-	140
Broome Network Recovery Centre	444	108
CAEP	670	-
Disability Services Commission - Community Aids & Equipment Program	1,319	1,717
East Kimberley Development Programme	-	1,280
Enhancing the Pilbara	2,430	1,241
General Medicine Progress Report	117	-
Grants for Medical Specialists Outreach Assistance Program	1,023	870
Great Southern GP Network - For Ante Natal Program	118	118
HealthWays	90	182
Indigenous Healthy Lifestyle Project	-	127
Indigenous Mental Health Peri Natal Funding	-	141
McGrath Foundation - Breast Care Nurse Funding	260	210
Mental Health Commission (service delivery agreement) (a)	52,261	52,783
Midwest Development Commission - Bidi Bidi Centre & Programs	100	200
Nindilingarri Cultural Health	136	-
Ord Valley Aboriginal Health Service	442	-
Personally Controlled Electronic Health Record	1,220	-
PBS Reform	113	-
Prevocational General Practice Placements	262	160
Royal Aust College of Physicians	232	-
Specialist Training Program	1,343	-
Telethon Funding	-	418
Other	3,312	1,737
	65,892	61,433

(a) Prior to 1 July 2010, the Health Service received service appropriations from the State Government for the delivery of mental health services. The funding has been provided by the Mental Health Commission from the 2010-11 financial year onwards.

Note 16 Donation revenue		
General public contributions	459	467
Hospital auxiliaries	351	105
Deceased estates	341	30
	1,151	602

Note 17 Other revenue		
Services to external organisations	9,735	8,995
Use of hospital facilities	1,529	1,646
Rent from commercial properties	182	99
Rent from residential properties	235	237
Boarders' accommodation	6,811	5,082
Other	3,749	2,478
	22,241	18,537

WA Country Health Service

Notes to the Financial Statements
For the year ended 30th June 2012

	2012 $000	2011 $000
Note 18 Service appropriations		
Appropriation revenue received during the period:		
Service appropriations (funding from the Department of Health)	1,010,914	907,624

Service appropriations fund the net cost of services delivered. Appropriation revenue comprises a cash component and a receivable (asset). The receivable (holding account) comprises the depreciation expense for the year and any agreed increase in leave liability during the year.

Note 19 Assets assumed / (transferred)		
The following assets have been assumed from / (transferred to) other state government agencies during the period:		
Video conferencing equipment from the Department of Health	18	-
Mammogram equipment from Metropolitan Health Services	286	-
	304	-

Discretionary transfers of assets between State Government agencies are reported as assets assumed/(transferred) under Income from State Government. Non-discretionary non-reciprocal transfers of net assets (i.e. restructuring of administrative arrangements) are designated as contributions by owners under Treasurer's Instruction 955 and are recognised directly to equity.

Note 20 Resources received free of charge		
Resources received free of charge have been determined on the basis of the following estimates provided by agencies.		
Department of Finance - government accommodation	12	68

Assets or services received free of charge or for nominal cost, are recognised as revenues at fair value of the assets and/or the services that can be reliably measured and which would have been purchased if they were not donated. Contribution of assets or services in the nature of contributions by owners, are recognised direct to equity.

Note 21 Royalties for Regions Fund		
Regional Community Services Account:		
Patient Assisted Travel Scheme	8,816	9,038
Rural in Reach - Women Support	635	-
Southern Inland Health Initiative		
- District Medical Workforce (Stream 1)	9,780	-
- Redevelopment Integrated District HS (Stream 2)	3,017	-
- Telehealth (Stream 3)	654	-
St John Ambulance	254	-
District Allowances	15,986	-
Pilbara Health Partnership (Asset Investment)	2,826	-
Rural Generalists Pathways	1,500	1,000
Nickol Bay Hospital	1,000	1,000
Pilbara Redevelopment Plan	-	2,242
	44,468	13,280

This is a sub-fund within the over-arching 'Royalties for Regions Fund' established under the Royalties for Regions Act 2009. The recurrent funds are committed to projects and programs in WA regional areas.

Note 22 Restricted cash and cash equivalents (a)		
Current		
Royalties for Regions Fund	5,296	-
Capital grant from the Commonwealth Government (b)	34,193	23,493
Patient receipts under section 19 (2) of the Health Insurance Act 1973	1,527	600
Bequests	548	593
	41,564	24,686

(a) Restricted cash and cash equivalents are assets, the uses of which are restricted, by specific legal or other externally imposed requirements.

(b) Unspent funds from the Commonwealth Government are committed to projects and programs in WA regional areas.

WA Country Health Service

Notes to the Financial Statements
For the year ended 30th June 2012

	2012 $000	2011 $000
Note 23 Receivables		
Current		
Patient fee debtors	8,896	8,110
Other receivables	7,740	8,227
Less: Allowance for impairment of receivables	(4,333)	(3,624)
Accrued revenue	3,688	1,122
	15,991	13,835
Reconciliation of changes in the allowance for impairment of receivables:		
Balance at start of period	3,624	3,040
Doubtful debts expense	709	584
Balance at end of period	4,333	3,624

The Health Service does not hold any collateral or other credit enhancements as security for receivables.

See also note 2(p) 'Receivables' and note 51 'Financial instruments'.

Note 24 Amounts receivable for services (Holding Account)		
Non-current		
Amounts receivable for services	303,974	253,328

Represents the non-cash component of service appropriations. It is restricted in that it can only be used for asset replacement or payment of leave liability. See note 2(n) 'Amounts receivable for services'.

Note 25 Inventories		
Current		
Supply stores - at cost	1,593	1,908
Pharmaceutical stores - at cost	2,488	2,049
Other - at cost	893	837
	4,974	4,794

See note 2(o) 'Inventories'.

Note 26 Other current assets		
Prepayments	4,044	2,856
Note 27 Non-current assets classified as held for sale		
Opening balance	79	-
Land reclassified as held for sale	-	13
Buildings reclassified as held for sale	-	66
Less assets sold	(79)	-
Closing balance	-	79
Note 28 Property, plant and equipment		
Land		
At fair value (a)	178,876	165,527
Buildings		
At fair value (a)	1,060,246	1,070,037
Accumulated depreciation	-	-
	1,060,246	1,070,037
Total land and buildings	1,239,122	1,235,564

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Notes to the Financial Statements

For the year ended 30th June 2012

Note 28 Property, plant and equipment (continued)	2012 $000	2011 $000
Leasehold improvements		
At cost	1,682	1,758
Accumulated depreciation	(769)	(873)
	913	885
Computer equipment		
At cost	1,714	1,501
Accumulated depreciation	(1,154)	(989)
	560	512
Furniture and fittings		
At cost	2,556	2,113
Accumulated depreciation	(841)	(692)
	1,715	1,421
Motor vehicles		
At cost	5,585	4,887
Accumulated depreciation	(3,846)	(3,148)
	1,739	1,739
Medical equipment		
At cost	83,594	72,887
Accumulated depreciation	(35,505)	(27,585)
	48,089	45,302
Other plant and equipment		
At cost	16,317	12,956
Accumulated depreciation	(6,755)	(5,780)
	9,562	7,176
Works in progress		
Buildings under construction (at cost)	209,711	66,491
Other Work in Progress (at cost)	3,790	6,495
	213,501	72,986
Artworks		
At cost	70	71
Total property, plant and equipment	1,515,271	1,365,656

(a) Land and buildings were revalued as at 1 July 2011 by the Western Australian Land Information Authority (Valuation Services). The valuations were performed during the year ended 30 June 2012 and recognised at 30 June 2012. In undertaking the revaluation, fair value was determined by reference to the market value for land: $ 87,241,400 and buildings: $ 112,955,854. For the remaining balance, fair value of land and buildings was determined on the basis of depreciated replacement cost. See also note 2(f) 'Property, plant and equipment'.

Reconciliations

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

Land		
Carrying amount at start of period	165,527	147,518
Additions	450	-
Transfer from/(to) other reporting entities	211	(880)
Disposals	(253)	(157)
Classified as held for sale	-	(13)
Revaluation increments / (decrements)	12,941	17,852
Transfer between asset classes	-	1,207
Carrying amount at end of period	178,876	165,527

WA Country Health Service

Notes to the Financial Statements
For the year ended 30th June 2012

Note 28 Property, plant and equipment (continued)	2012 $000	2011 $000
Buildings		
Carrying amount at start of period	1,070,037	941,773
Additions	3,505	371
Transfers from Work in Progress	19,676	140,238
Transfer from/(to) other reporting entities	-	(44)
Disposals	(278)	(3,887)
Classified as held for sale	-	(66)
Revaluation increments / (decrements)	(697)	24,079
Depreciation	(31,848)	(31,237)
Transfer between asset classes	(149)	(1,190)
Carrying amount at end of period	1,060,246	1,070,037
Leasehold improvements		
Carrying amount at start of period	885	517
Transfers from work in progress	320	602
Depreciation	(292)	(275)
Transfer between asset classes	-	41
Carrying amount at end of period	913	885
Computer equipment		
Carrying amount at start of period	512	584
Additions	167	87
Transfers from Work in Progress	120	-
Disposals	(9)	(2)
Depreciation	(215)	(188)
Transfer between asset classes	(15)	65
Write-down of assets	-	(34)
Carrying amount at end of period	560	512
Furniture and fittings		
Carrying amount at start of period	1,421	1,681
Additions	379	294
Transfers from Work in Progress	108	19
Disposals	(6)	(77)
Depreciation	(154)	(153)
Transfer between asset classes	108	(293)
Write-down of assets	(141)	(50)
Carrying amount at end of period	1,715	1,421
Motor vehicles		
Carrying amount at start of period	1,739	1,439
Additions	926	1,037
Disposals	(26)	-
Depreciation	(882)	(774)
Transfer between asset classes	-	37
Write-down of assets	(18)	-
Carrying amount at end of period	1,739	1,739

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For the year ended 30th June 2012

	2012 $000	2011 $000
Note 28 Property, plant and equipment (continued)		
Medical equipment		
Carrying amount at start of period	45,302	35,260
Additions	9,395	15,745
Transfers from Work in Progress	2,182	638
Transfer from/(to) other reporting entities	190	-
Disposals	(176)	(357)
Depreciation	(8,348)	(6,159)
Transfer between asset classes	(386)	194
Write-down of assets	(70)	(19)
Carrying amount at end of period	48,089	45,302
Other plant and equipment		
Carrying amount at start of period	7,176	7,403
Additions	2,981	993
Transfers from Work in Progress	112	114
Transfer from/(to) other reporting entities	18	-
Disposals	(75)	(39)
Depreciation	(1,076)	(1,112)
Transfer between asset classes	442	(61)
Write-down of assets	(16)	(122)
Carrying amount at end of period	9,562	7,176
Works in progress		
Carrying amount at start of period	72,986	118,848
Additions	165,856	95,792
Capitalised to asset classes	(22,518)	(141,611)
Write-down of assets	(2,823)	(43)
Carrying amount at end of period	213,501	72,986
Artworks		
Carrying amount at start of period	71	72
Disposals	(1)	(1)
Carrying amount at end of period	70	71
Total property, plant and equipment		
Carrying amount at start of period	1,365,656	1,255,095
Additions	183,659	114,319
Disposals	(824)	(4,520)
Transfer from/(to) other reporting entities	419	(924)
Classified as held for sale	-	(79)
Revaluation increments / (decrements)	12,244	41,931
Depreciation	(42,815)	(39,898)
Write-down of assets	(3,068)	(268)
Carrying amount at end of period	1,515,271	1,365,656
Note 29 Intangible assets		
Computer software		
At cost	293	311
Accumulated amortisation	(194)	(165)
	99	146
Reconciliation:		
Reconciliation of the carrying amount of intangible assets at the beginning and end of the period is set out below.		
Computer software		
Carrying amount at start of period	146	143
Additions	-	52
Disposals	(2)	-
Amortisation expense	(45)	(49)
Carrying amount at end of period	99	146

WA Country Health Service

Notes to the Financial Statements

For the year ended 30th June 2012

	2012 $000	2011 $000

Note 30 Impairment of assets

There were no indications of impairment to property, plant and equipment or intangible assets as at 30 June 2012.

The Health Service held no goodwill or intangible assets with an indefinite useful life during the reporting period. At the end of the reporting period, there were no intangible assets not yet available for use.

All surplus assets at 30 June 2012 have either been classified as assets held for sale or written off.

Note 31 Payables

Current		
Trade creditors	12,162	10,172
Accrued expenses	37,663	29,713
Accrued salaries	23,028	17,607
Accrued interest	56	75
	72,909	57,567

See also note 2(q) 'Payables' and note 51 'Financial instruments'.

Note 32 Borrowings

Current		
Department of Treasury loans (a)	1,373	1,192
Non-current		
Department of Treasury loans (a)	11,164	12,605
	12,537	13,797

(a) 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 by the Department of Health on behalf of the Health Service. Interest rates are linked to the State Government's debt servicing costs.

Note 33 Provisions

Current		
Employee benefits provision		
Annual leave (a)	52,331	48,784
Time off in lieu leave (a)	19,174	16,783
Long service leave (b)	29,472	27,077
Gratuities	849	1,082
Deferred salary scheme	1,932	1,824
	103,758	95,550
Non-current		
Employee benefits provision		
Long service leave (b)	18,324	16,293
Gratuities	254	253
	18,578	16,546
	122,336	112,096

(a) Annual leave liabilities and time off in lieu leave liabilities have been classified as current as there is no unconditional right to defer settlement for at least 12 months after the end of the reporting period. Assessments indicate that actual settlement of the liabilities is expected to occur as follows:

Within 12 months of the end of the reporting period	55,386	49,845
More than 12 months after the end of the reporting period	16,119	15,722
	71,505	65,567

(b) Long service leave liabilities have been classified as current where there is no unconditional right to defer settlement for at least 12 months after the end of the reporting period. Assessments indicate that actual settlement of the liabilities is expected to occur as follows:

Within 12 months of the end of the reporting period	9,856	9,102
Within 12 months of the end of the reporting period	37,940	34,268
	47,796	43,370

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Notes to the Financial Statements
For the year ended 30th June 2012

	2012 $000	2011 $000
Note 33 Provisions (continued)		
(c) Deferred salary scheme liabilities have been classified as current where there is no unconditional right to defer settlement for at least 12 months after the end of the reporting period. Assessments indicate that actual settlement of the liabilities is expected to occur as follows:		
Within 12 months of the end of the reporting period	772	809
More than 12 months after end of the reporting period	1,160	1,015
	1,932	1,824
Note 34 Other liabilities		
Current		
Income received in advance	-	1,845
Refundable deposits	1	1
Other	30	-
	31	1,846
Note 35 Contributed equity		
The Government holds the equity interest in the Health Service on behalf of the community. Equity represents the residual interest in the net assets of the Health Service. The asset revaluation reserve represents that portion of equity resulting from the revaluation of non-current assets (note 36).		
Balance at start of period	1,141,999	1,038,833
Contributions by owners		
Capital appropriation (a)	98,873	75,856
Royalties for Regions Fund – Regional Infrastructure and Headworks Account	42,522	28,234
Transfer of net assets from other agencies (b) (c)	390	-
	141,785	104,090
Distributions to owners		
Transfer of net assets to other agencies (b) (c)	(179)	(924)
Balance at end of period	1,283,605	1,141,999
(a) Treasurer's Instruction (TI) 955 *Contributions by Owners Made to Wholly Owned Public Sector Entities* designates capital appropriations as contributions by owners in accordance with AASB Interpretation 1038 *Contributions by Owners Made to Wholly-Owned Public Sector Entities.*		
(b) AASB 1004 *Contributions* requires transfers of net assets as a result of a restructure of administrative arrangements to be accounted for as contributions by owners and distributions to owners.		
Under TI 955 non-discretionary and non-reciprocal transfers of net assets between state government agencies as contributions by owners in accordance with AASB Interpretation 1038. Where the transferee agency accounts for a non-discretionary and non-reciprocal transfer of net assets as a contribution by owners, the transferor agency accounts for the transfer as a distribution to owners.		
(c) TI 955 requires non-reciprocal transfers of net assets to Government to be accounted for as distribution to owners in accordance with AASB Interpretation 1038.		
Note 36 Reserves		
Asset revaluation reserve (a)		
Balance at start of period	342,074	300,143
Net revaluation increments / (decrements) (b) :		
Land	12,941	17,852
Buildings	(697)	24,079
Balance at end of period	354,318	342,074
(a) The asset revaluation reserve is used to record increments and decrements on the revaluation of non-current assets.		
(b) Any increment is credited directly to the asset revaluation reserve, except to the extent that any increment reverses a revaluation decrement previously recognised as an expense.		

WA Country Health Service

Notes to the Financial Statements

For the year ended 30th June 2012

	2012 $000	2011 $000
Note 37 Accumulated surplus/(deficit)		
Balance at start of period	2,327	(5,535)
Result for the period	51,304	7,862
Balance at end of period	53,631	2,327
Note 38 Notes to the Statement of Cash Flows		
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 and cash equivalents	13,450	6,326
Restricted cash and cash equivalents	41,564	24,686
	55,014	31,012
Reconciliation of net cost of services to net cash flows used in operating activities		
Net cash used in operating activities (Statement of Cash Flows)	(936,881)	(865,195)
Increase/(decrease) in assets:		
Receivables	2,866	3,049
Inventories	180	1,141
Prepayments and other current assets	1,187	1,038
Decrease/(increase) in liabilities:		
Payables	(15,342)	2,287
Current provisions	(8,208)	(6,077)
Non-current provisions	(2,032)	(1,925)
Income received in advance	1,845	(1,650)
Other current liabilities	(30)	1
Non-cash items:		
Doubtful debts expense	(709)	(584)
Depreciation and amortisation expense (note 10)	(42,860)	(39,947)
Loss from disposal of non-current assets (note 11)	(608)	(3,955)
Interest paid by Department of Health	(735)	(960)
Donation of non-current assets	16	-
Resources received free of charge (note 20)	(12)	(68)
Write down of property, plant and equipment (note 28)	(3,068)	(268)
Adjustment for other non-cash items	(3)	3
Net cost of services (Statement of Comprehensive Income)	(1,004,394)	(913,110)
Notional cash flows		
Service appropriations as per Statement of Comprehensive Income	1,010,914	907,624
Royalties for Regions Fund as per Statement of Comprehensive Income	44,468	13,280
Royalties for Regions Fund credited directly to Contributed Equity (Refer Note 35)	42,522	28,234
Capital contributions credited directly to Contributed Equity (Refer Note 35)	98,873	75,856
Holding account drawdowns credited to Amounts Receivable for Services	-	1,782
	1,196,777	1,026,776
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 Department of Treasury	(735)	(960)
Repayment of interest-bearing liabilities to Department of Treasury	(1,261)	(1,137)
Accrual appropriations	(50,647)	(45,896)
	(52,643)	(47,993)
Cash Flows from State Government as per Statement of Cash Flows	1,144,134	978,783

At the end of the reporting period, the Health Service had fully drawn on all financing facilities, details of which are disclosed in the financial statements.

WA Country Health Service

Notes to the Financial Statements
For the year ended 30th June 2012

	2012 $000	2011 $000
Note 39 Revenue, public and other property written off		
a) Revenue and debts written off under the authority of the Accountable Authority.	-	-
b) Public and other property written off under the authority of the Accountable Authority.	-	-
	-	-
Note 40 Gifts of public property		
Gifts of public property provided by the Health Service.	275	-

Note 41 Resources provided free of charge

During the period there were no resources provided to other agencies free of charge for functions outside the normal operations of the Health Service.

Note 42 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 WA Country Health Service. The remuneration of the Director General of Health is paid by the Department of Health.

The number of members of the Accountable Authority, whose total of fees, salaries, superannuation, non monetary benefits and other benefits for the financial year falling within the following bands are:

	2012	2011
$510,001 - $520,000	-	1
$610,001 - $620,000	1	-
Total	1	1
	$000	$000
The total remuneration of members of the Accountable Authority is:	618	518

The total remuneration includes the superannuation expense incurred by the Health Service in respect of the members of the Accountable Authority.

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

$40,001 - $50,000	1	1
$50,001 - $60,000	1	-
$70,001 - $80,000	1	-
$100,001 - $110,000	1	-
$120,001 - $130,000	-	1
$140,001 - $150,000	-	1
$160,001 - $170,000	1	-
$170,001 - $180,000	2	-
$180,001 - $190,000	-	1
$190,001 - $200,000	-	5
$200,001 - $210,000	4	2
$210,001 - $220,000	2	2
$220,001 - $230,000	-	1
$240,001 - $250,000	1	-
$350,001 - $360,000	-	1
$390,001 - $400,000	1	1
$410,001 - $420,000	1	-
$430,001 - $440,000	1	-
Total	17	16
	$000	$000
The total remuneration of senior officers is:	3,520	3,283

The total remuneration includes the superannuation expense incurred by the Health Service in respect of senior officers other than senior officers reported as members of the Accountable Authority.

WA Country Health Service

Notes to the Financial Statements

For the year ended 30th June 2012

	2012 $000	2011 $000
Note 43 Remuneration of auditor		
Remuneration payable to the Auditor General in respect of the audit for the current financial year is as follows:		
Auditing the accounts, financial statements and key performance indicators	595	535
Note 44 Commitments		
The commitments below are inclusive of GST where relevant.		
Capital expenditure commitments Capital expenditure commitments, being contracted capital expenditure additional to the amounts reported in the financial statements, are payable as follows:		
Within 1 year	158,246	104,820
Later than 1 year, and not later than 5 years	188,935	362,577
	347,181	467,397
The capital commitments include amounts for buildings:	297,206	465,601
Operating lease commitments: Commitments in relation to non-cancellable leases contracted for at the end of the reporting period but not recognised as liabilities, are payable as follows:		
Within 1 year	18,505	15,271
Later than 1 year, and not later than 5 years	8,434	9,169
Later than 5 years	1,624	1,385
	28,563	25,825
Operating lease commitments predominantly consist of contractual agreements for office accommodation and residential accommodation. The basis of which contingent operating leases payments are determined is the value for each lease agreement under the contract terms and conditions at current values.		
Other expenditure commitments: Other expenditure commitments contracted for at the end of the reporting period but not recognised as liabilities, are payable as follows:		
Within 1 year	32,076	18,166
Later than 1 year, and not later than 5 years	27,743	18,004
Later than 5 years	25,717	19,529
	85,536	55,699
Note 45 Contingent liabilities and contingent assets		
Contingent liabilities In addition to the liabilities included in the financial statements, the Health Service has the following contingent liabilities:		
Litigation in progress		
Pending litigation that are not recoverable from RiskCover insurance and may affect the financial position of the Health Service.	9,310	9,165
Number of claims	7	12
Contaminated sites		
Estimated cost to remediate contaminated and suspected contaminated sites reported to the Department of Environment and Conservation (DEC)	970	914
Under the *Contaminated Sites Act 2003*, the Health Service is required to report known and suspected contaminated sites to the Department of Environment and Conservation (DEC). In accordance with the Act, DEC classifies these sites on the basis of the risk to human health, the environment and environmental values. Where sites are classified as *contaminated – remediation required* or *possibly contaminated – investigation required*, the Health Service may have a liability in respect of investigation or remediation expenses.		
Contingent assets		
At the reporting date, the Health Service is not aware of any contingent assets.		

WA Country Health Service

Notes to the Financial Statements

For the year ended 30th June 2012

Note 46 Events occurring after the end of the reporting period

There were no events occurring after the reporting period which had significant financial effects on these financial statements.

Note 47 Related bodies

A related body is a body which receives more than half its funding and resources from the Health Service and is subject to operational control by the Health Service.

The Health Service had no related bodies during the financial year.

Note 48 Affiliated bodies

An affiliated body is a body which receives more than half its funding and resources from the Health Service but is not subject to operational control by the Health Service.

The Health Service had no affiliated bodies during the financial year.

Note 49 Administered trust accounts

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

	2012 $000	2011 $000
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:		
Balance at the start of period	953	836
Add Receipts	1,821	1,923
	2,774	2,759
Less Payments	(1,535)	(1,806)
Balance at the end of period	1,240	953
b) The Health Service administers a trust account for salaried medical practitioners under the rights to private practice scheme.		
A summary of the transactions for this trust account is as follows:		
Balance at the start of period	154	186
Add Receipts	-	170
	154	356
Less Payments	(154)	(202)
Balance at the end of period	-	154
c) Other trust accounts - not controlled by the Health Service		
Staff Development and Diabetes Education Fund		
Balance at start of period	4	4
Add Receipts	-	-
	4	4
Less Payments	(4)	-
Balance at end of period	-	4

WA Country Health Service

Notes to the Financial Statements

For the year ended 30th June 2012

Note 50 Explanatory Statement

Significant variances between actual results for 2011 and 2012

Significant variations between actual results with the corresponding items of the preceding reporting period are detailed below. Significant variations are those greater than 10% or that are 4% or more of the current year's Total Cost of Services.

	Note	2012 Actual $000	2011 Actual $000	Variance $000
Expenses				
Employee benefits expense	(a)	723,879	632,704	91,175
Fees for visiting medical practitioners	(b)	69,803	59,512	10,291
Patient support costs	(c)	213,953	191,032	22,921
Finance costs	(d)	716	956	(240)
Depreciation and amortisation expense		42,860	39,947	2,913
Loss on disposal of non-current assets	(e)	608	3,955	(3,347)
Repairs, maintenance and consumable equipment		33,077	33,883	(806)
Other expenses	(f)	120,245	100,057	20,188
Income				
Patient charges	(g)	41,542	33,227	8,315
Commonwealth grants and contributions	(h)	69,905	35,008	34,897
Other grants and contributions		65,892	61,433	4,459
Donation revenue	(i)	1,151	602	549
Interest revenue	(j)	16	129	(113)
Other revenue	(k)	22,241	18,537	3,704
Service appropriations	(l)	1,010,914	907,624	103,290
Assets assumed / (transferred)		304	-	304
Resources received free of charge		12	68	(56)
Royalties for Regions Fund	(m)	44,468	13,280	31,188

(a) Employee benefits expense
Employee benefits expenses increased due to the combined effects of changes in salary rates under approved industrial agreements, increases in district allowances, growth in inpatient separations and Emergency Department (ED) presentations, and funded new or expanded programs.

(b) Fees for visiting medical practitioners
Increased expenditures for Visiting Medical Practitioners includes $7.8 million associated with the implementation of the Southern Inland Health Initiative. The balance of the increased expenditures represents annual fee increases in line with medical services agreements.

(c) Patient support costs
The increase in patient support costs is attributable to a combination of factors including increased utilisation and cost of Patients Assisted Travel Scheme (PATS), and increased funding to non government organisations particularly in relation to the Closing the Gap and Indigenous Early Childhood Development programs. Increasing demand for public hospital and ED services, together with the purchasing of additional public patient services from private hospitals and financial support for the South West Radio Oncology Service have resulted in increased patient support costs. Electricity and water charges have also contributed to cost increases.

(d) Finance costs
Finance costs have reduced due to reductions in interest rates and a decrease in the balance of Treasury loans.

(e) Loss on disposal of non-current assets
2010/11 losses on disposal included losses associated with the demolition of buildings at the Albany, Collie and Kalgoorlie Hospitals. There were no equivalent asset disposals in 2011/12.

(f) Other expenses
Other Expenses have been impacted by significant increases in staff accommodation expenses due to the combined effect of rising rental charges and an increase in the number of staff requiring accommodation as well as other factors such as increasing costs for staff travel and accommodation.

(g) Patient charges
Increased patient charges have resulted from the implementation of PBS reforms, increased revenues for services to Nursing Home Type Patients, and services to Ineligible Patients, including asylum seeking detainees.

(h) Commonwealth grants and contributions
Commonwealth Grants and Contributions are often received for specific and/or non recurrent programs and, consequently, are variable from year to year. Changes in Commonwealth Grants and Contributions are detailed in Note 15(a).

WA Country Health Service

Notes to the Financial Statements

For the year ended 30th June 2012

Note 50 Explanatory Statement (continued)

Significant variances between actual results for 2011 and 2012

(i) Donation revenue
Donations are highly variable from year to year.

(j) Interest revenue
The amalgamation of a number of donation and other accounts into the Public Bank Account, and reductions in interest rates have contributed to a reduction in interest revenues in 2011/12.

(k) Other revenue
Other Revenues have improved due to increased Arrangement A medical practitioner billing and increased rent recoveries from staff occupying Health Service accommodation.

(l) Service appropriations
Service Appropriations increased in 2011/12 in response to changes in industrial agreements, increasing costs for other goods and services, activity growth in public hospitals and Emergency Departments and the funding of new and expanded services, including the implementation of the Southern Inland Health Initiative.

(m) Royalties for Regions Fund
Revenues for Royalties for Regions projects vary according to the cashflow requirements of new and continuing projects. Changes in contributions from the Royalties for Regions Fund are detailed in Note 21.

Significant variances between estimated and actual results for 2012

Significant variations between the estimates and actual results for 2012 are detailed below. Significant variations are considered to be those greater than 10% of the budget estimates.

	Note	2012 Actual $000	2012 Estimates $000	Variance $000
Operating expenses				
Employee benefits expense		723,879	689,602	34,277
Other goods and services		481,262	478,083	3,179
Total expenses		1,205,141	1,167,685	37,456
Less: Revenues	(a)	(200,747)	(82,846)	(117,901)
Net cost of services		1,004,394	1,084,839	(80,445)

(a) Revenues
The favourable variance for Revenues is due in part to the initial approved budget not including revenues relating to Mental Health Commission funded services, the Commonwealth Highly Specialised Drug program and revenues associated with the Pilbara Health initiative which were the subject of budget variations totalling $55.1 million . A further $43.2 million represents the value of Commonwealth Grants received for capital works projects in the Kimberley and the South West. The balance of the favourable variance results from various unbudgeted grants and other specific purpose funding received during the financial year.

WA Country Health Service

Notes to the Financial Statements
For the year ended 30th June 2012

Note 51 Financial instruments

a) **Financial risk management objectives and policies**

Financial instruments held by the Health Service are cash and cash equivalents, restricted cash and cash equivalents, borrowings, receivables and payables. The Health Service has limited exposure to financial risks. The Health Service's overall risk management program focuses on managing the risks identified below.

Credit risk

Credit risk arises when there is the possibility of the Health Service's receivables defaulting on their contractual obligations resulting in financial loss to the Health Service.

The maximum exposure to credit risk at the end of the reporting period in relation to each class of recognised financial assets is the gross carrying amount of those assets inclusive of any allowance for impairment as shown in the table at note 51(c) 'Financial Instrument disclosures' and note 23 'Receivables'.

Credit risk associated with the Health Service's financial assets is minimal because the main receivable is the amounts receivable for services (holding account). For receivables other than government, the Health Service trades only with recognised, creditworthy third parties. The Health Service has policies in place to ensure that sales of products and services are made to customers with an appropriate credit history. In addition, receivable balances are monitored on an ongoing basis with the result that the Health Service's exposure to bad debts is minimal. At the end of the reporting period, there were no significant concentrations of credit risk.

All debts are individually reviewed, on a timely basis at 30, 60, 90 and 120 days. In circumstances where a third party is responsible for payment, or there are legal considerations, payment of accounts can be delayed considerably. Unpaid debts are referred to an external debt collection service within six months of the account being raised.

Allowance for impairment of financial assets is calculated based on objective evidence such as observable data indicating changes in client credit ratings. For financial assets that are either past due or impaired, refer to Note 51(c) 'Financial Instruments disclosures'.

Liquidity risk

Liquidity risk arises when the Health Service is unable to meet its financial obligations as they fall due. The Health Service is exposed to liquidity risk through its normal operations.

The Health Service has appropriate procedures to manage cash flows including drawdowns of appropriations by monitoring forecast cash flows to ensure that sufficient funds are available to meet its commitments.

Market risk

Market risk is the risk that changes in market prices such as foreign exchange rates and interest rates will affect the Health Service's income or the value of its holdings of financial instruments. The Health Service does not trade in foreign currency and is not materially exposed to other price risks. The Health Service's exposure to market risk for changes in interest rates relate primarily to the long-term debt obligations. The Health Service's borrowings were obtained through the Department of Treasury and are at fixed rates with varying maturities. The risk is managed by the Department of Treasury through portfolio diversification and variation in maturity dates.

b) **Categories of financial instruments**

In addition to cash, the carrying amounts of each of the following categories of financial assets and financial liabilities at the end of the reporting period are :

	2012 $000	2011 $000
Financial Assets		
Cash and cash equivalents	13,450	6,326
Restricted cash and cash equivalents	41,564	24,686
Loans and receivables	319,965	267,163
Financial Liabilities		
Financial liabilities measured at amortised cost	85,446	71,364

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Notes to the Financial Statements
For the year ended 30th June 2012

c) **Financial Instrument disclosures**

Credit Risk

The following table discloses the Health Service's maximum exposure to credit risk and the ageing analysis of financial assets. The Health Service's maximum exposure to credit risk at the end of the reporting period is the carrying amount of financial assets as shown below. The table discloses the ageing of financial assets that are past due but not impaired and impaired financial assets. The table is based on information provided to senior management of the Health Service.

The Health Service does not hold any collateral as security or other credit enhancements relating to the financial assets it holds.

Aged analysis of financial assets

	Carrying amount	Not past due and not impaired	Past due but not impaired				Impaired Financial assets
			Up to 12 months	1-2 years	2-5 years	More than 5 years	
	$000	$000	$000	$000	$000	$000	$000
2012							
Cash and cash equivalents	13,450	13,450	-	-	-	-	-
Restricted cash and cash equivalents	41,564	41,564	-	-	-	-	-
Receivables	15,991	9,895	3,731	2,365	-	-	-
Amounts receivable for services	303,974	303,974	-	-	-	-	-
	374,980	368,884	3,731	2,365	-	-	-
2011							
Cash and cash equivalents	6,326	6,326	-	-	-	-	-
Restricted cash and cash equivalents	24,686	24,686	-	-	-	-	-
Receivables	13,835	9,192	3,634	1,009	-	-	-
Amounts receivable for services	253,328	253,328	-	-	-	-	-
	298,175	293,532	3,634	1,009	-	-	-

Notes to the Financial Statements
For the year ended 30th June 2012

c) **Financial Instrument disclosures (continued)**

Liquidity risk and interest rate exposure

The following table details the Health Service's interest rate exposure and the contractual maturity analysis of financial assets and financial liabilities. The maturity analysis section includes interest and principal cash flows. The interest rate exposure section analyses only the carrying amounts of each item.

Interest rate exposure and maturity analysis of financial assets and financial liabilities

		Interest rate exposure					Maturity dates			
	Weighted average effective interest rate	Carrying amount	Fixed interest rate	Variable interest rate	Non-interest bearing	Nominal Amount	Up to 1 month	1 month to 1 year	1-5 years	More than 5 years
	%	$000	$000	$000	$000		$000	$000	$000	$000
2012										
Financial Assets										
Cash and cash equivalents	-	13,450	-	-	13,450	13,450	13,450	-	-	-
Restricted cash and cash equivalents	-	41,564	-	-	41,564	41,564	41,564	-	-	-
Receivables	-	15,991	-	-	15,991	15,991	15,991	-	-	-
Amounts receivable for services	-	303,974	-	-	303,974	303,974	-	-	6,600	297,374
		374,980	-	-	374,980	374,980	71,006	-	6,600	297,374
Financial Liabilities										
Payables	-	72,909	-	-	72,909	72,909	72,909	-	-	-
Borrowings	5.39%	12,537	-	12,537	-	15,950	162	1,886	8,079	5,823
		85,446	-	12,537	72,909	88,859	73,071	1,886	8,079	5,823

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Notes to the Financial Statements
For the year ended 30th June 2012

c) Financial instrument disclosures (continued)

Liquidity risk and interest rate exposure (continued)

Interest rate exposure and maturity analysis of financial assets and financial liabilities

	Interest rate exposure					Maturity dates			
	Weighted average effective interest rate	Carrying amount	Fixed interest rate	Variable interest rate	Non-interest bearing	Nominal Amount	Up to 1 month	1 month to 1 year	1-5 years	More than 5 years
	%	$000	$000	$000	$000		$000	$000	$000	$000
2011										
Financial Assets										
Cash and cash equivalents	2.2%	6,326	-	3,060	3,266	6,326	6,326	-	-	-
Restricted cash and cash equivalents	0.1%	24,686	-	593	24,093	24,686	24,686	-	-	-
Receivables	-	13,835	-	-	13,835	13,835	13,835	-	-	-
Amounts receivable for services	-	253,328	-	-	253,328	253,328	-	-	6,600	246,728
		298,175	-	3,653	294,522	298,175	44,847	-	6,600	246,728
Financial Liabilities										
Payables	-	57,567	-	-	57,567	57,567	57,567	-	-	-
Borrowings	6.7%	13,797	-	13,797	-	18,413	722	1,214	7,631	8,846
		71,364	-	13,797	57,567	75,980	58,289	1,214	7,631	8,846

Notes to the Financial Statements
For the year ended 30th June 2012

c) **Financial Instrument disclosures (continued)**

Interest rate sensitivity analysis

The following table represents a summary of the interest rate sensitivity of the Health Service's financial assets and liabilities at the end of the reporting period on the surplus for the period and equity for a 1% change in interest rates. It is assumed that the change in interest rates is held constant throughout the reporting period.

A change in banking arrangement effective from 1 July 2011 in accordance with the State Government's direction has resulted in the loss of interest earning capacity for all of the Health Service's bank accounts.

	Amount Exposed to Interest Rate Risk	-100 basis points		+100 basis points	
2012	$000	Surplus $000	Equity $000	Surplus $000	Equity $000
Financial Liabilities					
Borrowings	12,537	125	125	(125)	(125)
Total Increase/(Decrease)		125	125	(125)	(125)

	Amount Exposed to Interest Rate Risk	-100 basis points		+100 basis points	
2011	$000	Surplus $000	Equity $000	Surplus $000	Equity $000
Financial Liabilities					
Borrowings	13,797	138	138	(138)	(138)
Total Increase/(Decrease)		138	138	(138)	(138)

Fair values

All financial assets and liabilities recognised in the Statement of Financial Position, whether they are carried at cost or fair value, are recognised at amounts that represent a reasonable approximation of fair value unless otherwise stated in the applicable notes.

WA Country Health Service

Notes to the Financial Statements

For the year ended 30th June 2012

Note 52 Schedule of income and expenses by service

	Public Hospital Admitted Patients		Palliative Care		Emergency Department		Public Hospital Non-Admitted Patients		Patient Transport	
	2012 $000	2011 $000	2012 $000	2011 $000	2012 $000	2011 $000	2012 $000	2011 $000	2012 $000	2011 $000
COST OF SERVICES										
Expenses										
Employee benefits expense	336,681	298,342	2,215	2,407	58,446	50,837	108,810	85,402	2,142	2,524
Fees for visiting medical practitioners	46,308	39,734	13	11	8,339	6,838	12,387	11,279	5	2
Patient support costs	86,972	81,091	1,104	1,183	13,318	10,259	21,545	25,446	32,227	29,578
Finance costs	466	527	-	1	112	179	105	82	3	11
Depreciation and amortisation expense	25,128	21,097	16	47	4,725	5,136	6,791	4,989	468	679
Loss on disposal of non-current assets	248	2,215	-	1	39	287	69	948	1	10
Repairs, maintenance and consumable equipment	15,662	16,115	59	65	3,309	4,276	4,685	3,772	30	206
Other expenses	45,100	45,966	338	176	7,191	10,429	18,553	11,668	719	995
Total cost of services	556,565	505,087	3,745	3,891	95,479	88,241	172,945	143,586	35,595	34,005
Income										
Patient charges	15,933	13,310	-	-	695	570	19,155	14,173	-	-
Commonwealth grants and contributions	25,202	12,692	35	22	1,024	506	6,734	3,004	271	182
Other grants and contributions	3,240	3,181	14	17	411	396	858	746	109	142
Donation revenue	765	402	1	-	69	36	195	91	28	20
Interest revenue	10	80	-	-	1	9	2	16	-	2
Other revenue	14,781	12,371	11	12	1,337	1,098	3,772	2,796	543	605
Total income other than income from State Government	59,931	42,036	61	51	3,537	2,615	30,716	20,826	951	951
NET COST OF SERVICES	**496,634**	**463,051**	**3,684**	**3,840**	**91,942**	**85,626**	**142,229**	**122,760**	**34,644**	**33,054**
INCOME FROM STATE GOVERNMENT										
Service appropriations	509,622	463,656	3,865	3,872	95,617	86,138	149,175	123,647	4,375	24,152
Assets assumed / (transferred)	140	-	1	-	24	-	44	-	9	-
Resources received free of charge	5	32	-	-	1	6	2	9	-	2
Royalties for Regions Fund	8,471	3,380	4,233	2	10,801	228	2,117	175	6,355	9,109
Total income from State Government	518,238	467,068	8,099	3,874	106,443	86,372	151,338	123,831	10,739	33,263
SURPLUS FOR THE PERIOD	**21,604**	**4,017**	**4,415**	**34**	**14,501**	**746**	**9,109**	**1,071**	**(23,905)**	**209**

The Schedule of Income and Expenses by Service should be read in conjunction with the accompanying notes.

WA Country Health Service

Notes to the Financial Statements

For the year ended 30th June 2012

Note 52 Schedule of income and expenses by service (continued)

	Prevention, Promotion & Protection		Continuing Care		Contracted Mental Health		Total	
	2012 $000	2011 $000	2012 $000	2011 $000	2012 $000	2011 $000	2012 $000	2011 $000
COST OF SERVICES								
Expenses								
Employee benefits expense	83,682	71,549	77,352	76,235	54,551	45,408	723,879	632,704
Fees for visiting medical practitioners	331	22	1,335	1,291	1,085	335	69,803	59,512
Patient support costs	42,646	27,149	13,378	12,925	2,763	3,401	213,953	191,032
Finance costs	2	44	24	86	4	26	716	956
Depreciation and amortisation expense	1,746	2,249	3,661	4,974	325	776	42,860	39,947
Loss on disposal of non-current assets	216	148	23	207	12	139	608	3,955
Repairs, maintenance and consumable equipment	5,210	4,624	1,973	3,118	2,149	1,707	33,077	33,883
Other expenses	23,585	11,988	11,130	13,389	13,629	5,446	120,245	100,057
Total cost of services	157,418	117,773	108,876	112,225	74,518	57,238	1,205,141	1,062,046
Income								
Patient charges	-	-	4,542	4,220	1,217	954	41,542	33,227
Commonwealth grants and contributions	22,884	11,120	11,195	6,271	2,560	1,211	69,905	35,008
Other grants and contributions	3,184	3,016	2,200	2,403	55,876	51,532	65,892	61,433
Donation revenue	-	-	87	51	6	2	1,151	602
Interest revenue	-	-	2	18	1	4	16	129
Other revenue	-	-	1,679	1,563	118	92	22,241	18,537
Total income other than income from State Government	26,068	14,136	19,705	14,526	59,778	53,795	200,747	148,936
NET COST OF SERVICES	**131,350**	**103,637**	**89,171**	**97,699**	**14,740**	**3,443**	**1,004,394**	**913,110**
INCOME FROM STATE GOVERNMENT								
Service appropriations	138,082	104,224	93,856	98,494	16,322	3,441	1,010,914	907,624
Assets assumed / (transferred)	40	-	28	-	18	-	304	-
Resources received free of charge	2	8	1	7	1	4	12	68
Royalties for Regions Fund	6,141	308	4,233	51	2,117	27	44,468	13,280
Total income from State Government	144,265	104,540	98,118	98,552	18,458	3,472	1,055,698	920,972
SURPLUS FOR THE PERIOD	**12,915**	**903**	**8,947**	**853**	**3,718**	**29**	**51,304**	**7,862**

The Schedule of Income and Expenses by Service should be read in conjunction with the accompanying notes.

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Delivering a **Healthy WA**

Appendices

Appendix 1: Abbreviations

A	
ABF	Activity-Based Funding
C	
CAHS	Child and Adolescent Health Service
CDCD	Communicable Disease Control Directorate
CPI	Consumer Price Index
COAG	Council of Australian Governments
CRROH	The Centre for Rural and Remote Oral Health
CSF	Clinical Services Framework
D	
DAIP	Disability Access and Inclusion Plan
DG	Director General of Health
DOH	Department of Health
DOHA	Department of Health and Ageing
DMRP	Disaster Management, Regulation and Planning
E	
ED	Emergency Department
EH	Environmental Health
F	
FH	Fremantle Hospital
FINE	Friend in Need – Emergency
FMA	Financial Management Act 2006
G	
GBS	Government Budget Statements
GP	General Practitioner
H	
HACC	Home and Community Care
HITH	Hospital in the home
HCN	Health Corporate Network
K	
KPI	Key Performance Indicator
KEMH	King Edward Memorial Hospital
N	
NEHTA	National E-Health Transition Authority
NMAHS	North Metropolitan Area Health Service

O	
OAH	Office of Aboriginal Health
OHCWA	Oral Health Centre of WA
OPHG	Office of Population Health Genomics
OPSSC	Office of the Public Sector Standards Commissioner
OSH	Occupational Safety and Health
OSQHC	Office of Safety and Quality in Health Care

P	
PAC	Post Acute Care
PH	Public Health
PATS	Patient Assisted Travel Scheme
PEHS	Patient Evaluation of Health Services
PRA	Priority Response Assessment
PYLL	Person Years of Life Lost

R	
RAP	Reconciliation Action Plan
RFDS	Royal Flying Doctor Service
RGH	Rockingham General Hospital
RPH	Royal Perth Hospital

S	
SCGH	Sir Charles Gairdner Hospital
SQuIRE	Safety and Quality Investment for Reform
STI	Sexually Transmitted Infection

T	
TCP	Transition Care Program
TI	Treasurer's Instruction

W	
WACHS	WA Country Health Service
WHO	World Health Organisation

V	
VLAD	Variable Life Adjusted Display

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