Government of **Western Australia**
WA Country Health Service

Annual Report 2017-18

WA Country Health Service

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Accessibility: Copies of this publication are available in alternative formats upon request.

ABOUT THIS REPORT

This annual report describes the performance and operation of the WA Country Health Service during 2017–18. The report has been prepared according to parliamentary reporting and legislative requirements and is arranged as follows:

Overview

An introduction to the WA Country Health Service vision, values and strategic directions, reports by our Chair and Chief Executive and information about our Board and Executive members.

Agency performance

Summarises our performance against agreed financial and service delivery outcomes. This section includes our Financial statements and our performance against Key Performance Indicators.

Significant issues

Key issues for the WA Country Health Service, including current and emerging trends; responding to demand and activity complexity; workforce challenges; and our input to the sustainable health review.

Disclosure and compliance

Reports on governance, public accountability, financial management, information management, people management and equity and diversity.

Appendices

Additional information and data to supplement the report.

Statement of compliance

FOR YEAR ENDED 30 JUNE 2018

Hon Roger Cook MLA
Minister for Health

In accordance with section 63 of the *Financial Management Act 2006*, we 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 2018.

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

PROFESSOR NEALE FONG
CHAIR
WA COUNTRY HEALTH SERVICE BOARD

MR ALAN FERRIS
BOARD MEMBER
WA COUNTRY HEALTH SERVICE BOARD

19 September 2018

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01 FOREWORD

Foreword

Board Chair, Professor Neale Fong

Once again it has been an extremely rewarding year for the WA Country Health Service as we work to meet the healthcare needs of our vast and diverse communities. From nursing posts and outreach services, to child health clinics and bustling regional hospitals, the WA Country Health Service plays an important role in the lives of people in our country communities. This year's annual report highlights our many achievements which I feel immensely proud of.

With approximately 450,000 outpatient appointments attended, almost 400,000 emergency visits, just under 4600 births and over 124,000 hospital admissions and discharges, it has been a busy year of activity for country hospitals and health services. Our staff across the state have continued to provide quality care in some of the most complex and geographically dispersed health services in the world. Importantly, they have had the opportunity to utilise technology we now have available to provide care in new and innovative ways to provide their communities with access to the best possible healthcare.

In this second year of Board operations we have again seen the progress of significant change within the WA health system. In particular we have had the opportunity to consider what a sustainable health system means for Western Australia. The WA Country Health Service Board has led the organisation through a process to develop our recommendations to the Sustainable Health Review and we have harnessed that opportunity to emphasise areas which are critically important to country communities including patient pathways and equitable access to care.

Our staff provide quality care in some of the most complex and geographically dispersed country health services in the world...

I am proud of the way in which our organisation has articulated the significant challenges facing country communities and the critical importance of taking steps to ensure a sustainable health system into the future – one that recognises and enhances the delivery of services to country Western Australians whilst ensuring the ongoing viability and sustainability of those services so that they are responsive to the needs of country communities into the future. The Panel's Final Report is due in November 2018 and the Board and I look forward to continuing to advance the aims of the review.

The work of the Board committees for Finance; Safety, Quality and Performance; and Audit and Risk has evolved and matured. This year there has been an increased focus on safety, quality and clinical performance. We see the development of strategies in key priority areas such as cancer, maternal and newborn care and kidney health as positive steps in this regard.

The Board has again made it a priority to ensure that it conducts its work in the regions, with every second monthly Board meeting held at a regional site. This provides an opportunity for the Board to meet with staff and country communities and engage directly with our regional clinical services and hear ideas on how we can further improve operational performance and patient care. In our travels we have been consistently impressed by the dedication of our staff and their willingness to seek out innovation and best practice in the work they do.

Foreword

Board Chair, Professor Neale Fong

Innovation can also be seen in our capital works program that is replacing the legacy of ageing health infrastructure with contemporary technology-enabled healthcare hubs. The Board has had the opportunity to view many of the health service infrastructure developments and see how health care design can deliver contemporary and culturally secure care environments that are reflective of country landscapes.

The completion of redevelopments through our capital works program, such as the Harvey Health Service, Collie Health Service and the Esperance Health Campus maternity unit are among many achievements this year. We have continued the expansion of the Emergency Telehealth Service and the development of telehealth across our services. This included the introduction of a 24/7 emergency telehealth service and a pilot of afterhours emergency telehealth mental health services, demonstrating our commitment to providing access to high quality and contemporary care.

We will continue our focus on supporting our Executive team to pursue excellence and to transition from a high-performing health service to a leader in the delivery of rural and remote health care in Australia and the world. We have laid strong foundations that will serve us well as we continue the process for setting our strategic direction for 2018 and beyond and I look forward to sharing that journey with you.

PROFESSOR NEALE FONG
CHAIR
WA COUNTRY HEALTH SERVICE BOARD

We will continue our focus on the pursuit of excellence and to transition from a high-performing health service to a leader in the delivery of rural and remote health care in Australia and the world

Foreword

Chief Executive, Jeffrey Moffet

Notwithstanding the challenges that come with working across vast distances, our staff excel in providing health care to the communities in which they live and work. This year we have progressed many initiatives which deliver improved care access to our patients including the expansion of the Emergency Telehealth 24/7 service, expansion of the meet and greet service and infrastructure projects in no less than sixty of our facilities. Achieving these milestones and the benefits to the community gives an extraordinary sense of satisfaction in the work we do.

Our staff strive to provide exemplary care 24 hours a day, seven days a week and they do so with a passion and commitment that makes me proud to lead this critical service for country people. We also remain vigilant in our aims to continually improve the care we provide and in the ongoing development of our services by learning from our experiences and from the feedback we receive. It is a privilege to lead a workforce who come to work each day to care for people and support their journey to recovery. This year's Annual Report showcases just a handful of our highlights and achievements.

At the 2017 WA Health Excellence Awards we, in partnership with Diabetes WA and the WA Primary Health Alliance, were awarded the Director General's Award for the Diabetes Telehealth Program. I was also pleased to see Dr Diane Mohen as joint winner of the Minister for Health's Award for Outstanding Commitment to a Healthier WA and Steph Waters for the Jill Porteous Memorial Award for Safety and Quality.

Among the many staff who have received personal recognition throughout the year I congratulate Brett Hayes, Nurse Manager Specialist Palliative Care Wheatbelt. Brett was named WA Nurse of the Year and received the Award for Excellence in Regional and Remote Nursing in the Western Australian Nursing and Midwifery Awards for his work in using tele-palliative care to help more country people die at home, surrounded by their loved ones.

I also extend my congratulations to all of our team at Geraldton Hospital, which has been named the nation's most outstanding regional hospital at the Australian Patients Association (APA) awards. The Midwest was one of the first regions to 'go live' with Patient Opinion and the team has taken full advantage of the insights and feedback the application provides to ensure that patient feedback is utilised. This is critical to providing a voice in our communities and tangible feedback from which we can continually improve.

The APA, an independent not-for-profit organisation dedicated to protecting the rights and interest of patients across Australia, has recognised Geraldton Hospital as consistently demonstrating an unwavering commitment to public feedback through its use of the Patient Opinion site. As you will see in this report, Patient Opinion is now in place for all of our sites across the State and WA Country Health Service hospitals make up a significant part of the 'top-ten' registered users of this innovative platform across the nation.

Our staff excel in providing health care to the communities they live and work in.

Foreword

Chief Executive, Jeffrey Moffet

The executive team and our regional staff have enjoyed engaging with our Board members and highlighting the services, facilities, rewards and challenges of delivering health services in the country and discussing the key challenges and opportunities we face in these communities.

Our Board membership in 2017-18 includes nine diverse and experienced professionals who are highly respected in their individual fields and across the community. I sincerely thank our Board Chair, Professor Neale Fong, Ms Wendy Newman (Deputy Chair), Mr Michael Hardy, Dr Daniel Heredia, Dr Kim Isaacs, Mr Joshua Nisbet, Mrs Mary Anne Stephens, Mr Alan Ferris and Ms Meredith Waters for their support and fervor in supporting the delivery and development of health services in the bush. I sincerely thank retiring Board member Mr Joshua Nisbet, for his commitment, energy and corporate expertise over the past two years.

In closing, I would also like to thank the communities and our service partners in regional and remote Western Australia for their ongoing support of our staff and our health service. I commend the 2017-18 WA Country Health Service Annual Report to you.

JEFFREY MOFFET
CHIEF EXECUTIVE
WA COUNTRY HEALTH SERVICE

I would like to thank the communities in regional and remote Western Australia for their ongoing support of our staff and our health service.

Our Vision, Mission and Strategic Directions

The WA Country Health Service Strategic Directions 2015–18 focuses on the strategic directions to be achieved consistent with our Vision, Purpose, Values, and Guiding Principles.

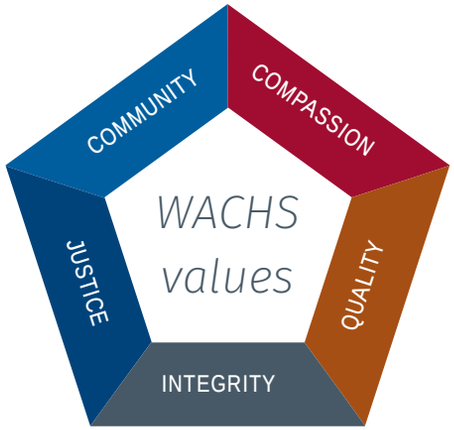
Key strategies have focused on improving health and the experience of care, valuing consumers, staff and partnerships, as well as governance, performance and sustainable services.

The WA Country Health Service Board has focused clearly on its role setting the strategic directions for WACHS for the future, and to this end, has commenced the development of a new strategic plan to commence in 2019. The plan will allow us to set a clear vision for the organisation into the future, while building on our many successes and achievements over time.

VISION

Healthier country communities through partnerships and innovation.

Our vision is for healthier country communities through partnerships and innovation.



PURPOSE

The WA Country Health Service improves country people's health and wellbeing through access to quality services and by supporting people to look after their own health.

VALUES

Community – making a difference through teamwork, cooperation, a 'can do' attitude, and country hospitality.

Compassion – listening and caring with empathy, respect, courtesy and kindness.

Quality – creating a quality health care experience for every consumer, continual improvement, innovation and learning.

Integrity – accountability, honesty and professional, ethical conduct in all that we do.

Justice – valuing diversity, achieving health equality, cultural respect and a fair share for all.

STRATEGIC DIRECTIONS

- Improving health and the experience of care.
- Valuing consumers, staff and partnerships.
- Governance, performance and sustainable services.

GUIDING PRINCIPLES

- Consumers first in all we do.
- Safe, high quality services and information at all times.
- Care closer to home where safe and viable.
- Evidence-based services.
- Partnerships and collaboration.

02 OVERVIEW

Executive summary

Year in review

The WA Country Health Service has maintained our commitment to improving the health and wellbeing of country people through access to quality services and by supporting people to look after their own health throughout 2017-18. The key to this focus are the partnerships formed with our communities, consumers, staff and service providers dedicated to delivering outstanding services to country people.

YEAR IN REVIEW

1,122 PEOPLE A DAY

Presented to a major country emergency department (ED) in 2017

DURING 2017-18 394,770

Times people presented at a country ED, were treated and cared for

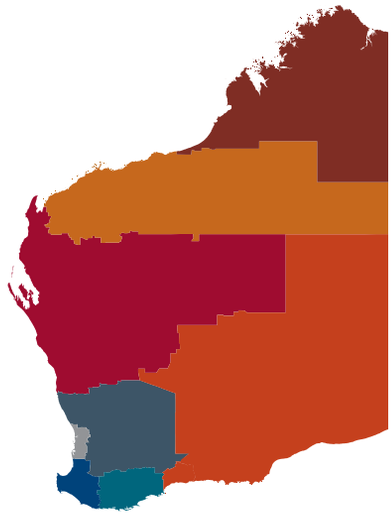
In 2017

124,316

Admitted patients were discharged

5,792 admissions

For people living in country WA for an acute mental health or alcohol and drug condition in 2017



In 2017/18 WACHS supported

4,564 Births

15,000+

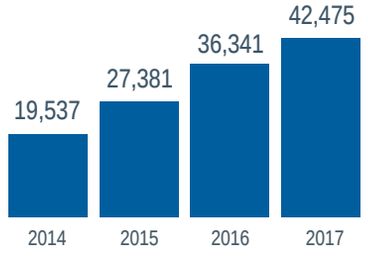
Elective surgery patients seen

35,647

Aboriginal patients provided inpatient care

42,475

Telehealth patient appointments and services 2017



UP 16+%

SINCE 2016

See Appendix 3 for Data Sources

Executive summary

WACHS in country communities

WORKPLACE PROFILE

As at March 2018

10,066

Country people employed

97%

Of our staff work from country locations.

4.4% **413**

Aboriginal people employed

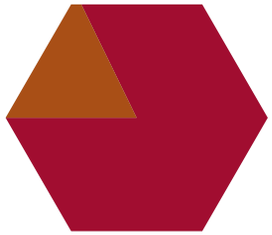
Staff with a self-declared disability

42 **0.4%**

Staff gender profile

18% MALES

82% FEMALES



Women in SES equivalent or Executive level positions **50%**

254

Interns and recent graduates started with us

AGE PROFILE

24 and under	5%
25-44 years	38.1%
45 and over	56.9%

Data source - Employee Establishment snapshot as at the end of March 2018

Executive summary

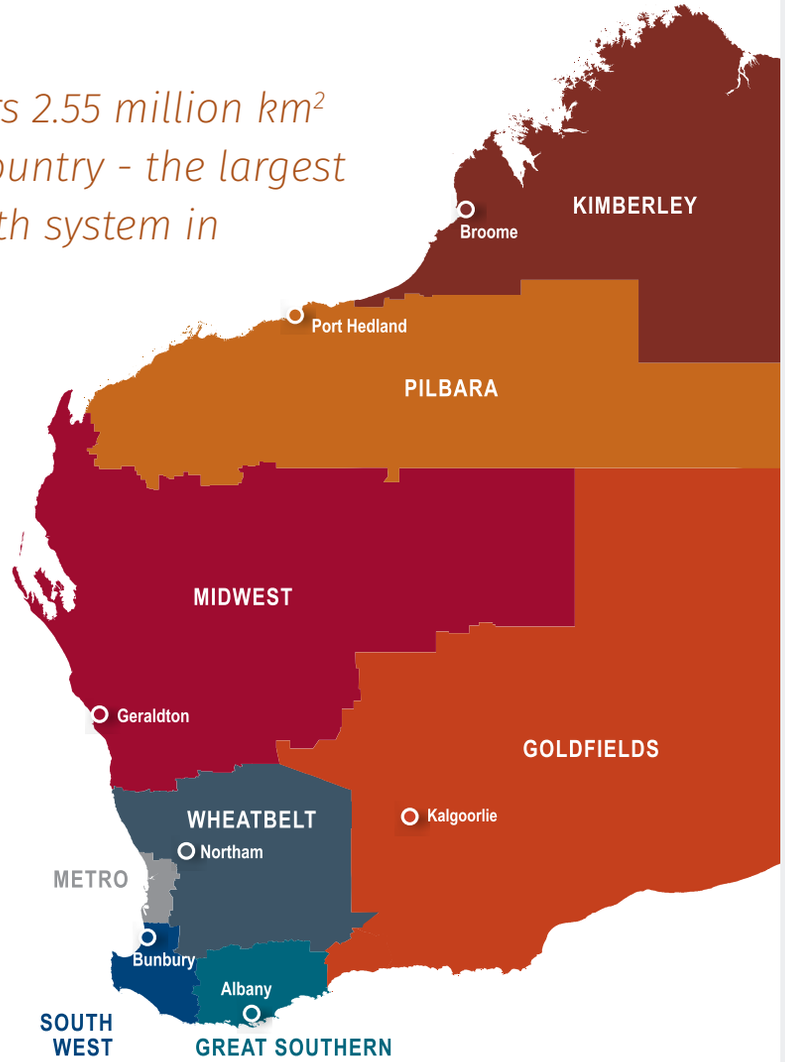
WA Country Health Service at a glance

The WA Country Health Service provides comprehensive health services to people living in country areas of Western Australia, from the most remote towns in the Kimberley, Pilbara and the Goldfields to coastal cities in the Great Southern, Midwest and the Southwest, and to numerous small towns in the Wheatbelt. The geographical area covered by country health spans approximately 2.55 million square kilometres. The WA Country Health Service is the largest country health system in Australia covering the whole of the State outside the Perth metropolitan area.

According to the latest available Australian Bureau of Statistics Estimated Resident Population (ERP) data (2016), the population of WACHS's catchment area is 531,934 people. Just over 10 per cent of these people (54,014) identify as Aboriginal. The population we service is diverse and expansive and as a result has widely varying health needs.

People living in rural and remote areas tend to experience poorer general health than those in metropolitan areas and Aboriginal health and life expectancy, in particular, is significantly less than that of non-Aboriginal people.

WACHS covers 2.55 million km² across the country - the largest country health system in Australia



531,934 people — *10%* — *54,934 Aboriginal people*

Executive summary

WA Country Health Service at a glance

Despite the challenges of vast distances and health inequalities, the WA Country Health Service offers comprehensive health services to country residents and visitors that encompass emergency and hospital services, population, public and primary health care, mental health, drug and alcohol services, Aboriginal health, child and community health and residential and community aged care services.

We do this in our 68 gazetted hospitals and 42 health centres, along with a large number of non-hospital and community based facilities such as multi-purpose services, nursing posts, remote clinics, community mental health services and population health facilities. In addition, WACHS provides an array of home and community care and aged care services for older people in country WA, including managing more than 550 aged care beds and two residential aged care facilities (nursing homes).

Government funding and industry investment over recent years have brought about a transformation of country health care through major and minor capital works. More towns now have contemporary health campuses, expanded hospitals, greater emergency service capacity and modern facilities and equipment. Coupled with technological and service innovations such as Telehealth, the WA Country Health Service is now delivering health care closer to home for more country Western Australians than ever before.

OUR VALUES IN ACTION

Bringing cancer care closer to home

A cancer diagnosis can be a traumatic experience. Cancer survivor Caroline Rowcroft knows only too well the implications such a diagnosis can have for a person's everyday life.

"There are often many treatment options to be considered and being with our loved ones and support networks at such a time is crucial," said Caroline. The Midwest mum-of-four has been the 'community voice' during the design phase of the new regional cancer hostel which is ideally situated close to the Midwest Cancer Centre.

"As a cancer survivor I felt I could positively contribute to this project. Having used the hostel facilities in Perth during my treatment, I wanted to replicate that 'home away from home' feeling here."

The new $1.38 million Midwest Cancer Hostel is funded through the Commonwealth Health and Hospitals Fund (HHF) and includes seven double rooms providing accommodation for cancer patients and their carers from communities outside of Geraldton, to enable access to cancer treatment and/or specialist cancer services closer to home.

Caroline also said that having a welcoming, non-clinical, safe, secure and culturally appropriate facility right next to the cancer centre would have a positive effect on people by removing some of the stress associated with travelling to Perth for appointments.

"With this new facility, interconnected doors open up to allow family members to stay which is especially helpful during the school holidays.

"This has been a great initiative and I am ecstatic that this hostel has been built. I hope the people who end up using this facility find comfort in the design and that the location makes attending appointments so much easier for them," said Caroline.

The facility, called Protea Lodge, opened in May 2018 and is a welcome addition to those who need a 'home away from home'.

Both projects are part of the Strengthening Cancer Services in Regional Western Australia initiative; a $22.9 million commitment by the Australian Government which will see ten projects delivered by WA Country Health Service across the state.

Protea Lodge – Midwest Cancer Centre opened in May 2018.

Caroline Rowcroft with Nick Silich and Ali Devellerez from SPH Architects.

Performance highlights

Throughout this report you will see that individuals and teams from across the health service have been recognised for their outstanding work and commitment and for leading the way in their field. Many have been recognised with formal awards, a testament to the calibre of our staff and their dedication to improving patient care across country WA.

PATIENT OPINION

Patient Opinion is an independent web-based consumer feedback platform that allows the people who use our services, their families and carers to comment on their experiences. The website allows people to communicate with health services and provides a channel for WA Country Health Service to keep in touch with people regarding the outcome of their feedback and what action we have taken.

The first Western Australian health service to fully adopt the platform, three regions in the WA Country Health Service initially joined a one-year pilot which concluded in December 2016. The pilot was hugely successful and in February 2017 the platform was extended across all seven regions.

The site is independently moderated and is intended to supplement and enhance existing feedback and complaints systems by providing a more informal and real-time avenue for consumers to be heard. The project has steadily gained momentum with consumers sharing their stories via the website regularly across the State. District Health Advisory Councils have helped to promote the feedback platform in the community and to encourage people to share their stories.

"Lack of women's health GP"

Posted by Racsf53 (as a staff member posting for a patient/service user)

As a full time worker, getting an appointment with a female GP has proven frustrating at Derby. Each time I try book an appointment I'm told to come back on Friday, they might know if there is a female GP visiting the next week. With only one male GP at the hospital and no appointments available to see the female GPs at Derby Aboriginal Health Service if you are not Aboriginal. I'm overdue for my regular checks by two years. I'd love to have the option of seeing a female GP please.

Response from Rachele Ferrari, Operations Manager, Derby Fitzroy Valley, WACHS 6 months ago

We have made a change

Good morning Racsf53,

Thank you for your story. I appreciate you telling your story when we met a few days ago. I have also passed on your message to DAHS, who are a separate organisation to Derby Hospital.

I wanted to let everyone know we have heard your story and a change is underway.

Access to a female GP is important and we are about to commence a women's health GP clinic at Derby Hospital. Dr Heather Langsford will start these clinics on Friday next week, 9th March. Appointments can be made by calling the GP clerk at Derby Hospital on 9193 3214.

We also have other female doctors and trained nurses who can take the tests you need. If a Friday is not suitable, you can contact me directly and I will make sure you have access to an appointment for this important test ASAP.

Kind regards,

Rachele Humbert.
Operations Manager, Derby Hospital.

VIEW STORY >

Performance highlights

FEEDBACK ABOUT OUR SERVICES FROM PATIENT OPINION

We had a really positive experience at the Margaret River Hospital - the midwives and the doctor were excellent and we were well looked after at every step. It was a very personal experience and we are glad that we choose to stay at our local hospital. Both the baby and mum are doing well. Margaret River Hospital Patient

I cannot begin to thank the staff at the Geraldton Hospital for the care they provided to me. Every staff member properly introduced themselves, including doctors, nurses, clerks and patient service assistant workers. I was constantly reassured and asked if I had any questions. This is the first time I've ever been hospitalised and I'm grateful for the care I received from all hospital staff. Geraldton Hospital Patient

We took our child to the Emergency Department at Broome Hospital ... Our child was later admitted to the Kids' ward with suspected appendicitis. We were there for 22 hours and in that time every single staff member we dealt with, including RNs, orderlies, admin, doctors, personal care assistants, cleaners and the surgeon were incredibly professional, positive and friendly. To finish off our visit we had a delicious roast lamb lunch! Thank you so much for making what could have been a very unpleasant break in our lovely Broome holiday more than bearable. Broome Hospital Patient

I just wanted to make a comment and say thank you for the wonderful care I received at Kununurra Hospital recently. I have never experienced this sort of exceptional and personal care in a hospital before and I really appreciated it. Kununurra Hospital Patient

The care I have received as a maternity patient at Bunbury Hospital has been outstanding. Overall ... a wonderful experience and I can't thank all the staff involved in my care enough for everything they did for me. Bunbury Hospital Patient

From the moment I arrived at hospital I was treated with the upmost care and kindness by everyone I came in contact with, from the surgeon and doctors, nurses, physiotherapists, two ladies and cleaners made what was a horrible and traumatic event for me, more bearable and less stressful. I'm very grateful – thank you. Geraldton Hospital Patient

Performance highlights

Consistent with our annual patient survey results, the majority of stories shared on Patient Opinion have been complimentary of our dedicated and caring staff. These stories are shared with the relevant staff and teams to highlight and celebrate their achievements, recognise and reinforce positive behaviours, and increase staff engagement. This contributes to building a strong, positive and person-centred service culture, which in turn, provides for positive and caring experiences for the people who use our services.

Prior to the implementation, District Health Advisory Councils and WA Country Health Service staff had identified that the existing patient feedback mechanisms were generally limited to formal processes and, while useful, may not address the aspects of care that are most important to the consumer. Patient Opinion allows people to provide feedback quickly, via their phone or other electronic device, and for us to respond quickly to that feedback.

Watch It takes a team: Geraldton Health Campus

VIEW VIDEO >

Over the course of 2017-18, we received 305 stories, and as of 30 June 2018 those stories have been viewed on Patient Opinion 85,144 times. 17 of these stories have led to the implementation of a material change in the way we provide our service. Feedback and responses are openly logged for everyone to view, including our Executive and Board members.

The project continues to be strongly supported by the District Health Advisory Councils and Health Consumers Council WA, and the site is monitored by both local health service staff, as well as local District Health Advisory Council members. In 2017-18 approximately 98.2 per cent of story authors who chose to indicate whether the response they received was helpful, agreed with that statement. You can find the site at www.patientopinion.org.au

OUR VALUES IN ACTION

Australian Patients Association names Geraldton Hospital most outstanding regional hospital in Australia

The Australian Patients Association, an **independent not-for-profit organisation** dedicated to protecting the rights and interest of patients across Australia, said the Midwest hospital had consistently demonstrated an unwavering commitment to public feedback.

Jeff Calver, Regional Director for the Midwest said while delighted to take out the award, listening to patient feedback was integral to providing safe, high quality person-centered care. "It goes without saying that I am exceptionally proud of the entire team at Geraldton Hospital. Whether it be positive, negative or indifferent feedback – it is a hospital that is open about its successes and not afraid to acknowledge lessons learnt."

Jeff said while the hospital was constantly engaging with the general public, it was only in 2015 they began using the Patient Opinion model. "We were originally part of the pilot program and liked that the platform allowed people the opportunity to provide feedback outside of traditional methods," he said.

"For us it was about facilitating honest and meaningful conversation."

The Midwest was one of the first regions to go live with Patient Opinion and Jeff said since inception, the region had received more than 138 stories via the service and provided 180 responses. "Of these, close to 100 involve Geraldton Hospital and have been viewed almost 60,000 times," he said.

"Needless to say, the team has taken full advantage of the feedback and I am confident they will continue to be responsive and agile in the way they deliver health services."

Jeff Calver, Derek Fraser and Michele Young in front of Geraldton Health Campus

Performance highlights

INFRASTRUCTURE PROGRAM

In regional cities and large towns, emergency, inpatient and outpatient services are being brought together with other important health services in modern, functional buildings to create health care hubs. In smaller towns and districts, emergency departments, hospitals and health centres are being modernised with upgraded facilities, digital systems and telehealth bringing together our experienced regional teams with emergency specialists when required.

The Karratha Health Campus construction is now complete and when the first patients are welcomed in late 2018 it will herald a new era in healthcare facility design for the Pilbara region. The campus is the biggest investment in a public hospital ever undertaken in regional WA. It will have an expanded emergency department, a new surgical centre, state-of-the-art CT scanner, new delivery suites and maternity wing, world-class telehealth services and expanded outpatients and essential services.

This year the State Government announced an exciting commitment for the $73.3 million stage 1 redevelopment of Geraldton Health Campus and a Midwest mental health service. Planning has begun and the investment, which begins in 2020 and occurs over a five-year period, will deliver a combination of new build and refurbished infrastructure. The investment will enable an expanded emergency department and critical care unit; an acute psychiatric unit; a mental health short stay unit; and essential engineering service upgrades to the existing infrastructure.

Watch the Karratha Health Campus time lapse

VIEW VIDEO >

External Wall artwork being installed at Karratha Health Campus.
Title: Metamorphic Life
Material: High fired porcelain with copper and iron glaze
Artist: Ian Dowling

Image courtesy of FORM

Performance highlights

Also in the Pilbara, construction of the Onslow Health Campus redevelopment in nearing completion with the final stage being scheduled for completion in October 2018.

As part of a half-a-billion-dollar program, upgrades transforming sites in the Wheatbelt, Great Southern, South West and Midwest into contemporary, integrated health services are well advanced. You can read about our building projects on our website.

Construction has continued in Katanning, Narrogin, Northam and Merredin, and in May 2018 the Warren Health Campus project achieved practical completion for the new hospital build component. The new Warren Health Service brings together a range of health services in one convenient location including a contemporary expanded, modern emergency department, upgraded medical imaging and improved technology support for clinicians and patients in Manjimup and surrounding districts. The architecture and design honors the heritage of the district and the finished build makes this hospital a public building of true civic presence and style.

Construction of the innovative Pingelly Health Centre was also completed in early May 2018. The new Health Centre includes facilities for chronic disease prevention and management, as well as an improved emergency department. Cunderdin Health Centre is also progressing and is expected to be operational in November 2018.

The new Warren Health Service brings together a range of health services in one convenient location.

The new Warren Health Service, Manjimup

Performance highlights

Physio treatment being provided via telehealth

EXPANSION OF INNOVATIVE TELEHEALTH SERVICES

The use of telehealth, such as videoconferencing and other digital technologies, continues to expand, providing innovative solutions that are improving health service access and the health journey for country people, particularly providing specialist and multi-disciplinary care closer to home.

The *"WA Telehealth Future State Plan 2017-2022"* details the telehealth technical roadmap including the underpinning information systems and architectures that will support the delivery of both clinical and non-clinical services.

The Emergency Telehealth Service continues to provide regional clinicians with emergency specialist support when treating critically ill and injured country patients. There are currently 79 of our hospitals and other health service sites connected, averaging 1600 consultations each month. On average, 75 per cent of Emergency Telehealth Service patients are assessed, diagnosed, treated and discharged in their home towns. The service operates as a 24-hour, 7 day a week service. In 2017-18 there were more than 1400 staff attendances across 59 Emergency Telehealth Service education sessions held by the telehealth team.

Further expanding our telehealth services, the Rural Acute TeleStroke Service links country emergency departments to metropolitan stroke consultants via telehealth, enabling a joint video consultation with the WA Country Health Service clinical team, the patient, their family and the specialist. This has greatly assisted in early stroke diagnosis and appropriate treatment and transfer where indicated, significantly improving patient recovery and outcomes. This has resulted in a significant increase in country stroke patients' access to highly specialised, time critical treatment.

We are trialing the use of telehealth to deliver cancer care closer to home. TeleOncology has grown significantly across the major specialties of medical oncology, radiation oncology and haematology in the past 12 months, with the emphasis now on expanding services while increasing the ability for people to receive care directly into their homes.

There is an area of sustained growth in outpatient and specialist services with over 1400 clinical consultations done each month with the top five specialties being plastic surgery, respiratory medicine, haematology, orthopedic, gastroenterology with proposed growth in several areas including neurology. This equates with a reduction in country patients' travel as an estimated 27.3 million kms, reducing inconvenience and costs for country people's travel and improving timely access to care.

Watch how telehealth is helping thousands of Western Australians

VIEW VIDEO >

OUR VALUES IN ACTION

Top health award for unique partnership program

An Australia-first program using telehealth to deliver diabetes education in regional WA, has taken out the Director General's Award at the 2017 WA Health Excellence Awards. The Diabetes Telehealth Program won the 'Overcoming inequities' category and was chosen as the overall winner out of an **impressive field of candidates. The program** uses telehealth to deliver much needed support to those with the chronic condition and has resulted in increased consumer satisfaction, decreased hospital admissions, and decreased emergency department presentations among users.

The program was developed by WA Country Health Service in partnership with Diabetes WA and later in collaboration with WA Primary Health Alliance (WAPHA). The collaboration allowed each party to contribute with WA Country Health Service providing seed funding, project and governance support along with telehealth infrastructure support. A key success factor of the partnership was the development of greater linkages between the primary health sector and networks to promote the service to a range of key stakeholders including general practitioners across the state and this engagement has been key to its success.

In presenting the award the Department of Health Director General Dr David Russell-Weisz said the Diabetes Telehealth Program had improved the health outcomes and reduced the burden of travel for rural West Australians, while also using health resources more efficiently.

"Diabetes is a leading cause of potentially preventable hospitalisations in Western Australia, particularly in regional areas," Dr Russell-Weisz said.

"This program, which is the first diabetes educator-led telehealth service in Australia, brings equitable and flexible diabetes education closer to home for rural Western Australians."

Since the program first commenced in 2015 it has received more than 1080 referrals, provided 2397 occasions of service and has been used to deliver professional development to more than 1100 health professionals. Diabetes WA estimate that since the program's inception close to 1 million kilometres of travel distance has been saved by consumers accessing diabetes education via telehealth rather than access through conventional service models.

The successful partnership between WA Country Health Service, WAPHA and Diabetes WA on this project has been the catalyst for broader collaboration between our organisations in working to ensure greater coordination and improved equity in access to services for consumers across country WA with complex chronic conditions.

Telehealth is being used to deliver diabetes education in regional WA

Performance highlights

ABORIGINAL HEALTH

Around 21 per cent of the Western Australian population (531,934 people) resides within regional Western Australia. Of this, 10 per cent (52,588 people) identify as Aboriginal people, compared with just two per cent of the metropolitan population. The proportion of Aboriginal people in the population varies immensely between regions, from three per cent in the South West up to 45 per cent in the Kimberley. As Aboriginal people are significantly represented in our country communities the WA Country Health Service strives to ensure that 'Aboriginal health is everyone's business.'

This year the State Government has made a commitment to the long term funding of Aboriginal health programs that are improving the health and wellbeing of Aboriginal people. The investment provides certainty of funding for programs across the state that support child and maternal health; sexual health education and support; tackling smoking; cancer screening; chronic disease prevention and treatment; improving access to mental health services; as well as promoting a healthy lifestyle and wellbeing. The commitment safeguards the long-term sustainability of Aboriginal health programs delivered in partnership with communities, non-government organisations, Aboriginal Community Controlled Health Organisations and other specialist providers.

Seventy three per cent of Aboriginal children suffer from otitis media, a serious ear infection, before reaching their first birthday. Untreated, this can lead to long-term chronic ear disease and hearing loss that can affect learning and social development. In 2017-18 the Earbus Foundation has received an additional $2.7 million in funding to expand the successful Earbus program to the east Kimberley, and into the east Fitzroy Valley. The Earbus service delivery model has been endorsed by the Kimberley Aboriginal Health Planning Forum and key stakeholders have supported the expansion of the service.

The Kimberley Grant Management Committee has overseen the expansion of the service. This vital program offers mobile ear health clinics to Aboriginal children in schools, kindergartens and playgroups, and works with local primary healthcare services to connect the community with General Practitioners, audiologists and ear, nose and throat specialists without duplication. The service, which is already operating in the Pilbara, Goldfields and South West, will provide Aboriginal children in the Kimberley with increased access to ear health screening and treatment services.

Aboriginal health is everyone's business.

OUR VALUES IN ACTION

Coming Home – Bringing renal dialysis and support services closer to home

A chronic diseases study in 2012-13 **showed that nearly one in five Aboriginal** people had signs of chronic kidney disease. **Those in remote areas were five times more** likely to have chronic kidney disease than non-Aboriginal people. For country patients treatment begins in Perth with specialist support and then patients wait for a dialysis chair to become available for them to come home.

The wait to come home can be long and many Aboriginal people report feeling sad and frustrated at being alone and away from their family, friends and community.

"We find that health outcomes are better for people who are able to access treatment close to home as their attendance at dialysis improves, they are more involved in managing and participating in their own care and they have the support of their family and loved ones around them." said Kim Tracey, Clinical Nurse Consultant.

In 2014 the Commonwealth Government funded the $45.8 million Bringing Renal Dialysis and Support Services Closer to Home initiative, of which $3.52 million was invested to refurbish the Kalgoorlie Dialysis Unit, increasing the number of dialysis chairs and bringing more Goldfields people home.

Watch: Coming Home: Kalgoorlie Dialysis Unit

VIEW VIDEO >

Performance highlights

Central to providing effective and culturally secure healthcare for Aboriginal people is attracting and retaining Aboriginal staff. The organisation continues to support Aboriginal leadership development, traineeships and the Aboriginal Mentorship Program. Regional Aboriginal health consultant positions have been appointed in the Midwest and Kimberley, and recruitment to the remaining five regions is underway. The consultants are members of the regional executive teams and play a significant role across all aspects of regional business.

In April 2017, we introduced the Aboriginal Entry Level Employment Framework to provide funding to support Aboriginal employees. As of April 2018, the total Aboriginal employee headcount was 413, which equates to 4.4% of the WA Country Health Service workforce. This is above the 3.2% State Government target.

Coming to Perth for specialist treatment can often be a distressing and disorienting time for Aboriginal patients. In 2017 the State Government committed $1.898 million over four years to expand the Country Health Connection Meet and Greet service. The newly expanded service now operates from 6.00am to 10.00pm Monday to Friday and as required on the weekends. This provides eligible Aboriginal patients who travel to Perth for specialist medical treatment with a friendly face to greet them and ensure they arrive safely at their destination.

Similarly, for many Aboriginal people going to hospital can be a difficult and unsettling experience, particularly when English is a second language. The WA Country Health Service, in collaboration with Aboriginal Interpreting WA, is leading the way with a six month trial to provide increased interpreting services in some Kimberley hospitals. The pilot enables Aboriginal interpreters to be on standby to support Aboriginal people and their families in need of medical attention.

The pilot will see hospitals across Broome, Derby, Fitzroy, Halls Creek and Kununurra engage with interpreters to create a health environment where Aboriginal people feel heard and understood.

Watch: WACHS is leading the way with unique interpreting service

VIEW VIDEO >

Josh Pilkington, Aboriginal Health Driver for Country Health Connection meet and greet service.

OUR VALUES IN ACTION

'Welcome to MK Nation' A Finalist at the WA Health Excellence Awards

The WA Country Health Service, Indigenous Hip Hop Projects and the Meekatharra Shire worked together to develop music video clip to increase awareness of sexually transmitted infections, their prevention and treatment.

'Welcome to the MK Nation' involved recruiting 12 young Meekatharra locals to work together over five days to devise, write and record their own original song and then film a video clip in various locations around Meekatharra. The video also tackles issues relating to drugs and alcohol when making choices about relationships.

Watch: 'Welcome to MK Nation'

VIEW VIDEO >

Performance highlights

MENTAL HEALTH

The WA Country Health Service continues to focus on improving access to services for country people experiencing mental health issues. We do this in partnership with the Mental Health Commission, the WA Primary Health Alliance and other government and non-government agencies.

Over $3 million in additional funding has been secured to increase access to mental health services, in particular for the 0-15 year age group, predominantly in the Midwest, South West, Great Southern and Wheatbelt regions. In the Midwest work is continuing on the development and implementation of a new mental health model of care that is more responsive to consumers. Feedback has shown us that the design of our service needs to ensure that there is 'no wrong door' for people to enter our service; the model focuses on ensuring an assessment within 24 to 48 hours and includes an assertive outreach component to reduce the need for mental health clients attend an Emergency Department at times of crisis. The work undertaken in the Midwest will be rolled out in our other regions and will inform changes to the way we deliver mental health services across the state in the future.

Also in 2017, Pilbara and South West Youth Services were established to provide high quality, mental health, wrap-around services while reducing inequality in youth healthcare. These services run in partnership with Headspace and local community alcohol and drug services to ensure comprehensive, coordinated care with a focus on recovery. These services are delivered as an evidence based clinical practice model, which is culturally sensitive and with a focus on promoting consumer centred care.

A pilot of the Emergency Telehealth Service Mental Health after-hours service has been completed and the outcomes of the pilot is informing the future planning of an Emergency Telehealth style mental health service model.

The model will enable clinicians to access specialist mental health advice, assessment and support, and will provide assistance with care planning and transfer to other services across WA Country Health Service and to primary care.

In addition to increasing access to mental health services, new training and support programs have been developed to improve the way we deliver services. We have partnered with Murdoch University and the University of Western Australia in two research activities focusing on perinatal mental health and identity development in young people at risk of mental health disorders. The outcome of these research projects will inform the design of our service delivery for these cohorts in the future.

Our Statewide Specialist Aboriginal Mental Health Program continues to provide culturally secure services to Aboriginal people. Additional staffing in this area, including a new leadership position means that the Aboriginal Mental Health workforce will now comprise 10% of our overall mental health workforce.

The governance of our mental health services across country health continues to be strengthened with improved capacity to monitor clinical and corporate performance, safety and quality improvement activities and compliance with the Chief Psychiatrist and other standards.

Performance highlights

NURSING AND MIDWIFERY

This year has seen the development of two major Nursing and Midwifery strategies which have been developed in partnership with our key stakeholders. The *WA Country Health Service Cancer Strategy 2017-2022* outlines the directions and priority areas for cancer services across the state. These priorities include investment and improvements in the areas of cancer prevention and screening, enabling a skilled cancer workforce and leveraging technology, innovation and partnerships to provide quality cancer services as close to home as is clinically possible for our country patients.

Similarly, the *Maternal and Newborn Care Strategy* seeks to guide the expected standards of maternity and newborn care regardless of a family's place of residence and the mother's birth location. This includes a focus on improving access to care closer to home through innovative models of service delivery and the creative use of technology. These exciting projects will enhance the delivery of patient care and services throughout country WA.

Midwifery Group Practice allows women and families having a baby to be cared for by a known midwife throughout their pregnancy, during labour and birth, and postnatally. A midwife or small team of midwives provide primary care with medical practitioners. In 2017-18 this model has been introduced in the Wheatbelt offering women a greater choice in all aspects of their pregnancy, delivery and after care.

Watch: Celebrating International Nurses Day!

VIEW VIDEO >

Nursing and Midwifery workforce planning continues to be a key focus with the successful introduction of central casual pools for nurse practitioners, nurse managers and registered nurses and midwives. We have continued to strengthen our future nursing workforce by offering 150 new midwife, registered and enrolled nurse graduates positions.

A nurse practitioner is an experienced registered nurse educated to a masters degree level and are authorised to function autonomously and collaboratively in an advanced and extended clinical role. The WA Country Health Service now has 36 nurse practitioners in place across the state who have been through the formal credentialing process alongside three endorsed midwives who have been credentialed.

Ongoing professional development, education and training is a high priority for the organisation and we have invested in the continued implementation of the Professional Practice Framework which is now firmly embedded across all nursing and midwifery units.

OUR VALUES IN ACTION

WA Nurse of the Year and Award for Excellence in Rural and Remote Health

WACHS staff member Brett Hayes has been awarded the prestigious WA Nurse of the Year and Award for Excellence in Rural and Remote Health. Brett has achieved outstanding results in his work progressing initiatives which allow **people to stay at home in their final stages of** care. He has been persistent and committed in building better options for palliative patients and works with them and their families to achieve a patient-centred outcome. Brett also took out the award for Excellence in Regional and Remote Nursing.

The *TelePalliative Care in the Home* Service led by Brett in the Wheatbelt in 2016 expanded to the Midwest in April 2018 and is shortly to be implemented in the South West and Great Southern.

"If we – as experienced palliative care practitioners – can use telehealth to talk carers through uncertain or stressful times and provide them with support and reassurance, more people in the regions will be able to die at home where they want to, surrounded by their loved ones." Brett said.

Brett Hayes pictured with Hon Roger Cook MLA and Meredith Walker of the WA Nurses Memorial Charitable Trust.

Brett Hayes, WA Nurse of the Year and Award for Excellence in Rural and Remote Health

03 GOVERNANCE

Governance

OUR PLACE IN THE WIDER HEALTH SYSTEM

The WA health system consists of the Department of Health, five board-governed health service providers, the Quadriplegic Centre and Health Support Services. The Department of Health, led by the Director General, provides leadership and management of the health system as a whole, ensuring the delivery of high quality, safe and timely health services.

Each health service provider, with the exception of Health Support Services, is governed by a Board appointed by the Minister for Health. Board members bring a wealth of experience in a range of fields such as health care, finance, law, and community and consumer engagement.

Health service providers are responsible and accountable for the delivery of safe, high quality, efficient and economical health services to their local areas and communities. They are the Child and Adolescent Health Service, East Metropolitan Health Service, North Metropolitan Health Service, South Metropolitan Health Service and the WA Country Health Service (WACHS). While WACHS is the State Government health care provider for country patients, it works together with the Department of Health and other health service providers to ensure country patients have coordinated care when needed.

System-wide support to health service providers, including some technology, supply, workforce and financial services, are provided through a shared services arrangement by Health Support Services, which is a chief executive-governed health service provider.

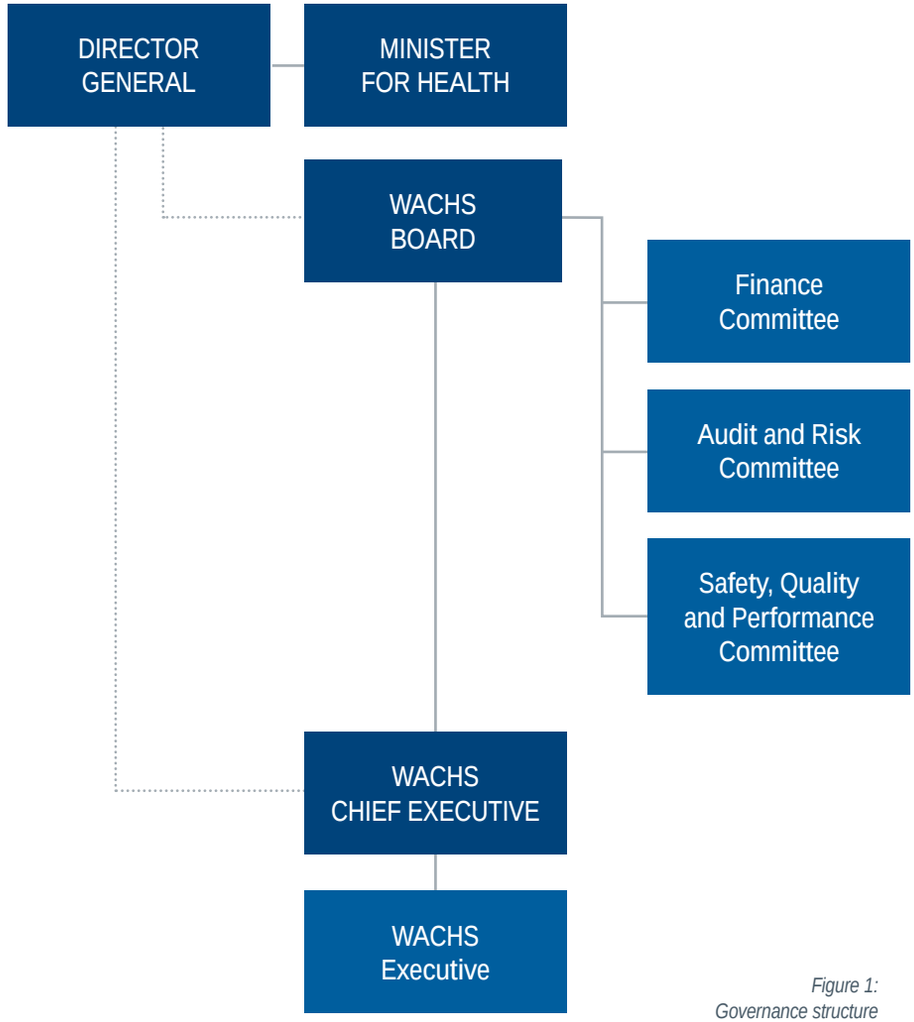


Figure 1: Governance structure

Governance

MINISTER

The WA Country Health Service is responsible to the Minister for Health, the Honourable Roger Cook MLA.

ACCOUNTABLE AUTHORITY

The WA Country Health Service is a board governed statutory authority, where the Board is directly accountable to the public and the Minister for Health, working with the Director General of the Department of Health.

The Board Chair Professor Neale Fong is the reporting officer for the WA Country Health Service in 2017–18.

ENABLING LEGISLATION

The WA Country Health Service was established as a board governed health service provider by the *Health Services (Health Service Provider) Order 2016* made by the Minister under section 32 of the *Health Services Act 2016*. The WA Country Health Service is responsible to the Minister for Health and the Department CEO of the Department of Health (System Manager) for the efficient and effective management of the agency.

WA Country Health Service Board

The WA Country Health Service is a State Government statutory authority under the *Health Services Act 2016*. The legislation, which came into effect on 1 July 2016, replaced the *Hospitals and Health Services Act 1927* and established boards responsible and accountable for delivering safe, high-quality, efficient and economical health services to their local communities.

From 1 July 2016, the WA Country Health Service Board commenced as the governing body for the organisation. It comprises highly capable and committed professionals with a diverse range of experience across the fields of medicine and health care, finance, law and community and consumer engagement.

The Board works closely with the Chief Executive, who manages the day-to-day operations to deliver safe, high-quality and efficient health services to communities across regional Western Australia.

The Board is supported by three committees; the Audit and Risk Committee; Finance Committee; and Safety, Quality and Performance Committee. These bodies assist the Board to perform its functions and provide support and advice to the Board in exercising its authority.

Note: Committees comprise Board members only and are not formally registered.

Each committee is directly responsible and accountable to the Board for the exercise of its duties and responsibilities.

Read more about the WA Country Health Service Board here

READ MORE >

Board members, Chief Executive Jeff Moffet and Regional Director Kimberley Bec Smith visit One Arm Point

WA Country Health Service Board

PROFESSOR NEALE FONG

Professor Neale Fong is a registered medical practitioner with over 30 years' experience in medical and health care delivery and leadership roles. His strengths lie in reform and change management, developing strategic direction for healthcare organisations and leading over the entire spectrum of health policy and service delivery.

In addition to his role as Chair of the WA Country Health Service Board, Neale is also Chairman of Bethesda Health Care and Chairman of the Ministerial Council for Suicide Prevention. A former Director General of the Department of Health (WA) and former CEO of St John of God Hospital Subiaco, Neale holds Masters degrees in Business Administration and Theological Studies, and Bachelor degrees in Medicine and Surgery. He consults to Curtin University on the establishment of WA's third medical school, is a Professor in Healthcare Leadership and is the National and WA President of the Australasian College of Health Service Management.

MS WENDY NEWMAN

Wendy Newman is CEO of the Wheatbelt Development Commission. She has extensive experience in individual, organisational and regional development and in addition to her role as Deputy Chair of the WA Country Health Service Board, is on the Board of Regional Development Australia, Wheatbelt and is Deputy Chair of Directions Workforce Solutions.

Wendy has extensive experience in working at all levels of government to develop strategy and drive reform. Wendy has a Masters in Commerce (Management), a Bachelor of Education and is a graduate of the Australian Institute of Company Directors' program.

Telehealth is supported by everyone at WACHS, especially our Board.

VIEW VIDEO >

WA Country Health Service Board

MR ALAN FERRIS

Alan Ferris has significant experience in Government and not-for-profit sectors and is currently managing his own consultancy business. Prior to starting his own consultancy business Alan led the consulting team at the accounting firm BDO. Alan has worked in the Senior Executive Service of the State Government in positions including General Manager of the Perth Theatre Trust and Acting Director General of the Department of Culture and the Arts. He also held the position of Chief Financial Officer at the Department of Culture and the Arts for seven years.

Alan is Chair of Palmerston Association Inc. a not for profit drug and alcohol service provider and is Chair of the Finance Committee for the WA Country Health Service. Alan also has significant local government experience having been Mayor of the Town of East Fremantle for six years and a Councillor for eight years. Alan holds Bachelor of Commerce (Accounting and Information Systems), is a Certified Practising Accountant and a Fellow of Leadership WA.

MR MICHAEL HARDY

Michael Hardy is a lawyer who practiced for some 40 years in a large national firm, a boutique firm and as a sole practitioner. Michael's principal areas of practice were administrative, contract, planning, environmental and property law.

In addition to his position on the Board of WA Country Health Service, he is a member of the Contaminated Sites Committee and a member of the Metro Central Joint Development Assessment Panel. Michael is a former chairman and non-executive director of Fleetwood Limited.

DR DANIEL HEREDIA

Dr Daniel Heredia is the Deputy CEO and Medical Director at Hollywood Private Hospital, the largest private hospital in WA. He has previously worked as a Medical Advisor to Medicare Australia and prior to this worked in clinical medicine at various hospitals in WA. Daniel sits on the WA Board of the Medical Board of Australia and is a former Director of the Australian Medical Association (WA).

Daniel has completed a Bachelor of Medicine and Bachelor of Surgery with Honours, an MBA with Distinction, and a Diploma of Public Health. He is a Graduate of the Australian Institute of Company Directors, Fellow of the Royal Australasian College of Medical Administrators and Fellow of the Australasian College of Health Service Management.

WA Country Health Service Board

DR KIM ISAACS

Dr Kim Isaacs is a Yawuru, Karajarri and Noongar woman and the current Deputy Medical Director of the Kimberley Aboriginal Medical Service. Kim has a strong background in rural and remote medicine and Aboriginal primary health care and is a General Practitioner in remote clinics north and south of Broome.

Kim is an Aboriginal health lecturer at the University of Notre Dame Australia, Fellow of the Royal Australian College of General Practitioners and a Fellow of the Australian Rural Leadership Foundation. Before starting a medical career, Kim completed a Bachelor of Commerce degree at UWA with a major in Accounting and Finance.

MR JOSHUA NISBET

Joshua Nisbet is most recently an Associate with Focal HR Consulting and his own consulting business. Formerly the Manager of Aboriginal Economic Participation with Rio Tinto, responsible for the employment and contracting obligations Rio Tinto Iron Ore has with the Traditional Owners of the Pilbara, arising from the commercial agreements and Indigenous Land Use Agreements.

Joshua has post graduate qualifications in Psychology and Commerce from UWA, Murdoch and the University of NSW and commenced his career working for WA's specialist psychiatric disability employment agency, Workright (WA).

**Retiring member from July 1 2018*

MS MARY ANNE STEPHENS

Mary Anne is a senior executive and non-executive director with more than 25 years' experience leading teams within the financial services, IT and not-for-profit sectors in Australia and the United States. She has extensive experience in strategy, finance, risk management, audit and governance. Mary Anne is currently the Chief Financial Officer for Amana Living.

Mary Anne is a Non-Executive Director of Diabetes WA, a Board Member of VenuesWest, and an external member of the Football West Finance and Audit Sub-committee.

She holds a Master of Accounting degree, is a Fellow of CPA Australia, a Fellow of the Institute of Public Accountants, a Fellow of the Australian Institute of Management WA and a Graduate of the Australian Institute of Company Directors.

WA Country Health Service Board

MRS MEREDITH WATERS

Meredith Waters arrived in the Esperance region 19 years ago from Melbourne, and quickly grew to love life in the regional community. With a background in the justice system as a Clerk of Courts in Victoria, Meredith commenced with the Esperance Court House in 2000.

Meredith has held a variety of roles in the community and volunteer sector including management roles with Bay of Isles Community Outreach and YouthCARE, project work with Esperance Community Arts and Esperance Volunteer Centre and volunteering with Esperance Care Services and Esperance Civic Centre.

Meredith is currently a member of Esperance Local Drug Action Team, Volunteer Manager for 103.9HopeFM community radio, board member with Esperance Community Arts, and the Chairperson of the South East District Health Advisory Council with the WA Country Health Service.

BOARD MEETING AND COMMITTEE ATTENDANCE

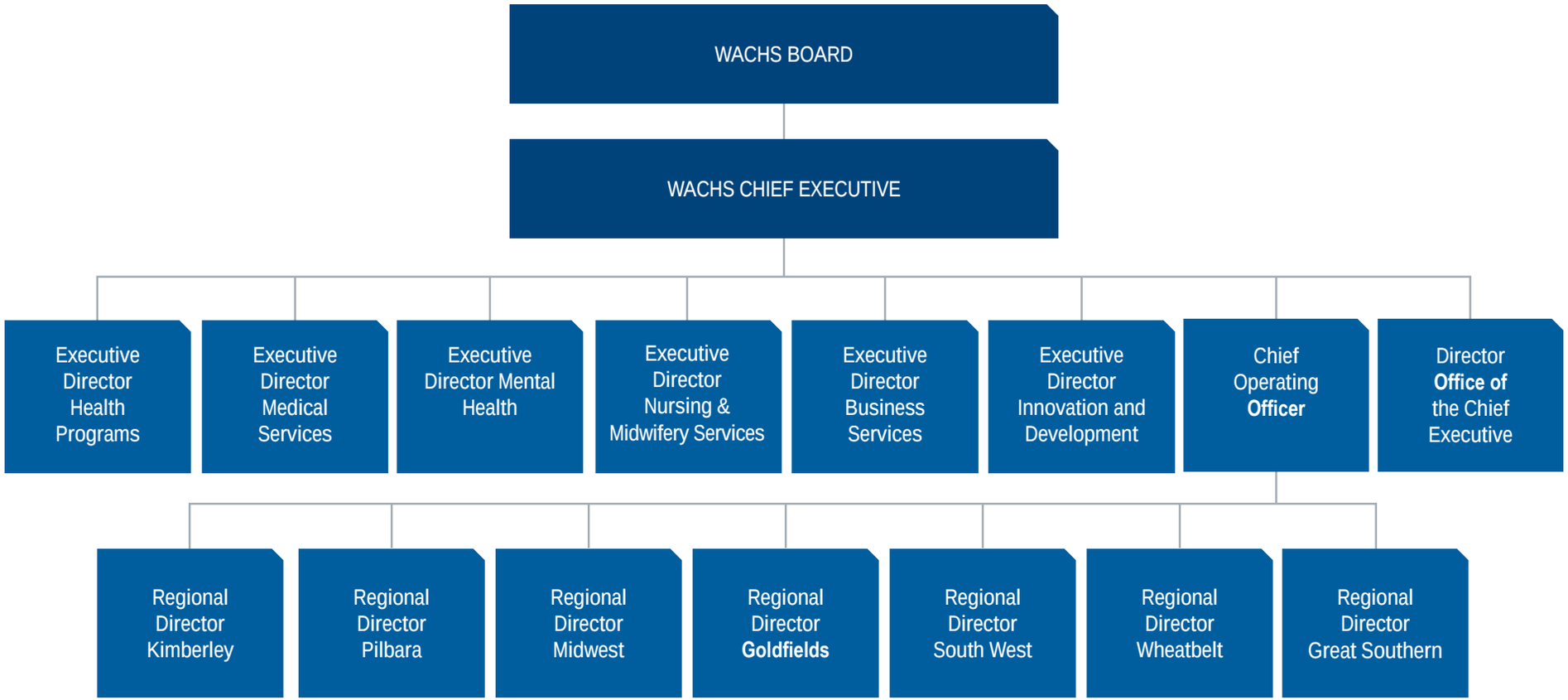
Table 1: Board meeting attendance for 2017-18

Name	Number of meetings	Meetings attended
Full Board Meeting		
Professor Neale Fong	11	10
Wendy Newman	11	10
Dr Daniel Heredia	11	11
Dr Kim Isaacs	11	10
Joshua Nisbet	11	8
Michael Hardy	11	10
Mary Anne Stephens	11	10
Meredith Waters	11	11
Alan Ferris	11	11
Finance Committee		
Alan Ferris (Chair)	11	11
Wendy Newman	11	11
Mary Anne Stephens	11	9
Audit and Risk Committee		
Michael Hardy (Chair)	11	9
Meredith Waters	11	10
Alan Ferris	11	10
Safety, Quality and Performance Committee		
Dr Daniel Heredia (Chair)	7	6
Dr Kim Isaacs	7	6
Meredith Waters	7	7
Joshua Nisbet	7	7

WA Country Health Service Executive

The WA Country Health Service Executive is the principal advisory body to the Chief Executive of the WA Country Health Service and as such assists with the management of the organisation by providing advice to the Chief Executive on strategic, service and policy issues.

The Executive provides an important unifying link between executive management across organisational divisions.



Note: Senior Officers and their area of responsibility for the 2017-18 year are listed in Other Legal Disclosures.

OUR VALUES IN ACTION

Artwork tells local story of fusion and renewal

The two-year redevelopment of the Narrogin Health Service has reached a new stage, with installation of feature artwork at the main entry of the hospital. The artwork is a tribute to ancient and recent history of the local environment and has been created in consultation with local Aboriginal elders and using local craftsmen.

Public Art contributes to our understanding and appreciation of cultural and natural heritage, enhancing our built environment and creating meaningful public spaces. Among its many social, economic and cultural benefits, public art can help to define a place and create a sense of cultural and community identity; improve the public experience of buildings and spaces; and encourage creative collaborations between artists and other professionals such as architects, designers, landscape architects and engineers. Wherever possible WA Country Health Service seeks to use artwork to improve the experience of people visiting our facilities.

Research released in 2016 by the WA Arts and Health Consortium Reference Group showed that art in clinical settings improves clinical outcomes for patients.

"Artwork in a healthcare setting is more than just decorative. It can give people a pause from the trauma or stress of their current situation and can improve their experience." said Sean Conlan, WA Country Health Service Wheatbelt Regional Director.

At Narrogin Health Service, artist Lorenna Grant has created a unique artwork that tells the story of the local eco system and environment in the creation of a sculptural piece featuring local granite and wandoo timber that was once the floorboards in the Narrogin Baptist Church.

Specialising in creating public artwork that has a local connection, Lorenna felt that the use of local craftsmen, and cooperation with local Aboriginal elders, were key to the creation of this piece.

To achieve the vision for the sculptural piece Lorenna joined forces with Narrogin woodworker Stan Samulkiewicz to create the wooden structure.

A passionate environmentalist, Lorenna's artwork tells a story that is particular to the Narrogin area. "The triangular timber panels are my interpretation of the triangular fissures created by the plants in the rock face," she said. "At the top of the work, between the panels, small flower buds reach up to the light, representing the continuation of the renewal process."

Lorenna Grant and Stan Samulkiewicz are also set to deliver a range of external feature seating options throughout the health service as part of the Percent for Art Scheme.

Artists Lorenna Grant and Stan Samulkiewicz

Performance Management Framework

OUTCOME BASED PERFORMANCE MANAGEMENT FRAMEWORK

To comply with its legislative obligation as a Western Australian government agency, the WA Country Health Service operates under the WA Health Outcome Based Management (OBM) Framework.

The framework was updated comprehensively for 2017-18 to reflect the new governance structure resulting from the introduction of the *Health Services Act 2016* and to update the previous framework which had been in place for fifteen years. The resulting changes include new outcomes, services and the replacement of some Key Performance Indicators (KPIs).

The framework describes how outcomes, services and KPIs are used to measure agency performance towards achieving the relevant overarching whole-of-government goal. WA Health's KPIs measure the effectiveness and efficiency of the WA Country Health Service in achieving the following outcomes:

- Outcome 1: Public hospital based services that enable effective treatment and restorative healthcare for Western Australians.
- Outcome 2: Prevention, health promotion and aged and continuing care services that help Western Australians to live healthy and safe lives.

These updated outcomes are reflective of a continuum of care approach and the split between delivering services in both a hospital and community based setting.

KPIs and services delivered by the WA Country Health Service to achieve WA Health outcomes are outlined in Table 2 (next page).

Performance against these outcomes and activities are summarised in the Summary of KPIs section on page 46 and described in detail in the KPI section starting on page 100.

Performance Management Framework

Table 2: KPIs and services delivered by WACHS to achieve WA Health outcomes

WA Government Goal: Strong Communities Safe communities and supported families.

WA Health Agency Goal: Delivery of safe, quality, financially sustainable and accountable healthcare for all Western Australians.

Outcome 1: Public hospital based services that enable effective treatment and restorative healthcare for Western Australians

Services delivered to achieve Outcome 1:

1. Public hospital admitted services
2. Public hospital emergency services
3. Public hospital non-admitted services
4. Mental health services

Key Performance Indicators for Outcome 1		
Effectiveness Indicators	Unplanned hospital readmissions of public hospital patients within 28 days for selected surgical procedures	Existing
	Proportion of elective wait list patients waiting over boundary for reportable procedures	Existing
	Hospital infection rates (Healthcare-associated Staphylococcus aureus bloodstream infections (HA-SABSI) per 10,000 occupied bed-days in public hospitals)	New
	Survival rates for sentinel conditions	Existing
	Percentage of admitted Aboriginal and Non-Aboriginal patients who discharged against medical advice	New
	Percentage of live-born term infants with an Apgar score of less than 7 at 5 minutes post delivery	Existing
	Rate of total hospital readmissions within 28 days to an acute designated mental health inpatient unit	New
	Percentage of contacts with community-based public mental health non-admitted services within seven days post discharge from and acute public mental health inpatient unit	Existing
Efficiency Indicators	Average admitted cost per weighted activity unit	New
	Average Emergency Department cost per weighted activity unit	New
	Average non-admitted cost per weighted activity unit	New
	Average cost per bed-day in specialised mental health inpatient units	Existing
	Average cost per treatment day of non-admitted care provided by public clinical mental health services	New

Outcome 2: Prevention, health promotion and aged and continuing care services that help Western Australians to live healthy and safe lives

Services delivered to achieve Outcome 2:

5. Aged and continuing care services
6. Public and community health services
7. Community dental health services
8. Small rural hospital services

Key Performance Indicators for Outcome 2		
Effectiveness Indicators	Response times for emergency air-based patient transport services (Percentage of emergency air-based inter-hospital transfers meeting the statewide contract target response time for priority 1 calls)	New
	Percentage of patients who access emergency services at a small rural or remote Western Australian hospital and are subsequently discharged home	New
Efficiency Indicators	Average cost per bed-day for specialised residential care facilities, flexible care (hostels) and nursing home type residents	Existing
	Average cost per person of delivering population health programs by population health units	Existing
	Cost per trip of patient emergency air-based transport, based on the total accrued costs of these services per the total number of trips	New
	Average cost per trip of Patient Assisted Travel Scheme (PATS)	Existing
	Average cost per rural and remote population (selected small rural hospitals)	New

Following a review of the Outcomes Based Management structure for WA Country Health Services, a number of Key Performance Indicators are reported for the first time in the 2017-18 Annual Report. These KPIs are identified in the table above, and will not report comparatives for the prior period.

Our partners

SHARED RESPONSIBILITIES

Health Service Providers across Western Australia work with a range of service providers across the patient journey to deliver high quality integrated healthcare. In the country providing integrated care for patients is even more complex.

The WA Country Health Service shares responsibility for delivering care with a range of other State agencies, including but not limited to: other Health Service Providers, the Mental Health Commission, WA Police, the Department of Corrective Services, and the Department of Communities and its Disability Services, Child Protection and Family Support sections. We also work closely with general practitioners, the WA Primary Health Alliance, Aboriginal Community Controlled Organisations, local shires and other care and service providers such as Silver Chain in regional and remote communities across the state.

In addition to the relationships we have with other agencies, WA Country Health Service also has a key partnership with the Royal Flying Doctor Service to ensure that country patients can access tertiary care when they require it. Royal Flying Doctors Service provides Inter-hospital patient transfer services across the state for transfer of patients between a WA Country Health Service site and another hospital facility such as the metropolitan tertiary hospitals.

6,542 patients accessed the Royal Flying Doctor Service in 2017

(for Inter-hospital Patient Transfer)

Similarly, we have a key partnership with St John Ambulance in ensuring that country patients can also be transferred by road either from the place of their emergency, or between hospitals or health sites and there are over 160 ambulance locations operating in country WA providing this important service. This is achieved through a combined model of volunteer ambulance officers, community paramedics and paid paramedic services. WA Country Health Service works closely with St John Ambulance so that country people have access to this vital service in their time of need.

04 AGENCY PERFORMANCE

Financial summary

The total cost of providing health services to rural and regional areas in Western Australia in 2017-18 was $1.78 billion. Results for 2017–18 against agreed financial targets (based on Budget statements) are presented in Table 3.

Full details of the WA Country Health Service's financial performance during 2017–18 are provided in the financial statements.

Table 3: Actual results versus budget targets for WA Country Health Service

	2017-18 Target ($'000)	2017-18 Actual ($'000)	Variation +/- ($000)	Explanation of Variance
Total cost of services	1,692,773	1,779,570	86,797	Key Factors: • Expenditures on continuing and new services for which funding had not been included in the initial target but were the subject of budget adjustments throughout the year and at Mid-year Review. • Impact of asset revaluation decrements
Net cost of services	1,066,863	1,109,409	42,546	Key Factors: • Expenditures on continuing and new services for which funding had not been included in the initial target but were the subject of budget adjustments throughout the year and at Mid-year Review. • Commonwealth and Other Grants received for services not included in the initial target but were the subject of budget adjustments throughout the year and at Mid-year Review. • Impact of asset revaluation decrements.
Total equity	2,579,148	2,475,159	-103,989	Delays in the Capital Works program and asset revaluation decrements.
Approved full-time equivalent staff level (salary associated with FTE)	7,794.9	7,773.3	-21.5	Reduced staffing levels in the first half of the year resulting in part from delays in the commencement of new programs.

Summary of key performance indicators

Key performance indicators (KPIs) assist the WA Country Health Service to assess and monitor the extent to which State Government outcomes are being achieved.

- Effectiveness indicators provide information that aids in the assessment of the extent to which outcomes have been achieved through the resourcing and delivery of services to the community.
- Efficiency indicators monitor the relationship between the service delivered and the resources used to provide the service.

Key performance indicators also provide a means to communicate to the community how the WA Country Health Service is performing. A summary of the WA Country Health Service key performance indicators' performance against targets is given in Table 4.

Note: Table 4 should be read in conjunction with detailed information on each key performance indicator found in the disclosure and compliance section of this report. The KPIs are prepared based on the latest available information.

Table 4: Actual results versus KPI targets

Key performance indicator	Target	Actual
OUTCOME 1: PUBLIC HOSPITAL BASED SERVICES THAT ENABLE EFFECTIVE TREATMENT AND RESTORATIVE HEALTHCARE FOR WESTERN AUSTRALIANS		
Unplanned hospital readmissions of public hospital patients within 28 days for selected surgical procedures (per 1,000 separations)		
a) Knee replacement	≤ 26.2	37.9
b) Hip replacement	≤ 17.2	21.8
c) Tonsillectomy & Adenoidectomy	≤ 61.0	61.6
d) Hysterectomy	≤ 41.3	15.8
e) Prostatectomy	≤ 38.8	40.4
f) Cataract surgery	≤ 1.1	0.4
g) Appendicectomy	≤ 32.9	39.2
Proportion of elective waitlist patients waiting over boundary for a reportable procedure:		
a) % Category 1 over 30 days	0%	8.7%
b) % Category 2 over 90 days	0%	9.4%
c) % Category 3 over 365 days	0%	4.8%
Total	0%	5.5%
Hospital infection rates (Healthcare-associated Staphylococcus aureus bloodstream infections (HA-SABSI) per 10,000 occupied bed-days in public hospitals)	≤ 1.0	0.64

Summary of key performance indicators

Table 4: Actual results versus KPI targets (continued)

Key performance indicator	Target	Actual
Survival rates for sentinel conditions:		
a) Stroke		
i 0-49 years	≥ 94.3%	100%
ii 50-59 years	≥ 92.4%	97%
iii 60-69 years	≥ 92.8%	95.9%
iv 70-79 years	≥ 89.5%	96.5%
v 80+ years	≥ 80.9%	85.2%
b) Acute Myocardial Infarction (AMI)		
i 0-49 years	≥ 99.2%	100%
ii 50-59 years	≥ 98.9%	100%
iii 60-69 years	≥ 98.1%	100%
iv 70-79 years	≥ 96.1%	96.8%
v 80+ years	≥ 91.7%	90.1%
c) Fractured Neck of Femur (FNOF)		
i 70-79 years	≥ 98.9%	100%
ii 80+ years	≥ 95.3%	96%
Percentage of admitted Aboriginal and Non-Aboriginal patients who discharged against medical advice	≤ 0.77%	1.7%
Percentage of live-born term infants with an Apgar score of less than 7 at 5 minutes post delivery	≤ 1.8%	1.6%
Rate of total hospital readmissions within 28 days to an acute designated mental health inpatient unit	≤ 12%	17.2%
Percentage of contacts with community-based public mental health non-admitted services within seven days post discharge from an acute public mental health inpatient unit	≥ 75%	75.6%
Average admitted cost per weighted activity unit	$7,285	$6,119
Average Emergency Department cost per weighted activity unit	$7,043	$7,292
Average non-admitted cost per weighted activity unit	$7,160	$6,035
Average cost per bed-day in specialised mental health inpatient units	$1,713	$1,728
Average cost per treatment day of non-admitted care provided by public clinical mental health services	$542	$591

Key performance indicator	Target	Actual
OUTCOME 2: PREVENTION. HEALTH PROMOTION AND AGED AND CONTINUING CARE SERVICES THAT HELP WESTERN AUSTRALIANS TO LIVE HEALTHY AND SAFE LIVES		
Response times for emergency air-based patient transport services (Percentage of emergency air-based inter-hospital transfers meeting the statewide contract target response time for priority 1 calls)	≥ 80%	78.9%
Percentage of patients who access emergency services at a small rural or remote Western Australian hospital and are subsequently discharged home	92%	90.4%
Average cost per bed-day for specialised residential care **facilities, flexible care (hostels) and nursing home type** residents	$321	$557
Average cost per person of delivering population health programs by population health units	$233	$374
Cost per trip of patient emergency air-based transport, based on the total accrued costs of these services per the total number of trips	$7,235	$7,121
Average cost per trip of Patient Assisted Travel Scheme (PATS)	$377	$440
Average cost per rural and remote population (selected small rural hospitals)	$390	$401

Improvements towards emergency department access

Emergency departments are specialist multidisciplinary units with expertise in managing acutely unwell patients for their first few hours in hospital. With an increasing demand on emergency departments and health services, it is imperative that health service provision is continually monitored to ensure the effective and efficient delivery of safe high-quality care.

PERCENTAGE OF EMERGENCY DEPARTMENT PATIENTS SEEN WITHIN RECOMMENDED TIMES (MAJOR RURAL HOSPITALS)

When patients first enter an emergency department they are assessed by specially trained nursing staff to determine how urgently treatment is required. 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.

The triage process and scores are recognised by the Australasian College for Emergency Medicine and are recommended for prioritising those who present to an emergency department. A patient is allocated a triage score between 1 (immediate) and 5 (least urgent) that indicates their treatment acuity. Treatment should commence within the recommended time of the triage category allocated (see Table 5).

Table 5: Triage category, treatment acuity and WA performance targets

Triage Category	Description	Treatment Acuity	Target
1	Immediate life-threatening	Immediate (≤ 2 minutes)	100%
2	Imminently life-threatening	≤ 10 minutes	≥ 80%
3	Potentially life-threatening or important time-critical treatment or severe pain	≤ 30 minutes	≥ 75%
4	Potentially life-serious or situational urgency or significant complexity	≤ 60 minutes	≥ 70%
5	Less urgent	≤ 120 minutes	≥ 70%

By measuring this indicator, changes over time can be monitored that assist in managing the demand on emergency department services and the effectiveness of service provision. This in turn can enable the development of improvement strategies that ensure optimal restoration to health for patients.

Improvements towards emergency department access

In 2017-18, the proportion of WA patients in major rural hospital emergency departments who were seen within recommended time was at or above the minimum benchmarks for all triage categories (see Table 6).

Table 6: Percentage of major rural hospital emergency department patients seen within recommended times by triage category 2017-18.

Triage Category	2017-18 Performance	Target
1	100%	100%
2	89%	≥80%
3	78.8%	≥75%
4	80.8%	≥70%
5	97.6%	≥70%

PERCENTAGE OF EMERGENCY ATTENDANCES WITH A TRIAGE SCORE OF 4 AND 5 NOT ADMITTED

Typically, patients who are clinically assessed as Australasian Triage Score (ATS) 4 and 5 at presentation to an emergency department are attending as lower acuity and are subsequently treated within the emergency department but may not require admission to an inpatient ward.

For a large number of country hospitals, triage 4 and 5 attendances may reflect the availability of primary care services and out-of-hours general practice options in that community. Where these services are unavailable or restrictive, community members may need to attend a rural hospital emergency department or service for treatment.

In 2017-18, the percentage of emergency department attendances triaged as category 4 and 5 and not admitted can be seen in Table 7.

Table 7: Percentage of major rural hospital emergency attendances with a triage score of 4 and 5 not admitted.

Triage Category	2016-17 (%)	2017-18 (%)
4 – Semi Urgent	91.3	91.1
5 – Non-Urgent	97.7	97.7

Clinical governance and performance

Robust systems and standards are essential for high quality health care. Independent assessment and testing of these systems and standards is important for assurance and improvement.

Clinical governance describes the system through which health organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care. This is achieved by creating an environment where there is transparent responsibility and accountability for maintaining standards and by striving for excellence in clinical care. The WA Country Health Service Clinical Governance Framework, endorsed in early 2018 has been developed to ensure that patients receive safe and high quality healthcare and that there are effective organisational safety and quality systems in place to achieve this.

QUALITY AND STANDARDS

The Australian Health Service Safety and Quality Accreditation (AHSSQA) Scheme provides the national coordination of accreditation processes required of Australian health services and the WA Country Health Service is fully accredited. The Australian Council on Safety and Quality has developed the National Safety and Quality Health Standards (NSQHS) to guide health service organisations and boards in their responsibility and obligation for clinical governance of their organisation. Accreditation under the NSQHS Standards and National Standards for Mental Health Services forms part of this assurance. In May 2018 the Pilbara region completed a rigorous five-day external assessment against the ten NSQHS Standards and National Standards for Mental Health Services (NSMHS) and has received positive feedback in advance of the official report.

The Australian Council on Healthcare Standards also oversees accreditation under the EQuIPNational Corporate Health Service Standards for corporate services with oversight of healthcare facilities, such as our regional and central corporate offices. Corporate accreditation includes the ten NSQHS Standards and is a comprehensive accreditation and quality improvement program that facilitates alignment between the corporate service and its health facilities. The application of the same standards across the organisation promotes high quality and safe care for consumers by ensuring that there are standard practices between our corporate offices and all of our hospitals and community based services.

In December 2017 Ms Christine Dennis, Chief Executive Officer of the Australian Council on Healthcare Standards presented the WA Country Health Service with a certificate to formally recognise the successful achievement of our accreditation under the corporate standards which was undertaken in May 2017. The WA Country Health Service is the first public health service in WA to achieve corporate accreditation under the NSQHS Standards.

Ms Christine Dennis, Chief Executive Officer Australian Council on Healthcare Standards presents Board Chair Professor Neale Fong with EQuIPNational Corporate Health Service Standards accreditation certificate.

Clinical governance and performance

LEARNING FROM CLINICAL INCIDENTS

The WA Country Health Service is proud of the improvements we continue to make in ensuring safe and high quality care for our patients. We strive to provide the very best, high quality consumer-centred care. In 2017-18 we achieved this for the vast majority of our patients. However, like other health services, despite the very best intentions of our dedicated staff, a small proportion of patients unfortunately experience poor outcomes which is contributed to by the care they receive.

We are committed to providing an open and transparent environment that supports and encourages our staff to report incidents in the event that something does not go to plan. Similarly, we are committed to full and open communication with patients and their families. It is internationally recognised that systems that support proactive reporting and investigation of clinical incidents are essential for learning to inform system improvements that reduce avoidable harm to patients.

In 2017-18 the WA Country Health Service utilised learnings from our clinical incident reporting and investigations to strengthen our services in the following areas:

- We continued the development of our *Patient Safety Matters* publication. *Patient Safety Matters* is a newsletter style publication that we provide to our clinicians. We use the themes that we identify through our clinical incident monitoring and reporting, combined with de-identified real clinical incidents to promote discussion between clinicians and share learnings across our many hospitals and health services. The publication highlights opportunities for improvement and provides practical guidance on how to approach similar situations, including links to evidence based resources.

In 2017-18 the publication included topics such as inter-hospital transfers, team communication and checking procedures required prior to surgical procedures.

- Falls by patients in health care facilities can lead to injury and other medical complications. Older people and patients with cognitive impairment are at increased risk of falls when they enter our facilities. As such a key part of our patient safety focus is to continually improve our practices to reduce the incidence of patient falls. Based on the national *A better way to care program* published by the Australian Commission on Safety and Quality in Health Care we are also making improvements to ensure there is early recognition and response to patients with cognitive impairment (dementia and delirium) so they receive high quality care and the risk of falls and subsequent complications is reduced.

- In early 2018 the WA Country Health Service Board and Executive approved a two-year plan to improve the safety and quality of care and services for our consumers. This includes specific actions to improve access and outcomes for people with Mental Health conditions; improve early recognition and management of patients with sepsis; and an independent process for patients and families to call staff for assistance if they are concerned about the health of the person in our care (Call and Respond Early program).

- Measuring access to emergency care and elective surgery is one way in which the WA Country Health Service ensures timely and equitable access to care as delays to treatment can affect health outcomes. We continually measure and monitor the times people need to wait for treatment, be that in a WA Country Health Service emergency department, or on a waiting list for elective surgery. Our performance against these indicators is tracked and monitored at an operational, Executive and Board level, and appropriate strategies implemented to improve performance.

Clinical governance and performance

Notwithstanding the significant effort we invest in ensuring safe and high quality care for our patients, sometimes the health care does not go to plan. In these instances clinical incidents are reported and assigned a Severity Assessment Code (SAC) rating that guides the level of investigation that is to take place. SAC 1 clinical incidents are the most serious category resulting in serious harm or death that is, or could be, specifically caused by health care rather than the patient's underlying condition or illness. All SAC 1 clinical incidents are investigated in line with the *WA Health Clinical Incident Management Policy*. We have a well-developed approach to the review of these clinical incidents and this includes oversight at the highest level by our Board Safety, Quality and Performance Committee.

During 2017-18, there were 137 incidents reported with a Severity Assessment Code rating of '1' (SAC 1). These incidents represent a very small proportion of the 124,000 annual admissions, over 450,000 outpatient appointments and nearly 400,000 patients who presented to our emergency departments. One third of the SAC 1 events resulted in no harm to the patient but were considered "near misses" that may have but did not cause harm, often through the timely intervention of our staff.

Of the 137 SAC 1 incidents, the patient outcome was noted as follows:

Patient outcome	Number
Death	38
Serious harm	54
No harm (near miss that may have but did not cause harm, either by chance or through timely intervention)	45
Total	137

WACHS applies a low threshold for reporting clinical incidents. Consistent with this approach, there were also 11 incidents that were originally reported as SAC 1 and were declassified following investigation findings that the health care provided was determined not to have contributed to the poor patient outcome and only factors related to the patient's clinical condition were identified.

One SAC 1 clinical incident reported in 2017-18 met the criteria for reporting as a national sentinel event (Medication error). National sentinel events are a discrete set of SAC 1 events that are considered wholly preventable and caused serious harm or death to a patient. Sentinel events occur infrequently and are independent of a patient's condition.

Clinical governance and performance

PREVENTING HEALTHCARE ASSOCIATED INFECTIONS

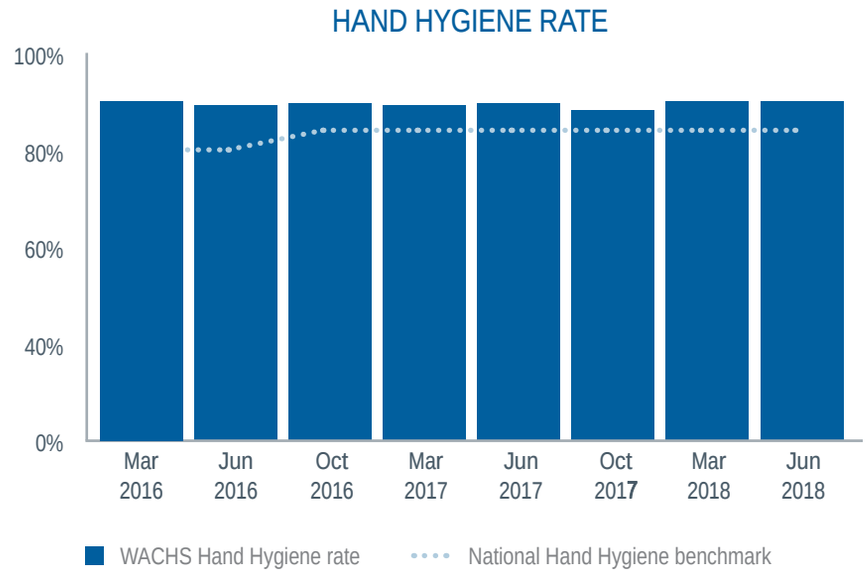
Healthcare-associated infections are the most common complication affecting patients in hospitals. They cause patients pain and suffering, prolong hospital stays and can cause significant morbidity and mortality. They also utilise significant human and financial resources for healthcare facilities.

At least half of healthcare-associated infections are thought to be preventable with infection prevention and control practices rather than inevitable complications of medical care and all healthcare facilities should aim to eliminate these infections. The reporting of hand hygiene compliance and surveillance of Staphylococcus aureus blood stream infections are infection prevention and control strategies that were incorporated into the National Healthcare agreement in 2009 as quality improvement processes to reduce Healthcare Associated Infections (HAI).

Effective hand hygiene is one of the most effective strategies in preventing healthcare associated infections. Hand Hygiene is a process that reduces the number of microorganisms on hands through the use of soap (non-antimicrobial and antimicrobial) and water or the application of an alcohol-based antimicrobial agent to the hands. The Australian Commission on Safety and Quality in Health Care introduced the National Hand Hygiene Initiative with the aim to improve hand hygiene compliance among health care workers and reduce transmission of infection. The National Hand Hygiene Initiative includes hand hygiene compliance auditing which is conducted nationally three times a year. The hand hygiene audit reviews compliance with the five key moments when healthcare workers should perform hand hygiene.

In 2017, 20,716 hand hygiene moments were captured in the national hand hygiene audits in WA Country Health Service hospitals. Our overall result has remained consistently above the national hand hygiene benchmark set by the Australian Health Ministers' Advisory which was raised in 2017 from 75% to 80%.

Chart 1: WACHS rate of hand hygiene compliance by national audit period



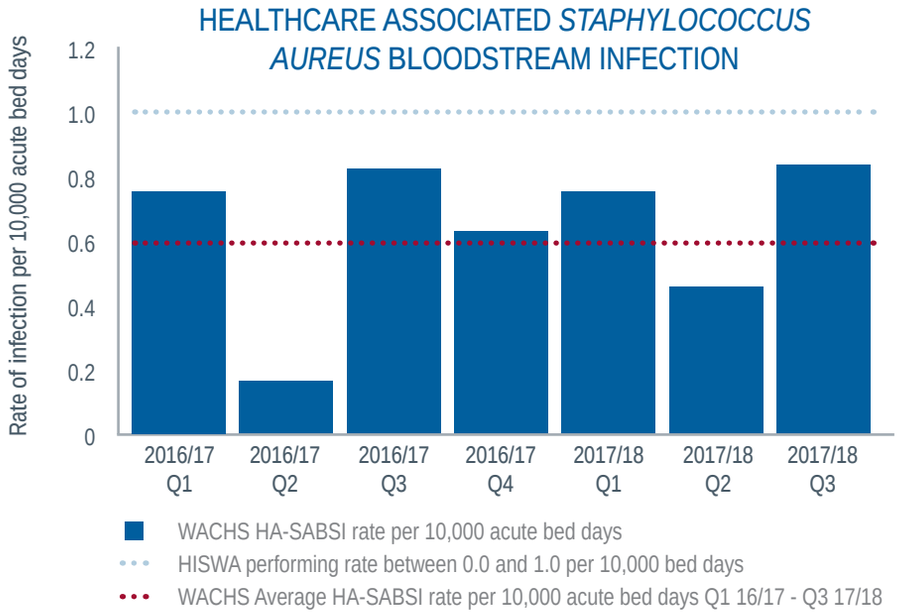
Clinical governance and performance

Healthcare associated infections (HAIs) are one of the most common causes of unintended harm suffered by health consumers. Staphylococcus aureus is a type of bacteria, often found on the skin of healthy people that can cause an infection of the bloodstream after a patient receives medical care or treatment in hospital.

Contracting a Staphylococcus aureus bloodstream infection while in hospital can be life threatening and hospitals aim to prevent these cases. The WA Country Health Service contributes to the surveillance of Healthcare-associated Staphylococcus aureus bloodstream infections (HA-SABSI) through the Healthcare Infection Surveillance Western Australia (HISWA) program. HA-SABSI's are measured as a rate of infection using the number of beds occupied by patients each day. The nationally agreed benchmark set under the National Healthcare Agreement (NHA) is a rate of less than 2.0 per 10,000 days of patient care for public hospitals in each State and Territory, however the Healthcare Infection Surveillance Western Australia (HISWA) has a lower benchmark of less than or equal to 1.0 per 10,000 bed days.

Healthcare-associated Staphylococcus aureus bloodstream infection rates at WA Country Health Service hospitals have remained within the HISWA "performing" target rate during 2016-17 and 2017-18. In 2017-18 (Q1 -3) 38% of the reported HA-SABSI in WA Country Health Service hospitals were related to intravascular devices and 31% related to a surgical procedure. The intravascular device related HA-SABSI rate has decreased from 0.35 in 2016-17 to 0.27 in 2017-18 (Q1 -3).

Chart 2: Healthcare-associated Staphylococcus aureus bloodstream infection rate per 10,000 acute bed days in WACHS hospitals



Patient experience and satisfaction

The Patient Evaluation of Health Services survey is conducted annually to gauge patient satisfaction levels with WA Country Health Service hospitals. In 2017–18, the Department of Health surveyed approximately 2,800 people who attended our hospitals asking them about their health care experiences during their stay.

Patient satisfaction is influenced by the seven stable aspects of health care:

- Access – getting into hospital
- Time and care – the time and attention paid to patient care
- Consistency – continuity and consistency of care
- Needs – meeting the patient's personal needs as well as clinical needs
- Informed – information and communication
- Involvement – involvement in decisions about care and treatment
- Residential – residential aspects of the hospital.

The relative importance a patient places on each of these aspects can vary over time and across patient groups.

At the beginning of each Patient Evaluation of Health Services survey, the patient is asked to rank these seven aspects of health care from most important (7) to least important (1). This helps determine the relative importance that the patients place on each aspect of care. The patient is then asked a series of questions that relate to these seven aspects of health care.

Responses from these questions are used to calculate the:

- Mean (average) satisfaction scores – represent how patients in WA Country Health Service hospitals rate each of the seven aspects of the health service, presented as a score out of 100*
- Overall indicator of satisfaction – determined by the average of the seven aspect scores, weighted by their importance as ranked by patients
- Outcome score – reflects how patients rate the outcome of their hospital stay (i.e. the impact on physical health and wellbeing).

In this year's annual report, admitted patients (children aged 0-15 years and adults aged 16-74 years) who were in hospital from 0-34 nights are presented for the WA Country Health Service.

*In 2017-18, the survey participation rate was 97 per cent, with 2,013 admitted adult patients and 724 admitted child patients** interviewed.*

*The mean scores do not represent the percentage of people who are satisfied with the service; rather they represent how patients in WACHS and WA hospitals rated a particular aspect of health service. If all the patients thought the service was average and that some improvements could be made, the score would be 50, and if they were totally satisfied with the service the score would be 100.

**Interviews for children 0–15 years are completed by a parent or carer on behalf of the child.

Patient experience and satisfaction

SATISFACTION WITH THE ASPECTS OF HEALTH CARE

The mean satisfaction scores for patients admitted to WA Country Health Service hospitals in 2017-18 were compared with the State mean satisfaction scores of each aspect (Table 9 and Table 10).

The mean scores for admitted children in WA Country Health Service hospitals did not differ significantly from the mean scores for the State (Table 9).

The mean scores for the aspects of Access and Residential were significantly higher for admitted adults for WA Country Health Service patients when compared with the State mean, as was the Overall Indicator of Satisfaction (see Table 10).

Table 9: Child admitted patients' mean scores, by location, 2017-18

Aspect	WACHS	State
Time and Care	88.6	88.2
Needs	92.0	92.2
Informed	85.5	85.3
Access	68.9	69.0
Involvement	76.9	77.2
Consistency	74.1	73.2
Residential	65.7	66.2
Overall Indicator	81.2	81.1
Outcome Score	90.1	89.7

Table 10: Adult admitted patients' mean scores, by location, 2017-18

Aspect	WACHS	State
Time and Care	90.8	90.0
Needs	93.1	92.5
Informed	86.8	85.8
Access	76.7↑	74.5
Involvement	77.4	76.6
Consistency	76.6↑	74.3
Residential	69.0↑	67.0
Overall Indicator	83.5↑	82.2
Outcome Score	88.2	87.2

↑ indicates that the WACHS mean score for 2017–18 is significantly higher than the State comparison score.

↓ indicates that the WACHS mean score for 2017–18 is significantly lower than the State comparison score.

Patient experience and satisfaction

Areas where changes or improvements might be most beneficial and appreciated by patients can be identified by comparing how patients rank the importance of the seven aspects of health care with their satisfaction with those aspects. In 2017-18, respondents of admitted children ranked Access as the fourth most important aspect of health care, however in terms of satisfaction this aspect was rated second last (see Figure 2).

In 2017-18, the order of rankings of importance and ratings of satisfaction scores were relatively equal for admitted adult patients. The greatest gains to further improve satisfaction could be made in the last four aspects: Access, Involvement, Consistency and Residential (see Figure 3).

Figure 2: Satisfaction with the aspects of health care by rank of importance, admitted children, 0–15 years, 2017-18

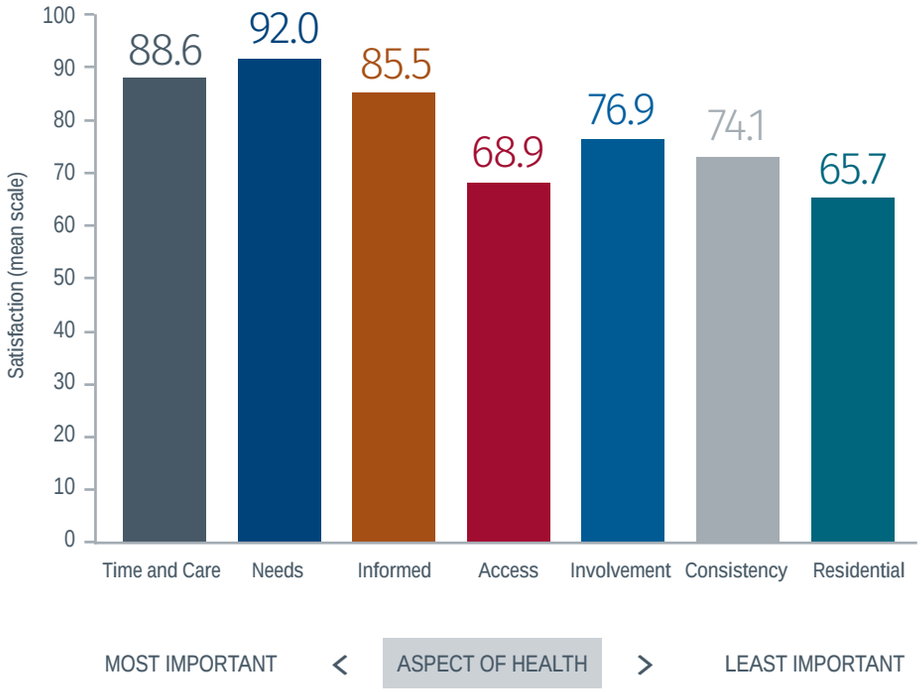
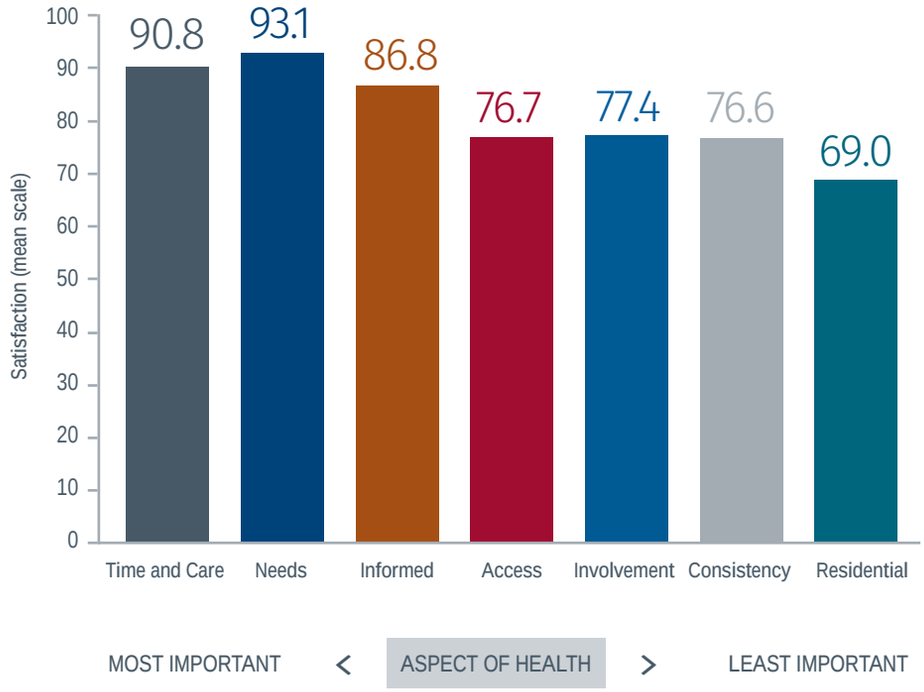


Figure 3: Satisfaction with the aspects of health care by rank of importance, admitted adults, 16–74 years, 2017-18



Patient experience and satisfaction

COMPARING SATISFACTION OVER TIME

Table 11 displays the seven major scale scores as well as the Overall Indicator of Satisfaction and Outcome Score over time for admitted children. The scores are stable over time with no significant differences between 2017-18 and the previous two years.

Table 12 displays the satisfaction scores for the seven aspects of health care as well as the Overall Indicator of Satisfaction and Outcome Score over time for admitted adults. The 2017–18 score for Consistency is significantly higher when compared with the 2016–17 score. The scores for Time and Care, Informed, Consistency, Residential and the Overall Indicator of Satisfaction were higher in 2017–18 when compared with 2015–16.

Table 11: Child admitted patients' mean scores over time, 2015-16 to 2017-18

Aspect	2017–18	2016–17	2015–16
Time and Care	88.6	87.5	87.4
Needs	92.0	91.7	91.3
Informed	85.5	84.2	83.7
Access	68.9	69.5	68.9
Involvement	76.9	76.6	77.7
Consistency	74.1	71.4	71.4
Residential	65.7	65.0	64.0
Overall Indicator	81.2	80.3	80.2
Outcome Score	90.1	89.6	90.7

Table 12: Adult admitted patients' mean scores over time, 2015-16 to 2017-18

Aspect	2017–18	2016–17	2015–16
Time and Care	90.8	89.7	89.0↑
Needs	93.1	92.5	92.3
Informed	86.8	85.5	84.7↑
Access	76.7	76.6	75.1
Involvement	77.4	76.4	76.2
Consistency	76.6	74.4↑	73.2↑
Residential	69.0	67.8	66.5↑
Overall Indicator	83.5	82.6	81.8↑
Outcome Score	88.2	88.3	88.0

↑ indicates that the WACHS mean score for 2017–18 is significantly higher than the State comparison score.

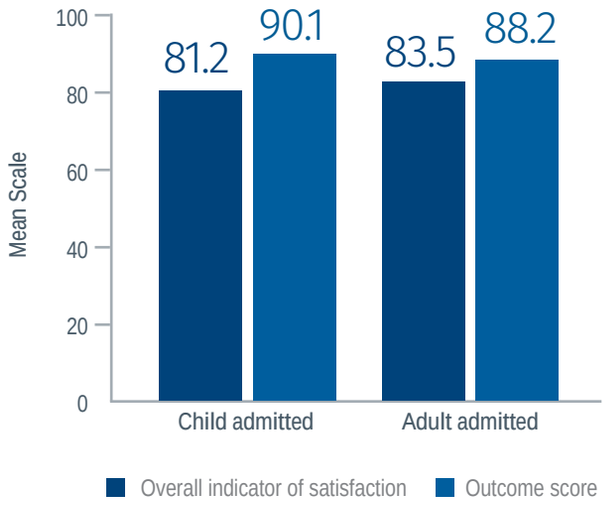
↓ indicates that the WACHS mean score for 2017–18 is significantly lower than the State comparison score.

Patient experience and satisfaction

COMPARING OVERALL SATISFACTION WITH PATIENT RATED OUTCOMES

There is a relationship between patients' overall satisfaction with health care and how patients rate the outcome of their hospital visit. Figure 4 shows that admitted child and adult patients' rated Outcome of their visit is higher than their Overall Indicator of Satisfaction. This suggests that although patients were satisfied with their experience in WA Country Health Service hospitals, they were even more satisfied with the outcome of their hospital visit and the improvement in their condition.

Figure 4: The overall indicator of satisfaction with the patient rated outcome, WACHS admitted child and adult patients, 2017-18



05 SIGNIFICANT ISSUES

Significant issues

The WA Country Health Service's primary responsibility is to provide hospital and related services to the population it serves. The population in regional WA is diverse and expansive and as a result has widely varying health needs.

HEALTH SNAPSHOT OF COUNTRY WA

The health status of country people is often poorer than the metropolitan population with a higher rate of illness and co-morbidity, particularly in areas where General Practitioners and other primary health care services are limited or not available. Life expectancy of people living in country WA is less than that of their metropolitan counterparts - 2.5 years less for men and 2.0 years less for women.

The burden of disease is higher in people living in socio-economically disadvantaged areas. In Australia, geographic areas are classed into five levels of disadvantage with level one being the most disadvantaged and level five being the least disadvantaged. Fourteen per cent of WA Country Health Service residents live in the least disadvantaged localities (those classed as level five), whereas 35 per cent of metropolitan residents live in this type of locality. Approximately 41 per cent (217,491) of country residents live in the highest areas of disadvantage (those areas classified as levels one and two). In contrast, no metropolitan residents live in localities classed as level one and only seven per cent live in localities classed as level two.

Addressing this disparity has required the WA Country Health Service to develop new and innovative models to deliver care to country communities. The expansion of telehealth, significant investments in infrastructure and technology and the development of partnerships with other health services and providers is helping us achieve great improvements in access to care.

Watch: Telehealthy - An introduction to telehealth in WA

VIEW VIDEO >

Health snapshot of country WA

COUNTRY WESTERN AUSTRALIA

Life expectancy

Metro Perth 83.1yrs VS Country WA 81.1yrs

(for births 2010-2012)

Aboriginal People		Non-Aboriginal People		Gap
Males	65yrs	Males	80.1yrs	15.1 years less
Females	70.2yrs	Females	83.7yrs	13.5 years less

(for births 2010-2012)

3X

2011- 2015 Deaths from motor vehicle accidents were almost 3x higher for country people than metro people.

12.9%

of country Aboriginal women have babies with a low birth weight.

13,144

Country people are living with cancer

2.8X

The infant mortality for Aboriginal babies is 2.8 times more than for non-Aboriginal babies.

Country people experience higher rates of chronic conditions and many are lifestyle related

Obesity statistics in 2013-16

34.6% country residents

27.8% across the State

More country people drink and smoke at high-risk levels compared with people living in the city.

Rates of:

- trachoma
- diarrhoeal disease
- skin infections

are higher in remote communities

Note: See Appendix 3 for data sources

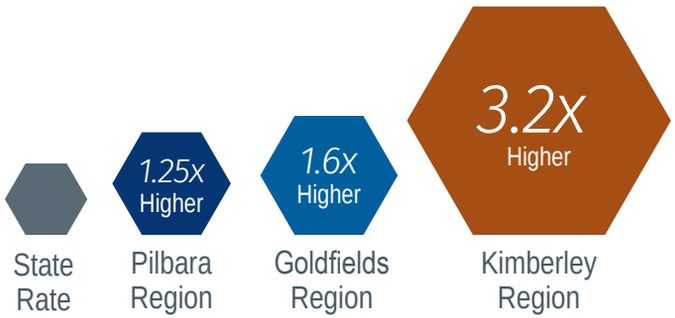
Health snapshot of country WA

COUNTRY WESTERN AUSTRALIA

43.2%

Of all potentially preventable hospitalisations in country WA were due to chronic conditions in 2015.

The rate of diabetes-related hospitalisations in 2017 was greatest in the northern regions of WA.



Hospitalisations for many types of potentially preventable conditions are greater in the Kimberley and other northern WA areas

For example

4x

The hospitalisation rate for respiratory disease is 4x higher in the Kimberley than the State rates.

4x

The hospitalisation rate for cardiac failure is 4x higher in the Kimberley than the State rates.

6.5x

The hospitalisation rate for cellulitis is 6.5x higher in the Kimberley than the State rates.

Note: See Appendix 3 for data sources

Current and emerging issues

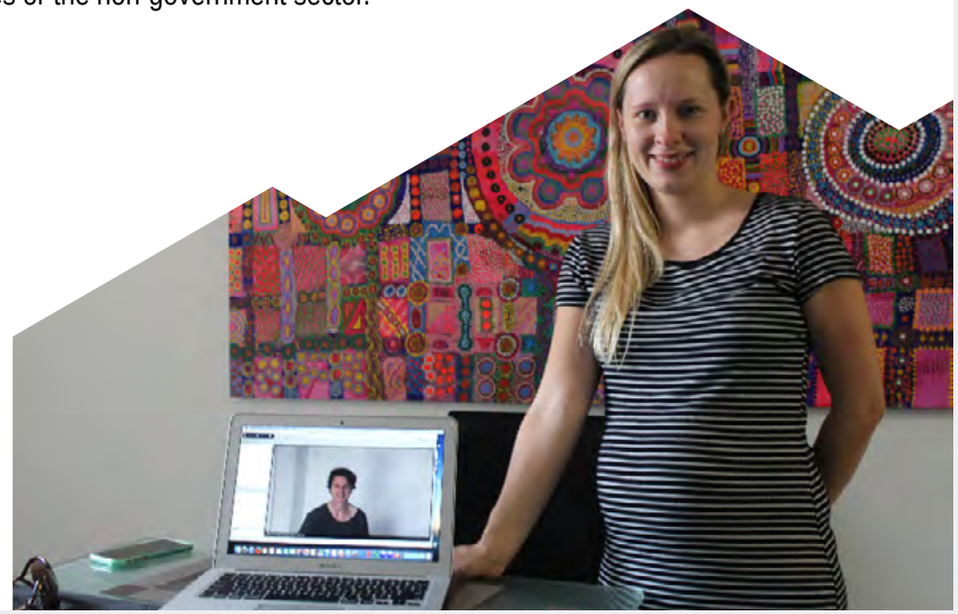
The WA Country Health Service is the major provider of hospital, health, mental health and aged care services across country WA. It is funded to provide emergency care in hospitals and nursing posts, as well as hospital-based acute services such as general medical, general surgery, mental health, obstetrics, renal dialysis and cancer services. It is also responsible for the provision of maternal and child health, public health, health promotion, chronic conditions services, mental health, drug and alcohol services and sub and post-acute services such as palliative care and rehabilitation.

In country WA, population growth and ageing in many communities is impacting on access to appropriate aged care beds and services. The total number of people aged 70 years and above has increased 21 per cent in the past five years, to more than 44,500. This age group is projected to grow 25 per cent in the next five years. The impact of an ageing population on the demand for health and older adult mental health services is well established. An ageing population changes both the mix and volume of medical procedures and services required.

Primary and aged care services are the primary responsibility of the Australian Government, however the current fee-for-service and consumer-driven funding arrangements mean that the State is often required to fill the gaps. In country WA where service viability often leads to market failure in many communities as a result of higher costs and lower volumes, the WA Country Health Service is required to fill these primary care and aged care service gaps. This ultimately has resulted in fewer GPs, fewer pharmacies and fewer aged care providers per capita in the bush.

The vast spread of the population and the corresponding small population numbers mean that it is challenging to sustain integrated health services across the state. Significant factors driving service demand include changes in population and population demographics, increased availability in the scope of local services and a higher than average burden of disease in Aboriginal and rural populations.

Systemic demographic factors also continue to be a driver, with the ageing regional population affecting residential and community aged care places. Comprehensive health services are required by, and provided to, people living in regional WA. However, limitations to service capability and capacity leads to some consumers not being able to stay in their home towns, especially as their care needs increase or become more specialised. Where this occurs, consumers need to navigate across the healthcare system, often requiring transport, acute, inpatient and outpatient services from metropolitan health services or the non-government sector.



Derby Mum-to-be Amanda Ogg completes her antenatal classes by telehealth

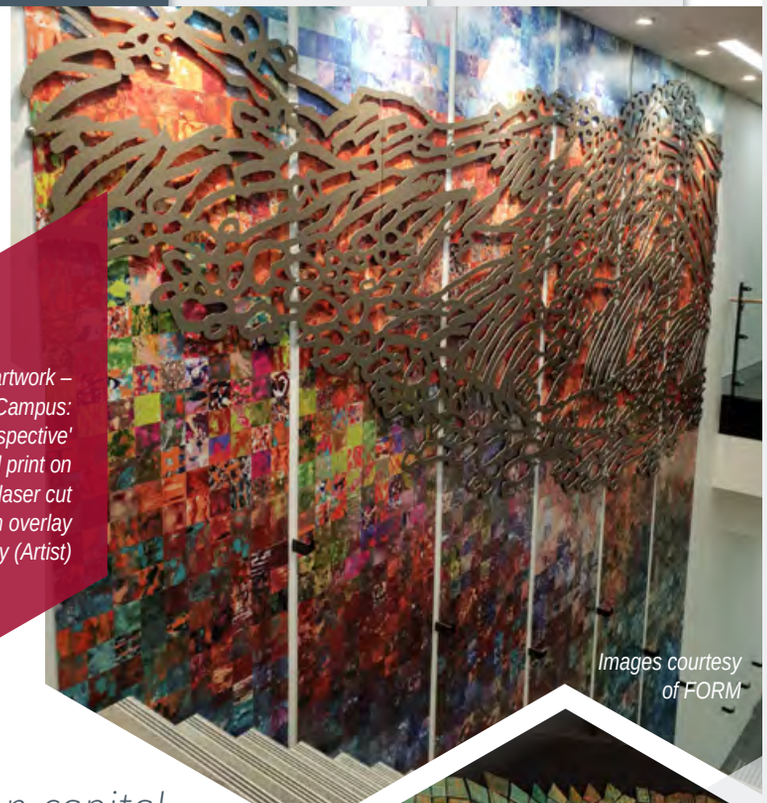
Responding to demand and activity complexity

Responding to our communities' current health needs is challenging and requires us to think innovatively about ways in which the WA Country Health Service can increase the sustainability of our services, and use our finite funding and resources in the most effective way. Initiatives aimed at improving access to services have been implemented and are expected to improve detection of chronic and other health conditions, particularly through the expansion of services available via telehealth.

The WA Country Health Service is building links with primary care providers, child health and development services, as well as building capacity in critical care and rehabilitation services. In addition, a $1.5 billion capital works program is bringing world-class health care closer to home for more people living in regional and remote WA.

Ongoing capital investment is aimed at facilitating higher levels of self-sufficiency within the regions, namely improved access and quality of emergency and primary care and improved inpatient services.

A $300 million capital works program is improving capital infrastructure in 37 towns across the Wheatbelt, Great Southern, Midwest and South West regions. In the Wheatbelt region, Merredin, Narrogin and Northam hospitals are being redeveloped, as well as upgrades to 23 small hospitals and health centres across the region.



Internal stairwell artwork – Karratha Health Campus: Title: 'A Differing Perspective' Material: digital print on aluminium and laser cut aluminium overlay Leanne Bray (Artist)

Images courtesy of FORM

A $300 million capital works program is improving capital infrastructure in 37 towns across the Wheatbelt, Great Southern, Midwest and South West regions

External Wall artwork Karratha Health Campus: Title: 'Metamorphic Life' Material: High fired porcelain with copper and iron glaze Ian Dowling -Artist, Beth Dowling – Installer, Troy Dowling – Installer

Responding to demand and activity complexity

"Redevelopments such as those happening throughout the Wheatbelt mean that we can continue to offer high quality care to our patients without them having to travel great distances to the city to receive treatment" Sean Conlan Regional Director Wheatbelt

Watch: Young Tayten gets her "normal" life back, thanks to telehealth

VIEW VIDEO >

Progress towards meeting service demand requirements in 2017-18 included:

- Continued construction of the $207.15 million Karratha Health Campus - the biggest investment in a public hospital ever undertaken in regional WA.
- Construction of the Onslow Health Campus redevelopment. The final stage being scheduled for completion in October 2018.
- Redevelopment of the emergency department at the Collie Health Service and the new $39 million Warren Health Service in Manjimup.
- Completion of the $13 million redevelopment at Harvey Health Service; and the Midwest Cancer Centre.
- Commencement of planning for the $73 million Geraldton Health Campus Stage 1 redevelopment and Midwest mental health service. This investment will deliver a combination of new build and refurbished infrastructure including an expanded emergency department and critical care unit; an acute psychiatric unit; a mental health short stay unit; and essential engineering service upgrades to the existing infrastructure.
- Increased access to the Emergency Telehealth Service, providing patients and staff with state-of-the-art access to high quality emergency and inpatient care.
- Increased access to outpatient and clinical services via telehealth.

Mural: Title: 'Efflorescence' Material: Paint
Pictured - Kyle Hughes Odgers (Artist)
Image courtesy of FORM

Workforce challenges and initiatives

The WA Country Health Service area covers approximately 2.55 million square kilometres. Some of our hospitals and many of our health services and nursing posts are in remote locations and attracting permanent clinical staff to these locations can be difficult.

Key workforce challenges in attracting and retaining clinical staff can at times require innovative or alternate solutions to ensure the uninterrupted provision of medical, nursing and allied health care services within regional areas. Ensuring that we are able to attract and retain a diverse and skilled workforce remains an ongoing and key area of focus for the organisation.

During 2017-18, we implemented innovative staffing models to address regional staff requirements across nursing and midwifery, medical, allied health, mental health and Aboriginal health. This included the continuation of the WA Country Health Service Aboriginal Mentorship Program which now has trained 42 Aboriginal mentors across the state.

Our staff have access to a range of leadership development opportunities which include formal programs offered externally via the Public Sector Commission as well as tailored development coordinated internally. New and aspiring managers have access to an internal management development program that includes ten modules designed to assist existing and aspiring managers to understand and gain knowledge in managing services within the organisation. Over the course of 2017-18 we have also developed a Future Leaders Program which is a tailored program designed to assist staff who aspire to senior roles within the health service to obtain targeted and essential leadership and management development.

Supporting and facilitating learning programs that enable the development and maintenance of professional skills is a key focus for the organisation in attracting and retaining a competent and skilled workforce that is aligned with service needs across disciplines. The WA Country Health Service Learning and Development framework ensures ongoing skills development and learning to support the delivery of safe, high quality and consumer-centred care.

Learning and development across the organisation is facilitated through the Learning and Development Network, an organisation-wide network represented by a range of discipline areas, including the Medical Education Unit, Nursing and Midwifery Services, aged care, allied health, regional staff development educators and learning and development coordinators. Further to this, the management, publication and reporting of training and development achievements and delivery of tailored programs is enabled and supported by an organisation-wide Learning Management System.

In January 2018, the organisation welcomed the second cohort of medical interns who are based at Bunbury and Albany Hospitals. Both hospitals benefit with five interns each, but experience shows that regional Western Australia will be the big winner; doctors who train in the country are more likely to practice in country areas. This is evidenced by the 2017 group of ten interns all choosing to take up employment in country WA as Resident Medical Officers in Albany, Bunbury and Geraldton in 2018.

Working in partnership with key stakeholders, such as the Integrated Rural Training Hubs, in 2017-18 the Medical Education Unit team attended many events aimed at medical students and early career doctors to promote the benefits of working in the country as part of our efforts to attract and retain the rural medical workforce for the future. In addition, the team manages a range of specialist training programs, including the highly successful Community Residency Program (CRP) which continues to be over-subscribed by medical officers seeking the opportunity to gain experience in rural and community-based health care. In 2018 three new CRP placements were commenced in Esperance, Narrogin and Albany.

OUR VALUES IN ACTION

Great Southern staff reaching for new heights

Staff in the Great Southern region are working hard to deliver culturally secure health services to improve the lives of Aboriginal people in their local communities. The WA Country Health Service is committed to developing a workforce culture and environment that supports the employment and retention of Aboriginal people to help 'close the gap' between Aboriginal patients and other health services.

Having familiar faces within the community to provide a local connection and help reach those who would not normally engage with traditional health services is a key driver.

The Great Southern Aboriginal Health Service is working with staff across the region, supporting those with aspirations to reach new heights in their health careers.

Katanning Aboriginal Health Workers Debbie Yarran and Marie Abrahams are both currently training in a Certificate IV Aboriginal Health Work with the 18-month course providing a mix of online and face-to-face learning in Bunbury.

In the lower Great Southern a trio of staff are embarking on Enrolled Nurse training. Senior Aboriginal Health Worker Chantelle Van Der Brugge and Health Promotion Officer Jye Walker began their training in 2017 and have extensive training and practical blocks under their belts. Albany receptionist Eden Coyne is also undertaking bridging qualifications to enable her to enter the Enrolled Nursing course and is currently at South Regional TAFE completing a Certificate II in Health Services.

While all five admit their communities and colleagues miss them when they are away, the skills they are learning will enable them to provide a greater depth of services for their communities in the long run.

Health Promotion Officer Jye Walker, Albany receptionist Eden Coyne and Senior Aboriginal Health Worker Chantelle Van Der Brugge

New skills will enable staff to provide a greater depth of services for the community

Katanning Aboriginal Health Workers Marie Abraham and Debbie Yarran

Sustainable Health Review

The Sustainable Health Review (SHR) was announced by the State Government in June 2017 to develop a more sustainable health system for Western Australia. The Review, chaired by a panel of experts appointed by the Government of Western Australia, seeks to prioritise the delivery of patient-centred, high quality and financially sustainable healthcare across the State into the future.

In 2017 the panel sought input and received submissions from a range of individuals and organisations. After collecting input from our consumers, clinicians, managers and staff from across our regional areas the WA Country Health Service Board and management have provided a response and recommendations for consideration of the Panel. Input to our submission included insights from our key consumer advisory groups the District Health Advisory Committees.

In its submission, the organisation provided a summary of the significant challenges facing country communities and the critical importance of taking steps to ensure a sustainable health system into the future – one that recognises and enhances the delivery of services to country communities while ensuring the ongoing viability and sustainability of those services such that they are responsive to the needs of country communities into the future. These included strategies to make enhancements to regional aged care, patient transport and ambulance services, investment in digital capacity to ensure access to technology across the state.

Many of the issues raised by the WA Country Health Service have been recognised in the panel's interim report released in early 2018 highlighting in particular in their preliminary directions a need to develop new ways to support equity in country health and better utilising resources with more care in the community. Telehealth and virtual care has been acknowledged as a key enabler of new models of care in the community and as a means of supporting country health service delivery with areas noted for immediate action including a pilot of the Emergency Telehealth Service model in at least one other specialty in the country and metropolitan area. Further work to be investigated includes developing options for seamless and safe patient movement across the system and more formalised links between metropolitan and country hospitals to better support patient care and professional development for staff.

The valuable insights gathered from our stakeholders throughout the process of developing the WA Country Health Service submission have been gathered to be further utilised in the development of the organisation's strategic plan beyond 2018.

The panel's final report is due in late 2018 and we look forward to continuing to work towards the aims of the review.

Pemberton Emergency Telehealth Service - Marion and Ava Fuge with WACHS Nurse Jess Byers and Dr Mlungisi Mahlangu

OUR VALUES IN ACTION

Aboriginal mentorship blazing trails in Kimberley

Since its inception in 2014 the successful WA Country Health Service Aboriginal Mentorship Program (AMP) has supported many Aboriginal staff to study, apply for promotions, undergo training and create career pathways. The program continued this year with two courses held in the Kimberley. The program **aims to help build confidence and mentoring** support for our Aboriginal staff across the state. Aboriginal staff play a critical role in providing accessible and culturally secure services ultimately to assist in improving health outcomes for Aboriginal people.

In February, eight staff took part in an AMP train the trainer course in Broome, followed by a workshop in Kununurra where 14 staff underwent training to become mentors.

"We are excited about the AMP for the Kimberley." Aboriginal Health Consultant Jo Gray said, "Tailoring the program for our region has been important in helping us ensure that our Aboriginal workforce feel supported and to increase our staff retention."

"The Kimberley region has many communities that will benefit from mentoring Aboriginal people to seek employment with the WA Country Health Service in hospital and community settings," Jo said. "The pressure within diverse health professional roles in the workplace and contributing social and cultural responsibilities in the family and community can be challenging."

Corporate Aboriginal staff member Johari Bin Demin agreed that mentoring would contribute to retaining Aboriginal staff. "This is especially important in remote areas such as the Kimberley, where the health issues within the Aboriginal population can be both personal and overwhelming for WACHS's Aboriginal staff."

Supporting and mentoring Aboriginal staff within our organisation plays a very crucial role in addressing the huge disparity in health outcomes between Aboriginal people and non-Aboriginal people throughout the state. Kununurra course participant Sam Miller said the mentor program had led to better communication within the service about Aboriginal and non-Aboriginal ways. "There is better support for Aboriginal people, someone to go to and talk about issues and understand processes," she said.

"Through my work I have been mentored and supported so that now I have the confidence to be able to support, mentor and give advice to others. I feel very proud and it's like my previous hurt is healing."

Front (L-R): Bev Stone, Wendy George, Cecilia Rivers, Mareeka Patrick, Aimee Trust, Dr Duy Tran, Sam Miller, Jo Warren; Back: Jo Gray, Nawoola Davey, Sarah Tobias, Johari Bin Demin, Vernon Dann, Nicola Turschwell, Will Morrow, Kate Woods.

Supporting and mentoring Aboriginal staff within our organisation plays a very crucial role

06 DISCLOSURE & COMPLIANCE

Audit Opinion

Auditor General

INDEPENDENT AUDITOR'S REPORT

To the Parliament of Western Australia

WA COUNTRY HEALTH SERVICE

Report on the Financial Statements

Opinion
I have audited the financial statements of the WA Country Health Service which comprise the Statement of Financial Position as at 30 June 2018, the Statement of Comprehensive Income, Statement of Changes in Equity, Statement of Cash Flows for the year then ended, and Notes comprising a summary of significant accounting policies and other explanatory information.

In my opinion, the financial statements are based on proper accounts and present fairly, in all material respects, the operating results and cash flows of the WA Country Health Service for the year ended 30 June 2018 and the financial position at the end of that period. They are in accordance with Australian Accounting Standards, the *Financial Management Act 2006* and the Treasurer's Instructions.

Basis for Opinion
I conducted my audit in accordance with the Australian Auditing Standards. My responsibilities under those standards are further described in the *Auditor's Responsibilities for the Audit of the Financial Statements* section of my report. I am independent of the Health Service in accordance with the *Auditor General Act 2006* and the relevant ethical requirements of the Accounting Professional and Ethical Standards Board's APES 110 *Code of Ethics for Professional Accountants* (the Code) that are relevant to my audit of the financial statements. I have also fulfilled my other ethical responsibilities in accordance with the Code. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Responsibility of the Board for the Financial Statements
The Board is responsible for keeping proper accounts, and the preparation and fair presentation of the financial statements in accordance with Australian Accounting Standards, the *Financial Management Act 2006* and the Treasurer's Instructions, and for such internal control as the Board determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Board is responsible for assessing the agency's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Western Australian Government has made policy or funding decisions affecting the continued existence of the Health Service.

Auditor's Responsibility for the Audit of the Financial Statements
As required by the *Auditor General Act 2006*, my responsibility is to express an opinion on the financial statements. The objectives of my audit are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with Australian Auditing Standards will always detect a material misstatement when it exists.

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

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

As part of an audit in accordance with Australian Auditing Standards, I exercise professional judgment and maintain professional scepticism throughout the audit. I also:

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for my opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the agency's internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Board.
- Conclude on the appropriateness of the Board's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the agency's ability to continue as a going concern. If I conclude that a material uncertainty exists, I am required to draw attention in my auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify my opinion. My conclusions are based on the audit evidence obtained up to the date of my auditor's report.
- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

I communicate with the Board regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

Report on Controls

Opinion
I have undertaken a reasonable assurance engagement on the design and implementation of controls exercised by the WA Country Health Service. The controls exercised by the Health Service are those policies and procedures established by the Board 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 (the overall control objectives).

My opinion has been formed on the basis of the matters outlined in this report.

In my opinion, in all material respects, 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 2018.

Audit Opinion

The Board's Responsibilities
The Board is responsible for designing, implementing and maintaining controls to ensure that the receipt, expenditure and investment of money, the acquisition and disposal of property, and the incurring of liabilities are in accordance with the *Financial Management Act 2006*, the Treasurer's Instructions and other relevant written law.

Auditor General's Responsibilities
As required by the *Auditor General Act 2006*, my responsibility as an assurance practitioner is to express an opinion on the suitability of the design of the controls to achieve the overall control objectives and the implementation of the controls as designed. I conducted my engagement in accordance with Standard on Assurance Engagements ASAE 3150 *Assurance Engagements on Controls* issued by the Australian Auditing and Assurance Standards Board. That standard requires that I comply with relevant ethical requirements and plan and perform my procedures to obtain reasonable assurance about whether, in all material respects, the controls are suitably designed to achieve the overall control objectives and the controls, necessary to achieve the overall control objectives, were implemented as designed.

An assurance engagement to report on the design and implementation of controls involves performing procedures to obtain evidence about the suitability of the design of controls to achieve the overall control objectives and the implementation of those controls. The procedures selected depend on my judgement, including the assessment of the risks that controls are not suitably designed or implemented as designed. My procedures included testing the implementation of those controls that I consider necessary to achieve the overall control objectives.

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

Limitations of Controls
Because of the inherent limitations of any internal control structure it is possible that, even if the controls are suitably designed and implemented as designed, once the controls are in operation, the overall control objectives may not be achieved so that fraud, error, or noncompliance with laws and regulations may occur and not be detected. Any projection of the outcome of the evaluation of the suitability of the design of controls to future periods is subject to the risk that the controls may become unsuitable because of changes in conditions.

Report on the Key Performance Indicators

Opinion
I have undertaken a reasonable assurance engagement on the key performance indicators of the WA Country Health Service for the year ended 30 June 2018. The key performance indicators are the key effectiveness indicators and the key efficiency indicators that provide performance information about achieving outcomes and delivering services.

In my opinion, in all material respects, 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 2018.

Matter of Significance
The Under Treasurer approved the removal of the following indicator as an audited key performance indicator (KPI):

- Percentage of Emergency Department patients seen within recommended times (major rural hospitals)

The approval was conditional on its inclusion as an unaudited performance indicator in the Annual Report and that it be reinstated as an audited KPI following the implementation of a new Emergency Department data collection system. A new system had not been developed at 30 June 2018. Consequently, the KPI has not been included in the audited KPIs for the year ended 30 June 2018. My opinion is not modified in respect of this matter.

Emphasis of Matter
Attention is drawn to the effectiveness indicator "Proportion of elective wait list patients waiting over boundary for reportable procedures". The notes to this indicator explain that comparative information has not been reported because of errors in the data used to calculate this KPI in 2016-17. My opinion is not modified in respect of this matter.

The Board's Responsibility for the Key Performance Indicators
The Board 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 internal control as the Board determines necessary to enable the preparation of key performance indicators that are free from material misstatement, whether due to fraud or error.

In preparing the key performance indicators, the Board is responsible for identifying key performance indicators that are relevant and appropriate having regard to their purpose in accordance with Treasurer's Instruction 904 *Key Performance Indicators*.

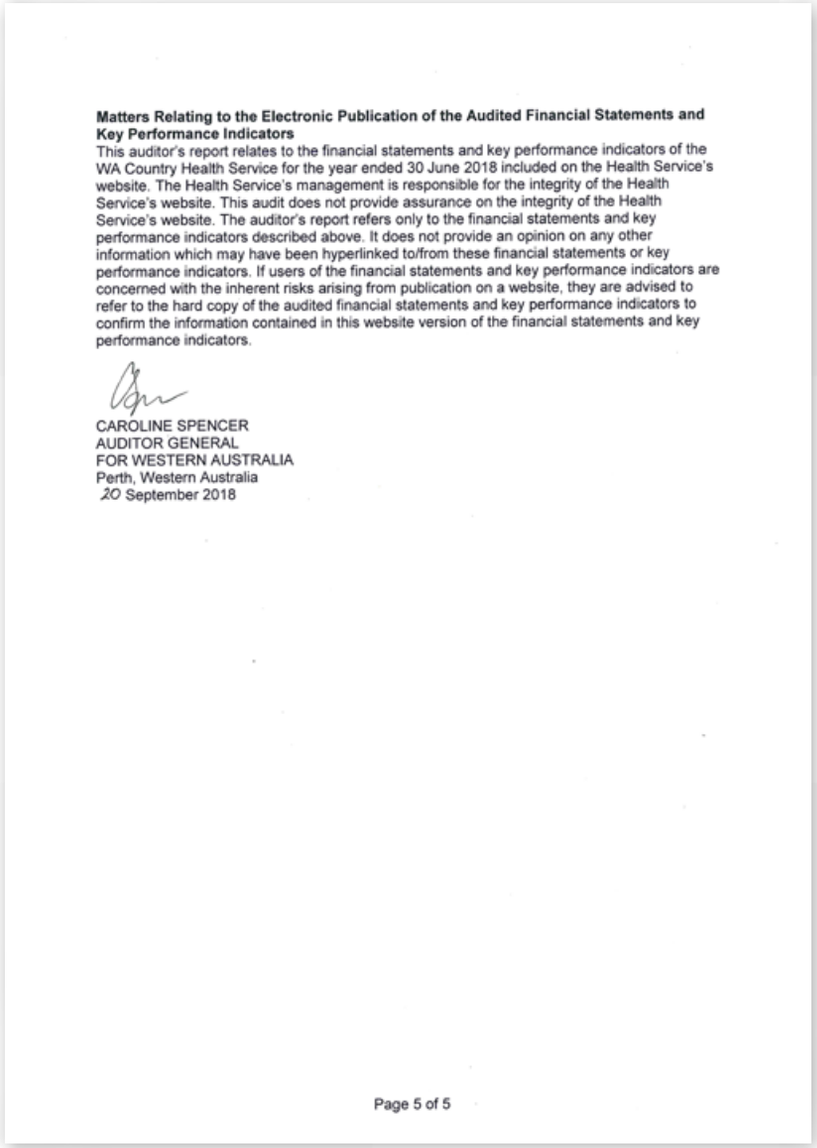
Auditor General's Responsibility
As required by the *Auditor General Act 2006*, my responsibility as an assurance practitioner is to express an opinion on the key performance indicators. The objectives of my engagement are to obtain reasonable assurance about whether the key performance indicators are relevant and appropriate to assist users to assess the agency's performance and whether the key performance indicators are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. I conducted my engagement in accordance with Standard on Assurance Engagements ASAE 3000 *Assurance Engagements Other than Audits or Reviews of Historical Financial Information* issued by the Australian Auditing and Assurance Standards Board. That standard requires that I comply with relevant ethical requirements relating to assurance engagements.

An assurance engagement involves performing procedures to obtain evidence about the amounts and disclosures in the key performance indicators. It also involves evaluating the relevance and appropriateness of the key performance indicators against the criteria and guidance in Treasurer's Instruction 904 for measuring the extent of outcome achievement and the efficiency of service delivery. The procedures selected depend on my judgement, including the assessment of the risks of material misstatement of the key performance indicators. In making these risk assessments I obtain an understanding of internal control relevant to the engagement in order to design procedures that are appropriate in the circumstances.

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

My Independence and Quality Control Relating to the Reports on Controls and Key Performance Indicators
I have complied with the independence requirements of the *Auditor General Act 2006* and the relevant ethical requirements relating to assurance engagements. In accordance with ASQC 1 *Quality Control for Firms that Perform Audits and Reviews of Financial Reports and Other Financial Information, and Other Assurance Engagements*, the Office of the Auditor General maintains a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

Audit Opinion



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 2018 included on the Health Service's website. The Health Service's management is 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.

CAROLINE SPENCER
AUDITOR GENERAL
FOR WESTERN AUSTRALIA
Perth, Western Australia
20 September 2018

Page 5 of 5

Certification of financial statements

WA COUNTRY HEALTH SERVICE CERTIFICATION OF FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2018

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 2018 and financial position as at 30 June 2018.

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

MR JOHN ARKELL
CHIEF FINANCE OFFICER
WA COUNTRY HEALTH SERVICE

19 September 2018

PROFESSOR NEALE FONG
CHAIR WA COUNTRY HEALTH SERVICE BOARD

19 September 2018

MR ALAN FERRIS
BOARD MEMBER
WA COUNTRY HEALTH SERVICE BOARD

19 September 2018

Financial statements

Statement of Comprehensive Income

For the year ended 30 June 2018

	Note	2018 $000	2017 $000
COST OF SERVICES			
Expenses			
Employee benefits expense	3.1	1,002,713	958,399
Fees for visiting medical practitioners	3.2	85,859	84,071
Patient support costs	3.2	381,124	398,039
Finance costs	7.2	138	199
Depreciation and amortisation expense	5.1, 5.2	74,005	77,016
Asset revaluation decrement	5.1	17,566	54,218
Loss on disposal of non-current assets	5.1	3,406	1,338
Repairs, maintenance and consumable equipment	3.3	49,200	48,147
Other expenses	3.3	165,559	161,643
Total cost of services		**1,779,570**	**1,783,070**
INCOME			
Revenue			
Patient charges	4.4	67,187	68,996
Commonwealth grants and contributions	4.2	484,181	467,570
Other grants and contributions	4.3	95,652	102,849
Donation revenue		551	637
Other revenue	4.5	22,589	23,738
Total revenue		670,160	663,790
Total income other than income from State Government		**670,160**	**663,790**
NET COST OF SERVICES		**1,109,410**	**1,119,280**
INCOME FROM STATE GOVERNMENT			
Service appropriations	4.1	948,805	943,451
Assets assumed	4.1	(67)	43
Services received free of charge	4.1	55,373	56,107
Royalties for Regions Fund	4.1	71,723	86,489
Total income from State Government		**1,075,834**	**1,086,090**
DEFICIT FOR THE PERIOD		**(33,576)**	**(33,190)**
OTHER COMPREHENSIVE INCOME/(LOSS)			
Items not reclassified subsequently to profit or loss			
Changes in asset revaluation reserve		-	-
Gains/(losses) recognised directly in equity		-	-
Total other comprehensive income		-	-
TOTAL COMPREHENSIVE INCOME/(LOSS) FOR THE PERIOD		**(33,576)**	**(33,190)**

Refer also to note 2.2 'Schedule of Income and Expenses by Service'.

The Statement of Comprehensive Income should be read in conjunction with the accompanying notes.

Statement of Financial Position

As at 30 June 2018

	Note	2018 $000	2017 $000
ASSETS			
Current Assets			
Cash and cash equivalents	7.3	18,173	18,949
Restricted cash and cash equivalents	7.3	25,342	37,369
Receivables	6.1	23,647	23,752
Inventories	6.3	5,157	5,270
Prepayments	6.3	4,328	5,067
Total Current Assets		76,647	90,407
Non-Current Assets			
Restricted cash and cash equivalents	7.3	7,463	3,840
Amounts receivable for services	6.2	748,497	674,420
Property, plant and equipment	5.1	1,916,214	1,777,418
Intangible assets	5.2	17,338	13,941
Total Non-Current Assets		2,689,512	2,469,619
Total Assets		**2,766,159**	**2,560,026**
LIABILITIES			
Current Liabilities			
Payables	6.4	116,019	119,198
Borrowings	7.1	1,779	1,701
Provisions	3.1	143,401	131,606
Other current liabilities		52	22
Total Current Liabilities		261,251	252,527
Non-Current Liabilities			
Borrowings	7.1	1,865	3,644
Provisions	3.1	27,885	26,405
Total Non-Current Liabilities		29,750	30,049
Total Liabilities		**291,001**	**282,576**
NET ASSETS		**2,475,158**	**2,277,450**
EQUITY			
Contributed equity	9.9	2,541,924	2,310,640
Reserves		-	-
Accumulated deficit		(66,766)	(33,190)
TOTAL EQUITY		**2,475,158**	**2,277,450**

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

Financial statements

Statement of Changes in Equity
For the year ended 30 June 2018

	Note	2018 $000	2017 $000
CONTRIBUTED EQUITY	9.9		
Balance at start of period		2,310,640	-
Transfer of net asset by owners		-	2,196,393
Transactions with owners in their capacity as owners:			
Capital appropriations		27,781	20,439
Royalties for Regions Fund		206,831	94,506
Other contributions by owners		695	2
Distributions to owners		(4,023)	(700)
Balance at end of period		2,541,924	2,310,640
RESERVES			
Asset Revaluation Reserve			
Balance at start of period		-	-
Comprehensive income/(loss) for the period		-	-
Balance at end of period			-
ACCUMULATED SURPLUS			
Balance at start of period		(33,190)	-
Deficit for the period		(33,576)	(33,190)
Balance at end of period		(66,766)	(33,190)
TOTAL EQUITY			
Balance at start of period		2,277,450	-
Total comprehensive income/(loss) for the period		(33,576)	(33,190)
Transactions with owners in their capacity as owners		231,284	2,310,640
Balance at end of period		**2,475,158**	**2,277,450**

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

Statement of Cash Flows
For the year ended 30 June 2018

	Note	2018 $000 Inflows (Outflows)	2017 $000 Inflows (Outflows)
CASH FLOWS FROM STATE GOVERNMENT			
Service appropriations		874,584	855,497
Capital appropriations		26,080	18,815
Royalties for Regions Fund		278,554	180,995
Net cash provided by State Government		**1,179,218**	**1,055,307**
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Employee benefits		(997,236)	(938,947)
Supplies and services		(604,092)	(636,892)
Receipts			
Receipts from customers		64,412	70,696
Commonwealth grants and contributions		484,181	467,570
Other grants and contributions		95,653	102,849
Donations received		521	622
Other receipts		26,532	21,795
Net cash used in operating activities	7.3	**(930,029)**	**(912,307)**
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments			
Purchase of non-current physical assets		(258,369)	(149,067)
Net cash used in investing activities		**(258,369)**	**(149,067)**
Net increase / (decrease) in cash and cash equivalents		(9,180)	(6,067)
Cash and cash equivalents at the beginning of the period		60,158	-
Cash and cash equivalents transferred in from abolished entity		-	66,225
CASH AND CASH EQUIVALENTS AT THE END OF PERIOD	7.3	**50,978**	**60,158**

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

Financial statements

Notes to the Financial Statements
For the year ended 30 June 2018

Note 1 Basis of preparation

WA Country Health Service is a WA Government entity and is controlled by the State of Western Australia, which is the ultimate parent. It is a not-for-profit entity (as profit is not its principal objective).

A description of the nature of its operations and its principal activities have been included in the '**Overview**' which does not form part of these financial statements.

These annual financial statements were authorised for issue by the Accountable Authority of the WA Country Health Service on 19 September 2018.

Statement of compliance

These general purpose financial statements have been prepared in accordance with:

1) The *Financial Management Act 2006*
2) The Treasurer's Instructions
3) Australian Accounting Standards including applicable interpretations
4) Where appropriate, those AAS paragraphs applicable for not-for-profit entities have been applied.

The *Financial Management Act 2006* and the Treasurer's Instructions take precedence over the Australian Accounting Standards. Several Australian Accounting Standards are modified by the Treasurer's Instructions to vary application, disclosure format and wording. 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.

Basis of preparation

These financial statements are presented in Australian dollars applying the accrual basis of accounting and using the historical cost convention. Certain balances will apply a different measurement basis (such as the fair value basis). Where this is the case the different measurement basis is disclosed in the associated note. All values are rounded to the nearest thousand dollars

Judgements and estimates

Judgements, estimates and assumptions are required to be made about financial information being presented. The significant judgements and estimates made in the preparation of these financial statements are disclosed in the notes where amounts affected by those judgements and/or estimates are disclosed. Estimates and associated assumptions are based on professional judgements derived from historical experience and various other factors that are believed to be reasonable under the circumstances.

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 TI 955 *Contributions by Owners made to Wholly Owned Public Sector Entities* and have been credited directly to Contributed Equity.

The transfers 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.

Note 2 WA Country Health Service outputs

How WA Country Health Service operates

This section includes information regarding the nature of funding the WA Country Health Service receives and how this funding is utilised to achieve its objectives. This note also provides the distinction between controlled funding and administered funding:

	Note
WA Country Health Service objectives	2.1
Schedule of Income and Expenses by Service	2.2

2.1 WA Country Health Service objectives

Mission

WA Country Health Service's purpose is to improve country people's health and wellbeing through access to quality services and by supporting people to look after their own health.

WA Country Health Service is predominantly funded by Parliamentary appropriations.

Notes to the Financial Statements
For the year ended 30 June 2018

Note 2 WA Country Health Service outputs (continued)

2.1 WA Country Health Service objectives (continued)

Services

The key services of WA Country Health Service are:

1. Public Hospital Admitted Services

The provision of healthcare services to patients in major rural hospitals that meet the criteria for admission and receive treatment and/or care for a period of time, including public patients treated in private facilities under contract to WA Health. Admission to hospital and the treatment provided may include access to acute and/or subacute inpatient services, as well as hospital in the home services. Public Hospital Admitted Services includes teaching, training and research activities provided by the public health service to facilitate development of skills and acquisition or advancement of knowledge related to admitted services. This Service does not include any component of the Mental Health Services reported under Service four "Mental Health Services".

2. Public Hospital Emergency Services

The provision of services for the treatment of patients in emergency departments of major rural hospitals, inclusive of public patients treated in private facilities under contract to WA Health. The services provided to patients are specifically designed to provide emergency care, including a range of pre-admission, post-acute and other specialist medical, allied health, nursing and ancillary services. Public Hospital Emergency Services includes teaching, training and research activities provided by the public health service to facilitate development of skills and acquisition or advancement of knowledge related to emergency services. This Service does not include any component of the Mental Health Services reported under Service four "Mental Health Services".

3. Public Hospital Non-admitted Services

The provision of major rural hospital services to patients who do not undergo a formal admission process, inclusive of public patients treated by private facilities under contract to WA Health. This Service includes services provided to patients in outpatient clinics, community based clinics or in the home, procedures, medical consultation, allied health or treatment provided by clinical nurse specialists. Public Hospital Non-Admitted Services includes teaching, training and research activities provided by the public health service to facilitate development of skills and acquisition or advancement of knowledge related to non-admitted services. This Service does not include any component of the Mental Health Services reported under Service four "Mental Health Services".

4. Mental Health Services

The provision of inpatient services where an admitted patient occupies a bed in a designated mental health facility or a designated mental health unit in a hospital setting; and the provision of non-admitted services inclusive of community and ambulatory specialised mental health programs such as prevention and promotion, community support services, community treatment services, community bed based services and forensic services. This Service includes the provision of state-wide mental health services such as perinatal mental health and eating disorder outreach programs as well as the provision of assessment, treatment, management, care or rehabilitation of persons experiencing alcohol or other drug use problems or co-occurring health issues. Mental Health Services includes teaching, training and research activities provided by the public health service to facilitate development of skills and acquisition or advancement of knowledge related to mental health or alcohol and drug services. This service includes public patients treated in private facilities under contract to WA Health.

5. Aged and Continuing Care Services

The provision of aged and continuing care services and community based palliative care services. Aged and continuing care services include programs that assess the care needs of older people, provide functional interim care or support for older, frail, aged and younger people with disabilities to continue living independently in the community and maintain independence, inclusive of the services provided by the WA Quadriplegic Centre. Aged and Continuing Care Services is inclusive of community based palliative care services that are delivered by private facilities under contract to WA Health, which focus on the prevention and relief of suffering, quality of life and the choice of care close to home for patients.

6. Public and Community Health Services

The provision of healthcare services and programs delivered to increase optimal health and wellbeing, encourage healthy lifestyles, reduce the onset of disease and disability, reduce the risk of long-term illness as well as detect, protect and monitor the incidence of disease in the population. Public and Community Health Services includes public health programs, Aboriginal health programs, disaster management, environmental health, the provision of grants to non-government organisations for public and community health purposes, emergency road and air ambulance services, services to assist rural based patients travel to receive care, and statewide pathology services provided to external WA Agencies.

7. Small Rural Hospital Services

Provides emergency care & limited acute medical/minor surgical services in locations 'close to home' for country residents/visitors, by small & rural hospitals classified as block funded. Include community care services aligning to local community needs.

Financial statements

Notes to the Financial Statements

For the year ended 30 June 2018

Note 2 WA Country Health Service outputs (continued)

2.2 Schedule of income and expenses by service

	Public Hospital Admitted Services		Public Hospital Emergency Services		Public Hospital Non-Admitted Services		Mental Health Services (a)	
	2018 $000	2017 $000	2018 $000	2017 $000	2018 $000	2017 $000	2018 $000	2017 $000
COST OF SERVICES								
Expenses								
Employee benefits expense	363,315	338,701	160,562	163,968	63,147	62,841	86,005	82,686
Fees for visiting medical practitioners	43,639	43,351	20,599	18,485	9,193	8,423	378	2,104
Patient support costs	125,477	134,308	32,280	36,077	20,482	17,088	3,934	4,863
Finance costs	81	91	22	54	12	22	-	-
Depreciation and amortisation expense	30,767	27,024	9,610	13,010	4,829	5,855	207	515
Asset revaluation decrement	6,851	41,709	1,230	1,869	527	913	351	50
Loss on disposal of non-current assets	2,306	453	559	144	345	119	0	68
Repairs, maintenance and consumable equipment	18,345	16,383	5,811	6,855	3,269	3,031	2,252	2,343
Other expenses	41,201	48,698	16,912	24,203	7,136	11,108	26,090	19,854
Total cost of services	631,982	650,718	247,585	264,665	108,940	109,400	119,217	112,483
Income								
Patient charges	19,381	19,214	1,618	1,674	17,335	15,818	307	455
Commonwealth grants and contributions	199,127	179,861	54,609	56,644	34,207	34,381	25,754	22,995
Other grants and contributions	2,216	1,970	2,278	2,262	1,211	940	83,677	81,031
Donation revenue	270	316	115	64	15	44	13	23
Other revenue	7,674	3,793	2,923	1,683	2,112	363	1,514	830
Total income other than income from State Government	228,668	205,154	61,543	62,327	54,880	51,546	111,265	105,334
NET COST OF SERVICES	**403,314**	**445,564**	**186,042**	**202,338**	**54,060**	**57,854**	**7,952**	**7,149**
INCOME FROM STATE GOVERNMENT								
Service appropriations	370,360	378,866	157,575	185,454	47,529	53,630	-	502
Assets assumed	38	36	(26)	1	(4)	-	(12)	-
Services received free of charge	19,718	20,843	7,704	8,335	3,390	3,455	3,710	3,540
Royalties for Regions Fund	4,314	17,947	13,564	7,177	1,870	2,975	688	3,048
Total income from State Government	394,430	417,692	178,817	200,967	52,785	60,060	4,386	7,090
DEFICIT FOR THE PERIOD	**(8,884)**	**(27,872)**	**(7,225)**	**(1,371)**	**(1,275)**	**2,206**	**(3,566)**	**(59)**

(a) Includes services in addition to those provided under agreement with the Mental Health Commission for specialised admitted patients and community mental health.

The Schedule of Income and Expenses by Service should be read in conjunction with the accompanying notes.

Financial statements

Notes to the Financial Statements

For the year ended 30 June 2018

Note 2 WA Country Health Service outputs (continued)

2.2 Schedule of income and expenses by service (continued)

	Aged and Continuing Care Services		Public and Community Health Services		Small Rural Hospital Services		Total	
	2018 $000	2017 $000	2018 $000	2017 $000	2018 $000	2017 $000	2018 $000	2017 $000
COST OF SERVICES								
Expenses								
Employee benefits expense	95,025	98,812	115,656	108,377	119,003	103,014	1,002,713	958,399
Fees for visiting medical practitioners	205	162	794	642	11,051	10,904	85,859	84,071
Patient support costs	17,174	24,793	147,083	145,155	34,694	35,755	381,124	398,039
Finance costs	-	-	1	1	22	31	138	199
Depreciation and amortisation expense	2,575	2,837	3,787	6,373	22,230	21,402	74,005	77,016
Asset revaluation decrement	878	581	3,162	(864)	4,567	9,960	17,566	54,218
Loss on disposal of non-current assets	22	218	22	99	152	237	3,406	1,338
Repairs, maintenance and consumable equipment	3,019	4,142	3,830	4,864	12,674	10,529	49,200	48,147
Other expenses	18,754	13,536	31,918	28,586	23,548	15,658	165,559	161,643
Total cost of services	137,652	145,081	306,253	293,233	227,941	207,490	1,779,570	1,783,070
Income								
Patient charges	11,997	12,565	12,982	15,780	3,567	3,490	67,187	68,996
Commonwealth grants and contributions	43,994	54,128	24,989	8,686	101,501	110,875	484,181	467,570
Other grants and contributions	1,819	2,124	4,049	4,541	402	9,981	95,652	102,849
Donation revenue	18	51	39	68	81	71	551	637
Other revenue	2,667	2,598	2,770	12,458	2,929	2,013	22,589	23,738
Total income other than income from State Government	60,495	71,466	44,829	41,533	108,480	126,430	670,160	663,790
NET COST OF SERVICES	**77,157**	**73,615**	**261,424**	**251,700**	**119,461**	**81,060**	**1,109,410**	**1,119,280**
INCOME FROM STATE GOVERNMENT								
Service appropriations	64,090	49,662	227,679	212,619	81,572	62,718	948,805	943,451
Assets assumed	(12)	1	(30)	2	(21)	3	(67)	43
Services received free of charge	3,700	3,786	9,529	9,227	7,622	6,921	55,373	56,107
Royalties for Regions Fund	6,440	18,656	18,308	26,586	26,539	10,100	71,723	86,489
Total income from State Government	74,218	72,105	255,486	248,434	115,712	79,742	1,075,834	1,086,090
DEFICIT FOR THE PERIOD	**(2,939)**	**(1,510)**	**(5,938)**	**(3,266)**	**(3,749)**	**(1,318)**	**(33,576)**	**(33,190)**

The Schedule of Income and Expenses by Service should be read in conjunction with the accompanying notes.

Financial statements

Notes to the Financial Statements
For the year ended 30 June 2018

Note 3 Use of our funding

Expenses incurred in the delivery of services

This section provides additional information about how WA Country Health Service's funding is applied and the accounting policies that are relevant for an understanding of the items recognised in the financial statements. The primary expenses incurred by WA Country Health Service in achieving its objectives and the relevant notes are:

	Notes	2018 $000	2017 $000
Employee benefits expense	3.1(a)	1,002,713	958,399
Employee benefits provisions	3.1(b)	171,286	158,011
Patient support costs	3.2	466,983	482,110
Repairs, maintenance, consumable equipment and other expenses	3.3	214,759	209,790

3.1(a) Employee benefits expense

	2018 $000	2017 $000
Salaries and wages	927,098	885,996
Superannuation - defined contribution plans	75,615	72,403
	1,002,713	958,399

Salaries and wages

Salaries and wages comprise of all costs related to employment including the value of the fringe benefits to employees plus the fringe benefits tax component, the value of superannuation contribution component of leave entitlements and redundancy

Superannuation expenses

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

The superannuation expense recognised in the Statement of Comprehensive Income comprises employer contribution to the Gold State Superannuation Scheme (GSS), the West State Superannuation Scheme (WSS), the GESB Super Scheme (GESBS), or other superannuation funds. The employer contribution paid to the GESB in respect of the GSS is paid back to the Consolidated Account by the GESB.

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 WA Country Health Service to GESB extinguishes WA Country Health Service's obligations to the related superannuation liability.

The WA Country 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 WA Country Health Service to the GESB.

Employment on-costs expenses (workers compensation insurance) are included at note 3.3 'Repair, maintenance, consumable equipment and other expenses'.

3.1(b) Employee benefits provisions

Provision is made for benefits accruing to employees in respect of salaries and wages, annual leave, time off in lieu leave and long service leave for services rendered up to the reporting date and recorded as an expense during the period the services are delivered.

	2018 $000	2017 $000
Current		
Employee benefits provisions		
Annual leave (a)	64,774	61,864
Time off in lieu leave (a)	31,189	24,860
Long service leave (b)	44,025	42,083
Gratuities	1,226	935
Deferred salary scheme (c)	2,187	1,864
	143,401	131,606
Non-current		
Employee benefits provisions		
Long service leave (b)	27,198	25,910
Gratuities	687	495
	27,885	26,405
	171,286	158,011

Notes to the Financial Statements
For the year ended 30 June 2018

Note 3 Use of our funding (continued)

3.1(b) Employee benefits provisions (continued)

	2018 $000	2017 $000

(a) Annual leave liabilities and time off in lieu leave liabilities are classified as current liabilities as WA Country 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.

Assessments indicate that actual settlement of the liabilities is expected to occur as follows:

Within 12 months of the end of the reporting period	77,449	69,251
More than 12 months after the end of the reporting period	18,514	17,473
	95,963	86,724

The provision for annual leave and time off in lieu leave is calculated at the present value of expected payments to be made in relation to services provided by employees up to the reporting date.

(b) Unconditional long service leave provisions are classified as current liabilities as WA Country 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 WA Country Health Service has an unconditional right to defer settlement of the liability until the employee has completed the requisite years of service.

Assessments indicate that actual settlement of the liabilities is expected to occur as follows:

Within 12 months of the end of the reporting period	11,718	11,254
More than 12 months after the end of the reporting period	59,505	56,739
	71,223	67,993

The provision for long service leave is calculated at present value as WA Country Health Service does not expect to wholly settle the amounts within 12 months. The present value is measured taking into account the present value of expected future payments to be made in relation to services provided by employees up to the reporting date. These payments are estimated using the remuneration rate expected to apply at the time of settlement, and 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.

(c) The provision for the deferred salary scheme relates to WA Country 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. Deferred salary scheme liabilities are classified as current liabilities as WA Country Health Service does not have an 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	538	416
More than 12 months after the end of the reporting period	1,649	1,448
	2,187	1,864

Key sources of estimation uncertainty – long service leave

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.

Several estimates and assumptions are used in calculating the WA Country Health Service's long service leave provision. These include:

- Expected future salaries 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.

Any gain or loss following revaluation of the present value of long service leave liabilities is recognised as employee benefits expense.

Financial statements

Notes to the Financial Statements
For the year ended 30 June 2018

Note 3 Use of our funding (continued)

3.2 Patient support costs

	2018 $000	2017 $000
Fees for visiting medical practitioners	85,859	84,071
Medical supplies and services	80,038	84,287
Domestic charges	10,320	9,818
Fuel, light and power	30,690	28,788
Food supplies	10,670	10,927
Patient transport costs	93,452	94,011
Aboriginal health services	36,367	35,685
Pathology services	41,557	46,749
Purchase of health care services	13,845	12,794
Purchase of outsourced medical services	28,526	26,680
Purchase of other outsourced services	25,192	27,921
Grant payments	10,467	20,379
Total patient support costs	466,983	482,110

Patient support costs are recognised as an expense in the reporting period in which they are incurred. The carrying amounts of any materials held for distribution are expensed when the materials are distributed.

3.3 Repairs, maintenance, consumable equipment and other expenses

Repairs, maintenance and consumable equipment		
Repairs and maintenance	29,617	25,570
Consumable equipment	19,583	22,577
Total repairs, maintenance and consumable equipment expenses	49,200	48,147
Other expenses		
Communications	5,107	4,614
Computer services	2,049	2,858
Workers compensation insurance	13,935	14,985
Other employee related expenses	29,190	26,162
Insurance	6,161	5,125
Legal expenses	506	294
Motor vehicle expenses	5,110	4,357
Operating lease expenses	27,298	29,441
Printing and stationery	4,067	4,163
Doubtful debts expense	1,514	4,018
Purchase of outsourced services	21,095	18,014
Shared services costs	31,799	26,536
Other	17,728	21,076
Total other expenses	165,559	161,643

Other operating expenses generally represent the day-to-day running costs incurred in normal operations.

Repairs and maintenance costs are recognised as expenses as incurred, except where they relate to the replacement of a significant component of an asset. In that case, the costs are capitalised and depreciated.

Doubtful debt expense is recognised as the movement in the provision for doubtful debt. Please refer to note 6.1.1 'Movement of the allowance for impairment of receivables'.

Shared services costs represent the value of services related to Information technology, Human resources, Supply and Finance provided by the Health Support Services; and pathology service provided by Pathwest during the financial year. These services are provided free of charge and the corresponding revenue is reflected under Services Provided Free of Charge.

Notes to the Financial Statements
For the year ended 30 June 2018

Note 4 Our funding sources

How we obtain our funding

This section provides additional information about how WA Country Health Service obtains its funding and the relevant accounting policy notes that govern the recognition and measurement of this funding. The primary income received by WA Country Health Service and the relevant notes are:

	Notes	2018 $000	2017 $000
Income from State Government	4.1	1,075,834	1,086,090
Commonwealth grants and contributions	4.2	484,181	467,570
Other grants and contributions	4.3	95,652	102,849
Patient charges	4.4	67,187	68,996
Other revenue	4.5	22,589	23,738

4.1 Income from State Government

Appropriation received during the period:		
Service appropriation (a)	948,805	943,451
	948,805	943,451
Assets transferred from/(to) other State government agencies during the period: (b)		
Medical equipment from East Metropolitan Health Services	24	10
Medical equipment from Child and Adolescent Health Services	104	-
Plant and equipment from Child and Adolescent Health Services	6	-
Medical equipment to Health Support Services	(201)	33
Total assets transferred	(67)	43
Services received free of charge from other State government agencies during the period: (c)		
Department of Finance - government accommodation	92	80
North Metropolitan Health Service (PathWest)	23,482	29,491
Health Support Services	31,799	26,536
Total services received	55,373	56,107
Royalties for Regions Fund:		
Regional Community Services Account: (d)		
Regional Workers Incentives Allowance Payments	7,878	7,974
Ear, Eye and Oral Health	1,872	531
Expand the ear bus program	616	-
Fitzroy Kids Health	-	50
Patient Assisted Travel Scheme	11,009	10,742
Regional Palliative Care	500	1,250
Meet and Greet Program	200	-
Royal Flying Doctor Service	2,792	7,899
Regional Infrastructure Headworks Account: (d)		
Pilbara Health Partnership (Asset Investment)	2,860	3,099
Renal Dialysis Service Expansion	920	511
Busselton ICT	915	-
Southern Inland Health Initiative		
- District Medical Workforce Investment Program (Stream 1)	18,599	30,421
- District Hospital Investment Program (Stream 2)	-	5,159
- Residential Aged and Dementia Care Investment Program (Stream 6)	5,222	14,146
- Telehealth Investment Program (Stream 5)	4,750	4,707
- District Medical Workforce Investment Program (NEW)	13,590	-
Total Royalties for Regions Fund	71,723	86,489
Total income from State Government	1,075,834	1,086,090

(a) Service appropriations are recognised at fair value in the period in which WA Country Health Service gains control of the appropriated funds. WA Country Health Service gains control of appropriated funds at the time those funds are deposited in the bank account or credited to the 'Amounts receivable for services' (holding account) held at Treasury.

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Note 4 Our funding sources (continued)

4.1 Income from State Government (continued)

Service appropriations fund the net cost of services delivered (as set out in note 2.2). Appropriation revenue comprises the following:

- Cash component; and
- A receivable (asset).

The receivable (holding account – note 6.2) comprises the following:

- The budgeted depreciation expense for the year; and
- Any agreed increase in leave liabilities during the year.

(b) Transfer of assets: Discretionary transfers of assets (including grants) and liabilities between State government agencies are reported under Income from State Government. Transfers of assets and liabilities in relation to a restructure of administrative arrangements are recognised as distribution to owners by the transferor and contribution by owners by the transferee under AASB 1004. Other non discretionary non-reciprocal transfers of assets and liabilities designated as contributions by owners under TI 955 are also recognised directly to equity.

(c) Services received free of charge or for nominal cost, are recognised as revenues at the fair value of those services that can be reliably measured and which would have been purchased if they were not donated.

(d) The Regional Community Services Accounts and the Regional Infrastructure and Headworks Account are sub-funds within the over-arching 'Royalties for Regions Fund'. The recurrent funds are committed to projects and programs in WA regional areas and are recognised as revenue when WA Country Health Service gains control on receipt of the funds.

4.2 Commonwealth grants and contributions

	2018 $000	2017 $000
Recurrent		
National Health Reform Agreement via the Department of Health (a)	376,330	369,449
National Health Reform Agreement via the Mental Health Commission (a)	24,909	21,839
Multi Purpose Service Units	29,547	28,850
Home and Community Care Program	10,560	10,361
Other	30,834	24,556
Capital		
Bringing Renal Dialysis & Support Services Closer	9,000	8,000
Strengthening Regional Cancer Services	3,000	2,000
Other	1	2,515
	484,181	467,570

(a) Activity based funding and block grant funding is received from the Commonwealth Government under the National Health Reform Agreement for services, health teaching, training and research provided by local hospital networks (Health Services). The funding arrangement established under the Agreement requires the Commonwealth Government to make funding payments to the State Pool Account from which distributions to the local hospital networks (Health Services) are made by the Department of Health and Mental Health Commission.

4.3 Other grants and contributions

	2018 $000	2017 $000
Recurrent		
Mental Health Commission - service delivery agreement	71,386	67,885
Mental Health Commission - SSAMHS	5,546	5,753
WA Alcohol and Drug Authority - Community Drug Service Team & other programs	-	4,875
Mental Health Commission - Community drug and alcohol service	4,821	-
Disability Services Commission - Community aids and equipment program	2,655	2,991
Other	11,244	11,893
Capital		
Onslow Health Service Redevelopment	-	9,452
	95,652	102,849

Notes to the Financial Statements
For the year ended 30 June 2018

Note 4 Our funding sources (continued)

4.2 and 4.3 grants and contributions (continued)

Grant income arises from transactions described as:

- Non reciprocal (where WA Country Health Service does not provide approximate equal value in return to a party providing goods or assets (or extinguishes a liability); or
- Reciprocal (where WA Country Health Service provides equal value to the recipient of the grant provider).

The accounting for these are set out below.

For non-reciprocal grants, WA Country Health Service recognises revenue when the grant is receivable at its fair value as and when its fair value can be reliably measured.

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

For reciprocal grants, WA Country Health Service recognises income when it has satisfied its performance obligations under the terms of the grant.

Grants can further be split between:

- General purpose grants
- Specific purpose grants

General purpose grants refers to grants which are not subject to conditions regarding their use. Specific purpose grants are received for a particular purpose and/or have conditions attached regarding their use.

4.4 Patient charges

	2018 $000	2017 $000
Inpatient bed charges	26,379	26,218
Outpatient charges	40,808	42,778
	67,187	68,996

4.5 Other revenue

Services to external organisations	7,481	9,666
Use of hospital facilities	2,493	1,997
Rent from commercial properties	755	876
Rent from residential properties	325	203
Staff and boarders' accommodation	7,984	8,254
Home and Community Care client fees	1,680	1,713
RiskCover insurance premium rebate	666	142
Other	1,205	887
	22,589	23,738

Revenue on provision of services is recognised by reference to the stage of completion of the transaction.

Note 5 Key assets

Assets WA Country Health Service utilises for economic benefit or service potential

This section includes information regarding the key assets WA Country Health Service utilises to gain economic benefits or provide service potential. The section sets out both the key accounting policies and financial information about the performance of these assets:

	Notes	2018 $000	2017 $000
Property, plant and equipment	5.1	1,916,214	1,777,418
Intangible assets	5.2	17,338	13,941
Total key assets		1,933,552	1,791,359

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Notes to the Financial Statements

For the year ended 30 June 2018

Note 5 Key assets (continued)

5.1 Property, plant and equipment

	Land $000	Buildings $000	Buildings under constructions $000	Site Infrastructure $000	Leasehold improvements $000	Computer equipment $000	Furniture and fittings $000	Motor vehicles $000	Medical equipment $000	Other plant and equipment $000	Other works in progress $000	Artworks $000	Total $000
Year ended 30 June 2018													
1 July 2017													
Gross carrying amount	100,941	1,259,933	187,814	187,938	1,175	4,539	2,084	770	39,480	6,960	5,080	70	1,796,784
Accumulated depreciation	-	-	-	(9,892)	(304)	(658)	(171)	(520)	(6,926)	(895)	-	-	(19,366)
Carrying amount at start of period	**100,941**	**1,259,933**	**187,814**	**178,046**	**871**	**3,881**	**1,913**	**250**	**32,554**	**6,065**	**5,080**	**70**	**1,777,418**
Additions	-	537	225,576	153	-	165	1,006	593	6,752	2,120	4,656	5	241,563
Transfers from/(to) other reporting entities	(2,256)	(1,072)	-	-	-	-	-	-	(73)	6	-	-	(3,395)
Transfers between asset classes	-	82,610	(91,282)	9,560	-	1,328	(313)	-	392	812	(3,328)	-	(221)
Other disposals	-	(2,690)	-	(597)	-	-	(15)	-	(78)	(26)	-	-	(3,406)
Revaluation increments/(decrements)	(16,398)	(1,168)	-	-	-	-	-	-	-	-	-	-	(17,566)
Impairment losses	-	-	-	-	-	-	-	-	-	-	-	-	-
Impairment losses reversed	-	-	-	-	-		-	-	-	-	-	-	-
Depreciation	-	(52,382)	-	(10,277)	(304)	(1,372)	(170)	(251)	(6,324)	(1,116)	-	-	(72,196)
Write-down of assets	(5)	-	(3,593)	-	-	(406)	(283)	-	(283)	(22)	(1,391)	-	(5,983)
Carrying amount at 30 June 2018	**82,282**	**1,285,768**	**318,515**	**176,885**	**567**	**3,596**	**2,138**	**592**	**32,940**	**7,839**	**5,017**	**75**	**1,916,214**
Gross carrying amount	82,282	1,285,768	318,515	196,987	1,176	5,627	2,478	1,363	46,161	9,844	5,017	75	**1,955,293**
Accumulated depreciation	-	-	-	(20,102)	(609)	(2,031)	(340)	(771)	(13,221)	(2,005)	-	-	**(39,079)**
	82,282	**1,285,768**	**318,515**	**176,885**	**567**	**3,596**	**2,138**	**592**	**32,940**	**7,839**	**5,017**	**75**	**1,916,214**
Year ended 30 June 2017													
1 July 2016													
Transferred from abolished entity	123,827	1,309,648	79,748	186,329	1,175	1,280	2,050	697	33,502	4,228	6,259	181	1,748,924
Carrying amount at start of period	**123,827**	**1,309,648**	**79,748**	**186,329**	**1,175**	**1,280**	**2,050**	**697**	**33,502**	**4,228**	**6,259**	**181**	**1,748,924**
Additions		51	148,295	-	-	2,926	396	31	5,986	1,185	1,576	-	160,446
Transfers from/(to) other reporting entities	(698)	-	-	-	-	-	-	-	-	-	-	-	(698)
Transfers between asset classes	-	39,446	(40,229)	1,612	-	327	(313)	42	388	1,575	(2,756)	(111)	(19)
Other disposals	-	(930)	-	(15)	-	-	(43)	-	(326)	(24)	-	-	(1,338)
Revaluation increments/(decrements)	(22,188)	(32,030)	-	-	-	-	-	-	-	-	-	-	(54,218)
Impairment losses	-	-	-	-	-	-	-	-	-	-	-	-	-
Impairment losses reversed	-	-	-	-	-	-	-	-	-	-	-	-	-
Depreciation	-	(56,252)	-	(9,880)	(304)	(651)	(177)	(520)	(6,996)	(899)	-	-	(75,679)
Write-down of assets	-	-	-	-	-	-	-	-	-	-	-	-	-
Carrying amount at 30 June 2017	**100,941**	**1,259,933**	**187,814**	**178,046**	**871**	**3,882**	**1,913**	**250**	**32,554**	**6,065**	**5,079**	**70**	**1,777,418**
Gross carrying amount	100,941	1,259,933	187,814	187,938	1,175	4,539	2,084	770	39,480	6,960	5,080	70	1,796,784
Accumulated depreciation	-	-	-	(9,892)	(304)	(658)	(171)	(520)	(6,926)	(895)	-	-	(19,366)
	100,941	**1,259,933**	**187,814**	**178,046**	**871**	**3,881**	**1,913**	**250**	**32,554**	**6,065**	**5,080**	**70**	**1,777,418**

Information on fair value measurements is provided in Note 8.3

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Notes to the Financial Statements
For the year ended 30 June 2018

Note 5 Key assets (continued)

5.1 Property, plant and equipment (continued)

Initial recognition

Items of property, plant and equipment and infrastructure, costing $5,000 or more are measured initially at cost. Where an asset is acquired for no or nominal cost, the cost is valued at its fair value at the date of acquisition. Items of property, plant and equipment and infrastructure 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).

Assets transferred as part of a machinery of government change are transferred at their fair value.

The cost of a leasehold improvement is capitalised and depreciated over the shorter of the remaining term of the lease or the estimated useful life of the leasehold improvement.

Subsequent measurement

Subsequent to initial recognition of an asset, the revaluation model is used for the measurement of land and buildings.

Land is carried at fair value and buildings are carried at fair value less accumulated depreciation and accumulated impairment losses.

All other property, plant and equipment are stated at historical cost less accumulated depreciation and accumulated impairment losses.

Land and buildings are independently valued annually by the Western Australian Land Information Authority (Valuations and Property Analytics) 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.

Land and buildings were revalued as at 1 July 2017 by the Western Australian Land Information Authority (Valuation and Property Analytics). The valuations were performed during the year ended 30 June 2018 and recognised at 30 June 2018. In undertaking the revaluation, fair value was determined by reference to the market value for land: $31.334 million (2017: $42.90 million) and buildings: $68.604 million (2017: $64.328 million). For the remaining balance, fair value of buildings was determined on the basis of current replacement cost and fair value of land was determined on the basis of comparison with market evidence for land with low level utility (high restricted use land).

Revaluation model:

1. Fair Value where market-based evidence is available:

The fair value of land and buildings is determined on the basis of current market values determined by reference to recent market transactions.

2. Fair value in the absence of market-based evidence:

Buildings are specialised or where land is restricted: Fair value of land and buildings is determined on the basis of existing use.

Existing use buildings: Fair value is determined by reference to the cost of replacing the remaining future economic benefits embodied in the asset, i.e. the current replacement cost.

Restricted use land: Fair value is determined by comparison with market evidence for land with similar approximate utility (high restricted use land) or market value of comparable unrestricted land (low restricted use land).

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.

Significant assumptions and judgements: The most significant assumptions and judgements in estimating fair value are made in assessing whether to apply the existing use basis to assets and in determining estimated economic 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.

Notes to the Financial Statements
For the year ended 30 June 2018

Note 5 Key assets (continued)

5.1.1 Depreciation and impairment

Charge for the period	2018 $000	2017 $000
Depreciation		
Buildings	52,382	56,252
Site Infrastructure	10,277	9,880
Leasehold improvements	304	304
Computer equipment	1,372	651
Furniture and fittings	170	177
Motor vehicles	251	520
Medical equipment	6,324	6,996
Other plant and equipment	1,116	899
Total depreciation for the period	72,196	75,679

As at 30 June 2018 there were no indications of impairment to property, plant and equipment.

All surplus assets at 30 June 2018 have either been classified as assets held for sale or have been written-off.

Please refer to note 5.2.1 for guidance in relation to the impairment assessment that has been performed for intangible assets.

Finite useful lives

All property, plant and equipment 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. The exceptions to this rule include assets held for sale, land and investment properties.

Depreciation is calculated on a straight line basis, at rates that allocate the asset's value, less any estimated residual value, over its estimated useful life. Estimated useful lives for the different asset classes for current and prior years are:

Buildings	50 years
Site infrastructure	50 years
Leasehold improvements	Shorter of the lease term and useful life
Computer equipment	4 to 10 years
Furniture and fittings	10 to 20 years
Motor vehicles	2 to 10 years
Medical equipment	3 to 20 years
Other plant and equipment	4 to 30 years

The estimated useful lives, residual values and depreciation method are reviewed at the end of each annual reporting period, and adjustments made where appropriate.

Land and artworks, which are considered to have an indefinite life, are not depreciated. Depreciation is not recognised in respect of these assets because their service potential has not, in any material sense, been consumed during the reporting period.

Impairment

Non-financial assets, including items of property, plant and equipment, are tested for impairment whenever there is an indication that the asset may be impaired. 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.

Where an asset measured at cost is written down to its recoverable amount, an impairment loss is recognised through profit or loss.

Where a previously revalued asset is written down to its recoverable amount, the loss is recognised as a revaluation decrement through other comprehensive income.

As WA Country Health Service is a not-for-profit entity, the recoverable amount of regularly revalued specialised assets is anticipated to be materially the same as fair value.

If there is an indication that there has been a reversal in impairment, the carrying amount shall be increased to its recoverable amount. However this reversal should not increase the asset's carrying amount above what would have been determined, net of depreciation or amortisation, if no impairment loss had been recognised in prior years.

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 declining replacement costs.

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Note 5 Key assets (continued)

	2018 $000	2017 $000
5.1.2 Revaluation decrements		
Land	16,398	22,188
Buildings	1,168	32,030
	17,566	54,218
5.1.3 Loss on disposal of non-current assets		
Net proceeds from disposal of non-current assets:		
Property, plant and equipment	-	-
Carrying amount of non-current assets:		
Property, plant and equipment	3,406	1,338
Net loss	3,406	1,338

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

Losses on the disposal of non-current assets are presented by deducting from the proceeds on disposal the carrying amount of the asset and related selling expenses. Losses are recognised in profit or loss in the statement of comprehensive income.

Selling expenses (e.g. sales commissions netted from WA Country Health Service's receipts) are ordinarily immaterial.

5.2 Intangible assets

	Computer software $000	Works in progress $000	Total $000
Year ended 30 June 2018			
1 July 2017			
Gross carrying amount	14,441	837	15,278
Accumulated amortisation	(1,337)	-	(1,337)
Carrying amount at start of period	**13,104**	**837**	**13,941**
Additions	-	5,101	5,101
Transfers between asset classes	1,771	(1,550)	221
Amortisation expense	(1,809)	-	(1,809)
Write-down of assets	-	(116)	(116)
Carrying amount at 30 June 2018	**13,066**	**4,272**	**17,338**
Year ended 30 June 2017			
1 July 2016			
Transferred from abolished entity	7,642	2,119	9,761
Carrying amount at start of period	**7,642**	**2,119**	**9,761**
Additions	2,582	2,916	5,498
Transfers between asset classes	4,217	(4,198)	19
Amortisation expense	(1,337)	-	(1,337)
Carrying amount at 30 June 2017	**13,104**	**837**	**13,941**

Notes to the Financial Statements
For the year ended 30 June 2018

Note 5 Key assets (continued)

5.2 Intangible assets (continued)

Initial recognition

Acquisitions of intangible assets costing $5,000 or more and internally generated intangible assets costing $5,000 or more that comply with the recognition criteria as per AASB 138.57, are capitalised.

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.

An internally generated intangible asset arising from development (or from the development phase of an internal project) is recognised if, and only if, all of the following are demonstrated

(a) The technical feasibility of completing the intangible asset so that it will be available for use or sale;

(b) An intention to complete the intangible asset and use or sell it;

(c) The ability to use or sell the intangible asset;

(d) The intangible asset will generate probable future economic benefit;

(e) The availability of adequate technical, financial and other resources to complete the development and to use or sell the intangible asset; and

(f) The ability to measure reliably the expenditure attributable to the intangible asset during its development.

Costs incurred in the research phase of a project are immediately expensed.

Subsequent measurement

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

5.2.1 Amortisation and impairment

Charge for the period	2018 $000	2017 $000
Computer software	1,809	1,337
Total amortisation for the period	1,809	1,337

As at 30 June 2018 there were no indications of impairment to intangible assets.

WA Country 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.

Amortisation of finite life intangible assets is calculated on a straight line basis at rates that allocate the asset's value over its estimated useful life. All intangible assets controlled by WA Country Health Service have a finite useful life and zero residual value. Estimated useful lives are reviewed annually.

The estimated useful lives for each class of intangible asset are:

Computer software	5 - 10 years

Computer 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 is recognised as an intangible asset.

Impairment

Intangible assets with finite useful lives are tested for impairment annually or when an indication of impairment is identified.

The policy in connection with testing for impairment is outlined in note 5.1.1.

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Notes to the Financial Statements
For the year ended 30 June 2018

Note 6 Other assets and liabilities

This section sets out those assets and liabilities that arose from WA Country Health Service's controlled operations and includes other assets utilised for economic benefits and liabilities incurred during normal operations:

	Notes	2018 $000	2017 $000
Receivables	6.1	23,647	23,752
Amounts receivable for services	6.2	748,497	674,420
Other assets	6.3	9,485	10,337
Payables	6.4	116,019	119,198

6.1 Receivables

	2018 $000	2017 $000
Current		
Patient fee debtors	13,100	15,425
Other receivables	2,902	4,566
Allowance for impairment of receivables	(4,428)	(9,001)
Accrued revenue	6,117	7,848
GST receivable	5,956	4,914
Total receivables	23,647	23,752

WA Country Health Service does not hold any collateral or other credit enhancements as security for receivables.

Receivables are recognised at original invoice amount less any allowances for uncollectible amounts (i.e. impairment). The carrying amount of net trade receivables is equivalent to fair value as it is due for settlement within 30 days.

6.1.1. Movement of the allowance for impairment of receivables

Reconciliation of changes in the allowance for impairment of receivables:		
Balance at start of period	9,001	-
Transfer in from abolished entity	-	5,946
Doubtful debts expense	1,514	4,018
Amounts written off during the period	(6,149)	(921)
Amounts recovered during the period	62	(42)
Balance at end of period	4,428	9,001

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 WA Country Health Service will not be able to collect the debts.

6.2 Amounts receivable for services (Holding Account)

Non-current	748,497	674,420
Balance at end of period	748,497	674,420

Amounts receivable for services represent 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.

WA Country Health Service receives funding on an accrual basis. The appropriations are paid partly in cash and partly as an asset (holding account receivable). The accrued amount receivable is accessible on the emergence of the cash funding requirement to cover leave entitlements and asset replacement.

Notes to the Financial Statements
For the year ended 30 June 2018

Note 6 Other assets and liabilities (continued)

6.3 Other assets

	2018 $000	2017 $000
Current		
Supply inventories	2,259	2,120
Pharmaceutical inventories	2,638	2,735
Other inventories	260	415
Prepayments	4,328	5,067
Balance at end of period	9,485	10,337

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.

Prepayments are payments in advance of receipt of goods or services or that part of expenditure made in one accounting period covering a term extending beyond that period.

6.4 Payables

	2018 $000	2017 $000
Current		
Trade payables	19,290	31,632
Accrued expenses	82,091	65,121
Accrued salaries	14,628	22,430
Accrued interest	10	15
Balance at end of period	116,019	119,198

Payables are recognised at the amounts payable when WA Country 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 settlement is generally within 30 days.

Accrued salaries represent the amount due to staff but unpaid at the end of the reporting period. Accrued salaries are settled within a fortnight of the reporting period end. WA Country Health Service considers the carrying amount of accrued salaries to be equivalent to its fair value.

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Notes to the Financial Statements
For the year ended 30 June 2018

Note 7 Financing

This section sets out the material balances and disclosures associated with the financing and cashflows of WA Country Health Service.

	Notes
Borrowings	7.1
Finance costs	7.2
Cash and cash equivalents	7.3
Reconciliation of cash	7.3.1
Reconciliation of operating activities	7.3.2
Commitments	7.4
Non-cancellable operating lease commitments	7.4.1
Capital commitments	7.4.2
Other expenditure commitments	7.4.3

7.1 Borrowings

	2018 $000	2017 $000
Current		
Department of Treasury loans (a)	1,779	1,701
Non-Current		
Department of Treasury loans (a)	1,865	3,644
	3,644	5,345

7.2 Finance costs

Interest expense (a)	138	199
	138	199

(a) 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. Interest incurred are expensed as finance costs.

	Notes	2018 $000	2017 $000
7.3 Cash and cash equivalents			
7.3.1 Reconciliation of cash			
Cash and cash equivalents		18,173	18,949
Restricted cash and cash equivalents (a)	8.1		
Royalties for Regions Fund		1,141	1,428
Capital grant from the Commonwealth Government (b)		16,512	12,180
Patient receipts under section 19 (2) of the Health Insurance Act 1973		4,838	4,062
Bequests		763	774
Capital funding from external sources		-	17,391
Mental Health Commission Funding (note 9.7)		234	955
Other		1,854	579
Accrued salaries suspense account (c)		7,463	3,840
Balance at end of period		50,978	60,158

(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.

(c) Funds held in the suspense account for the purpose of meeting the 27th pay in a reporting period that occurs every 11th year. This account is classified as non current for 10 out of 11 years.

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.

Notes to the Financial Statements
For the year ended 30 June 2018

Note 7 Financing (continued)

7.3.2 Reconciliation of net cost of services to net cash flows used in operating activities

	Notes	2018 $000	2017 $000
Net cost of services		1,109,410	1,119,280
Non-cash items			
Depreciation and amortisation expense	5.1.1, 5.2.1	(74,005)	(77,016)
Asset revaluation decrement	5.1.2	(17,566)	(54,218)
Loss from disposal of non-current assets	5.1.3	(3,406)	(1,338)
Interest paid by Department of Health		(144)	(204)
Donation of non-current assets		30	14
Services received free of charge	4.1	(55,373)	(56,107)
Write down of property, plant and equipment	5.1, 5.2	(6,099)	-
Net assets transferred in that are expensed		-	(11,305)
Adjustment for other non-cash items		(2)	(2)
Increase/(decrease) in assets			
Receivables		(105)	1,328
Inventories		(113)	(284)
Prepayments		(739)	1,935
(Increase)/decrease in liabilities			
Payables (a)		(8,554)	(3,938)
Current provisions		(11,795)	(4,625)
Non-current provisions		(1,480)	(1,205)
Other current liabilities		(30)	(8)
Other non-current liabilities		-	-
Net cash used in operating activities		930,029	912,307

(a) Note that the Australian Taxation Office (ATO) receivable/payable in respect of GST and the receivable/payable in respect of the sale/purchase of non-current assets are not included in these items as they do not form part of the reconciling items.

The mandatory application of AASB 2016-2 Amendments to Australian Accounting Standards – Disclosure Initiative: Amendments to AASB 107 imposed disclosure impacts only. WA Country Health Service is not exposed to changes in liabilities arising from financing activities, including both changes arising from cash flows and non-cash changes.

7.4 Commitments

The commitments below are inclusive of GST where relevant.

7.4.1 Non-cancellable operating lease commitments

Commitments for minimum lease payments are payable as follows:

	2018 $000	2017 $000
Within 1 year	8,616	8,907
Later than 1 year and not later than 5 years	5,312	6,469
later than 5 years	43	33
	13,971	15,409

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

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.

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Notes to the Financial Statements
For the year ended 30 June 2018

Note 7 Financing (continued)

7.4.2 Capital commitments

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

	2018 $000	2017 $000
Within 1 year	78,339	252,743
Later than 1 year and not later than 5 years	40,512	114,125
later than 5 years	-	-
	118,851	366,868

7.4.3 Other expenditure commitments

Other expenditure commitments contracted for at the end of the reporting period but not recognised as liabilities, are payable as follows:

	2018 $000	2017 $000
Within 1 year	176,993	162,608
Later than 1 year and not later than 5 years	61,096	109,390
later than 5 years	949	5,955
	239,038	277,953

Judgements made by management in applying accounting policies – operating lease commitments

WA Country Health Service has entered into a number of leases for buildings for branch office accommodation. Some of these leases relate to buildings of a temporary nature and it has been determined that the lessor retains substantially all the risks and rewards incidental to ownership. Accordingly, these leases have been classified as operating leases.

Note 8 Risks and Contingencies

This note sets out the key risk management policies and measurement techniques of WA Country Health Service.

	Notes
Financial risk management	8.1
Contingent assets	8.2.1
Contingent liabilities	8.2.2
Fair value measurements	8.3

8.1 Financial risk management

Financial instruments held by WA Country Health Service are cash and cash equivalents, restricted cash and cash equivalents, loans and receivables, payables, and borrowings. WA Country Health Service has limited exposure to financial risks. WA Country Health Service's overall risk management program focuses on managing the risks identified below.

(a) Summary of risks and risk management

Credit risk

Credit risk arises when there is the possibility of WA Country Health Service's receivables defaulting on their contractual obligations resulting in financial loss to WA Country Health Service.

The maximum exposure to credit risk at the end of the reporting period in relation to each class of recognised financial asset is the gross carrying amount of those assets inclusive of any allowance for impairment as shown in the table at Note 8.1(c) 'Financial instruments disclosures' and Note 6.1 'Receivables'.

Credit risk associated with WA Country Health Service's financial assets is minimal because the main receivable is the amounts receivable for services (holding account). For receivables other than Government, WA Country Health Service trades only with recognised, creditworthy third parties. WA Country 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 WA Country Health Service's exposure to bad debts is minimal. At the end of the reporting period there were no significant concentrations of credit risk.

Notes to the Financial Statements
For the year ended 30 June 2018

Note 8 Risks and Contingencies (continued)

8.1 Financial risk management (continued)

(a) Summary of risks and risk management (continued)

Liquidity risk

Liquidity risk arises when the agency is unable to meet its financial obligations as they fall due.

WA Country Health Service is exposed to liquidity risk through its trading in the normal course of business.

WA Country Health Service has appropriate procedures to manage cash flows including drawdown 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 WA Country Health Service's income or the value of its holdings of financial instruments. WA Country Health Service does not trade in foreign currency and is not materially exposed to other price risks. WA Country Health Service's exposure to market risk for changes in interest rates relate primarily to the long-term debt obligations.

WA Country Health Service's borrowings are with the Department of Treasury and are at variable interest rates with varying maturities. Other than as detailed in the interest rate sensitivity analysis table at Note 8.1(e), WA Country Health Service is not exposed to interest rate risk because the majority of cash and cash equivalents and restricted cash are non-interest bearing and it has no borrowings other than the Treasurer's loans.

(b) Categories of financial instruments

The carrying amounts of each of the following categories of financial assets and financial liabilities at the end of the reporting period are:

	2018 $000	2017 $000
Financial assets		
Cash and cash equivalents	18,173	18,949
Restricted cash and cash equivalents	32,805	41,209
Loans and receivables (a)	766,188	693,259
Total financial assets	817,166	753,417
Financial Liabilities		
Financial liabilities measured at amortised cost	119,663	124,543
Total financial liability	119,663	124,543

(a) The amount of loans and receivables excludes GST recoverable from the ATO (statutory receivable).

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Notes to the Financial Statements
For the year ended 30 June 2018

Note 8 Risks and Contingencies (continued)

8.1 Financial risk management (continued)

(c) Ageing analysis of financial assets

	Carrying amount	Not past due and not impaired	Not past due and impaired	Past due but not impaired				Impaired financial assets
				1 - 3 months	3 months to 1 year	1 - 5 years	More than 5 years	
	$000	$000	$000	$000	$000	$000	$000	$000
2018								
Cash and cash equivalents	18,173	18,173	-	-	-	-	-	
Restricted cash and cash equivalents	32,805	32,805	-	-	-	-	-	
Receivables (a)	17,691	11,126	-	2,758	3,268	539	1	
Amounts receivable for services	748,497	748,497	-	-	-	-	-	
	817,166	810,601	-	2,758	3,268	539	1	-
2017								
Cash and cash equivalents	18,949	18,949	-	-	-	-	-	
Restricted cash and cash equivalents	41,209	41,209	-	-	-	-	-	
Receivables (a)	18,839	12,656	-	2,827	2,661	694	2	
Amounts receivable for services	674,420	674,420	-	-	-	-	-	
	753,417	747,234	-	2,827	2,661	694	2	-

(a) The amount of receivables excludes the GST recoverable from ATO (statutory receivable).

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Notes to the Financial Statements
For the year ended 30 June 2018

Note 8 Risks and Contingencies (continued)

8.1 Financial risk management (continued)

(d) Liquidity risk and interest rate exposure

The following table details WA Country 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	1-3 months	3 months to 1 year	1-5 years	More than 5 years
	%	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000
2018											
Financial Assets											
Cash and cash equivalents	-	18,173	-	-	18,173	18,173	18,173	-		-	-
Restricted cash and cash equivalents	-	32,805	-	-	32,805	32,805	32,805	-	-	-	-
Receivables (a)	-	17,691	-	-	17,691	17,691	17,691	-	-	-	-
Amounts receivable for services	-	748,497	-	-	748,497	748,497	-	-	-	-	748,497
		817,166	-	-	817,166	817,166	68,669	-	-	-	748,497
Financial Liabilities											
Payables	-	116,019	-	-	116,019	116,019	116,019	-		-	-
Department of Treasury Loans	3.06%	3,644	-	3,644	-	3,819	158	315	1,419	1,927	-
		119,663	-	3,644	116,019	119,838	116,176	315	1,419	1,927	-

(a) The amount of receivables excludes the GST recoverable from ATO (statutory receivable).

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Notes to the Financial Statements
For the year ended 30 June 2018

Note 8 Risks and Contingencies (continued)

8.1 Financial risk management (continued)

(d) 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	1-3 months	3 months to 1 year	1-5 years	More than 5 years
	%	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000
2017											
Financial Assets											
Cash and cash equivalents	-	18,949	-	-	18,949	18,949	18,949	-		-	-
Restricted cash and cash equivalents		41,209	-		41,209	41,209	41,209				
Receivables (a)	-	18,839	-	-	18,839	18,839	18,839	-	-	-	-
Amounts receivable for services	-	674,420	-	-	674,420	674,420	-	-	-	-	674,420
		753,417	-	-	753,417	753,417	78,997	-	-	-	674,420
Financial Liabilities											
Payables	-	119,198	-	-	119,198	119,198	119,198	-		-	-
Department of Treasury Loans	3.18%	5,345	-	5,345	-	5,532	151	303	1,362	3,716	-
		124,543	-	5,345	119,198	124,730	119,349	303	1,362	3,716	-

(a) The amount of receivables excludes the GST recoverable from ATO (statutory receivable).

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Notes to the Financial Statements
For the year ended 30 June 2018

Note 8 Risks and Contingencies (continued)

8.1 Financial risk management (continued)

(e) Interest rate sensitivity analysis

The following table represents a summary of the interest rate sensitivity of WA Country 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.

		-100 basis points		+100 basis points	
	Carrying amount $000	Surplus $000	Equity $000	Surplus $000	Equity $000
2018					
Financial Liabilities					
Department of Treasury Loans	3,644	36	36	(36)	(36)
Total Increase/(Decrease)		36	36	(36)	(36)
2017					
Financial Liabilities					
Department of Treasury Loans	5,345	53	53	(53)	(53)
Total Increase/(Decrease)		53	53	(53)	(53)

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Notes to the Financial Statements
For the year ended 30 June 2018

Note 8 Risks and Contingencies (continued)

8.2 Contingent assets and liabilities

Contingent assets and contingent liabilities are not recognised in the statement of financial position but are disclosed and, if quantifiable, are measured at nominal value.

Contingent assets and liabilities are presented inclusive of GST receivable or payable respectively.

8.2.1 Contingent assets

At the reporting date, WA Country Health Service is not aware of any contingent assets.

8.2.2 Contingent liabilities

The following contingent liabilities are excluded from the liabilities included in the financial statements:

	2018 $000	2017 $000
Litigation in progress:		
Pending litigation that are not recoverable from RiskCover insurance and may affect the financial position of WA Country Health Service.	1,212	269
Number of claims	6	13
Contaminated sites		
Estimated cost to remediate contaminated and suspected contaminated sites reported to the Department of Water and Environmental Regulation.	70	70

Under the Contaminated Sites Act 2003, WA Country Health Service is required to report known and suspected contaminated sites to the Department of Water and Environmental Regulation (DWER). In accordance with the Act, DWER 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, WA Country Health Service may have a liability in respect of investigation or remediation expenses.

Public holiday time off in lieu (PH TOIL)

Due to an inconsistent interpretation of the employee industrial awards and configuration of the payroll system, it has been identified by the Health Support Services (HSS) that incorrect calculations of Public Holiday Time off in Lieu (PH TOIL) have occurred at WA Country Health Service. A system resolution has been implemented for the nursing cohort and the net effect of this ($3.6m) has been adjusted for in the employee benefits provisions (Note 3.1(b)) in these financial statements. HSS has commenced work on calculating the impact of the inconsistent interpretation on other employee classes that also earn PH TOIL; however, the impact on these employee classes cannot as yet be reliably estimated.

Hospital cladding

WA Country Health Service has conducted a review of its hospitals that have aluminium composite panels (ACPs), following concerns about the potential fire risks associated with the use of some ACP cladding products. The review has identified three sites where ACPs may not meet the requirements of the building code of Australia. The cladding at these sites will undergo additional testing to determine the need for remediation work. Any costs associated with potential remediation work at these sites has not been reliably estimated.

Notes to the Financial Statements
For the year ended 30 June 2018

Note 8 Risks and Contingencies (continued)

8.3 Fair value measurement

(a) Fair value hierarchy

AASB 13 requires disclosure of fair value measurements by level of the following fair value measurement hierarchy:

1) quoted prices (unadjusted) in active markets for identical assets (level 1).
2) input other than quoted prices included within level 1 that are observable for the asset either directly or indirectly (level 2); and
3) Inputs for the asset that are not based on observable market data (unobservable input) (level 3).

	Level 1 $000	Level 2 $000	Level 3 $000	Fair value at end of period $000
Assets measured at fair value 2018				
Land				
Vacant land	-	2,817	-	2,817
Residential	-	28,517	-	28,517
Specialised	-	-	50,948	50,948
Buildings				
Residential	-	68,604	-	68,604
Specialised	-	-	1,217,164	1,217,164
	-	99,938	1,268,112	1,368,050
Assets measured at fair value 2017				
Land				
Vacant land	-	3,550	-	3,550
Residential	-	39,350	-	39,350
Specialised	-	-	58,041	58,041
Buildings				
Residential	-	64,328	-	64,328
Specialised	-	-	1,195,605	1,195,605
	-	107,228	1,253,646	1,360,874

(b) Valuation technique to derive Level 2 fair values

Level 2 fair values of land and buildings are derived using the market approach. Market evidence of sales prices of comparable land and buildings in close proximity is used to determine price per square metre.

(c) Fair value measurements using significant unobservable inputs (Level 3)

	Land $000	Buildings $000
2018		
Fair value at start of period	58,041	1,195,605
Additions (including transfer from works in progress)	-	82,887
Revaluation increments/(decrements) recognised in Profit or Loss	(5,383)	(3,205)
Transfers from/(to) Level 2 (a)	170	(4,649)
Disposals	(1,880)	(2,590)
Depreciation expense	-	(50,884)
Fair value at end of period	50,948	1,217,164
2017		
Fair value at start of period	-	-
Fair value transferred from abolished entity	68,148	1,231,848
Additions (including transfer from works in progress)	2	39,377
Revaluation increments/(decrements) recognised in Profit or Loss	(9,409)	(20,028)
Disposals	(700)	(930)
Depreciation expenses	-	(54,662)
Fair value at end of period	58,041	1,195,605

(a) Represents residential accommodation buildings constructed in previous period and reflected at cost for which market values were provided in 2017/18.

Financial statements

Note 8 Risks and Contingencies (continued)

8.3 Fair value measurement (continued)

Valuation processes

There were no changes in valuation techniques during the period.

Land (Level 3 fair values)

Fair value for restricted use land is based on comparison with market evidence for land with low level utility (high restricted use land). The relevant comparators of land with low level utility is selected by the Western Australian Land Information Authority (Valuations and Property Analytics) and represents the application of a significant Level 3 input in this valuation methodology. The fair value measurement is sensitive to values of comparator land, with higher values of comparator land correlating with higher estimated fair values of land.

Buildings (Level 3 fair values)

Fair value for existing use specialised buildings is determined by reference to the cost of replacing the remaining future economic benefits embodied in the asset, i.e. the current replacement cost. Current replacement cost is generally determined by reference to the market observable replacement cost of a substitute asset of comparable utility and the gross project size specifications, adjusted for obsolescence. Obsolescence encompasses physical deterioration, functional (technological) obsolescence and economic (external) obsolescence.

Valuation using current replacement cost utilises the significant Level 3 input, consumed economic benefit/obsolescence of asset which is estimated by the Western Australian Land Information Authority (Valuations and Property Analytics). The fair value measurement is sensitive to the estimate of consumption/obsolescence, with higher values of the estimate correlating with lower estimated fair values of buildings.

Basis of valuation

In the absence of market-based evidence, due to the specialised nature of some non financial assets, these assets are valued at Level 3 of the fair value hierarchy on an existing use basis. The existing use basis recognises that restrictions or limitations have been placed on their use and disposal when they are not determined to be surplus to requirements. These restrictions are imposed by virtue of the assets being held to deliver a specific community service.

Mandatory application of AASB 2016-4 *Amendments to Australian Accounting Standards - Recoverable Amount of Non-Cash-Generating Specialised Assets of Not-for-Profit Entities* has no financial impact for the WA Country Health Service as it is classified as not-for-profit and regularly revalues its specialised property, plant and equipment assets. Therefore, fair value of the recoverable assets is expected to be materially the same as fair value.

Note 9 Other disclosures

This section includes additional material disclosures required by accounting standards or other pronouncements, for the understanding of this financial report.

	Notes
Events occurring after the end of the reporting period	9.1
Future impact of Australian standards issued not yet operative	9.2
Key management personnel	9.3
Related party transactions	9.4
Related bodies	9.5
Affiliated bodies	9.6
Special purpose accounts	9.7
Remuneration of auditors	9.8
Equity	9.9
Supplementary financial information	9.10
Explanatory statement	9.11
Administered trust accounts	9.12

9.1 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.

Notes to the Financial Statements
For the year ended 30 June 2018

Note 9 Other disclosures (continued)

9.2 Future impact of Australian Accounting Standards not yet operative

WA Country Health Service cannot early adopt an Australian Accounting Standard unless specifically permitted by TI 1101 Application of Australian Accounting Standards and Other Pronouncements or by an exemption from TI 1101. Where applicable, WA Country Health Service plans to apply the following Australian Accounting Standards from their application date.

		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. WA Country Health Service has not yet determined the application or the potential impact of the Standard.	01 Jan 2018
AASB 15	Revenue from Contracts with Customers This Standard establishes the principles that WA Country Health Service shall apply to report useful information to users of financial statements about the nature, amount, timing and uncertainty of revenue and cash flows arising from a contract with a customer. The mandatory application date of this Standard is currently 1 January 2019 after being amended by AASB 2016-7. WA Country Health Service's income is principally derived from appropriations which will be measured under AASB 1058 and will be unaffected by this change. However, WA Country Health Service has not yet determined the potential impact of the Standard on 'Grants and contributions' revenues. In broad terms, it is anticipated that the terms and conditions attached to these revenues will defer revenue recognition until WA Country Health Service has discharged its performance obligations.	01 Jan 2019
AASB 16	Leases This Standard introduces a single lessee accounting model and requires a lessee to recognise assets and liabilities for all leases with a term of more than 12 months, unless the underlying asset is of low value. Whilst the impact of AASB 16 has not yet been quantified, WA Country Health Service currently has commitments for $ 13.971 million worth of non cancellable operating leases which will mostly be brought onto the Statement of Financial Position. Interest and amortisation expense will increase and rental expense will decrease.	01 Jan 2019
AASB 1058	Income of Not-for-Profit Entities This Standard clarifies and simplifies the income recognition requirements that apply to not for profit (NFP) entities, more closely reflecting the economic reality of NFP entity transactions that are not contracts with customers. Timing of income recognition is dependent on whether such a transaction gives rise to a liability or other performance obligation (a promise to transfer a good or service), or a contribution by owners, related to an asset (such as cash or another asset) received by an entity. WA Country Health Service anticipates that the application will not materially impact appropriation or untied grant revenues.	01 Jan 2019
AASB 1059	Service Concession Arrangements: Grantors This Standard addresses the accounting for a service concession arrangement (a type of public private partnership) by a grantor that is a public sector entity by prescribing the accounting for the arrangement from the grantor's perspective. Timing and measurement for the recognition of a specific asset class occurs on commencement of the arrangement and the accounting for associated liabilities is determined by whether the grantee is paid by the grantor or users of the public service provided. WA Country Health Service has not identified any public private partnerships within scope of the Standard.	01 Jan 2019

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Notes to the Financial Statements
For the year ended 30 June 2018

Note 9 Other disclosures (continued)

9.2 Future impact of Australian Accounting Standards not yet operative (continued)

		Operative for reporting periods beginning on/after
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 mandatory application date of this Standard has been amended by AASB 2012-6 and AASB 2014-1 to 1 January 2018. Other than the exposures to AASB 9 noted above, WA Country Health Service is only insignificantly impacted by the application of the Standard.	01 Jan 2018
AASB 2014-1	Amendments to Australian Accounting Standards Part E of this Standard makes amendments to AASB 9 and consequential amendments to other Standards. These changes have no impact as Appendix E has been superseded and WA Country Health Service was not permitted to early adopt AASB 9.	01 Jan 2018
AASB 2014-5	Amendments to Australian Accounting Standards arising from AASB 15 This Standard gives effect to the consequential amendments to Australian Accounting Standards (including Interpretations) arising from the issuance of AASB 15. The mandatory application date of this Standard has been amended by AASB 2015-8 to 1 January 2018. WA Country Health Service has not yet determined the application or the potential impact of the Standard.	01 Jan 2018
AASB 2014-7	Amendments to Australian Accounting Standards arising from AASB 9 (December 2014) This Standard gives effect to the consequential amendments to Australian Accounting Standards (including Interpretations) arising from the issuance of AASB 9 (December 2014). WA Country Health Service has not yet determined the application or the potential impact of the Standard.	01 Jan 2018
AASB 2015-8	*Amendments to Australian Accounting Standards - Effective Date of AASB 15* This Standard amends the mandatory application date of AASB 15 to 1 January 2018 (instead of 1 January 2017). It also defers the consequential amendments that were originally set out in AASB 2014-5. There is no financial impact arising from this Standard.	01 Jan 2018
AASB 2016-3	Amendments to Australian Accounting Standards – Clarifications to AASB 15 This Standard clarifies identifying performance obligations, principal versus agent considerations, timing of recognising revenue from granting a licence, and, provides further transitional provisions to AASB 15. WA Country Health Service has not yet determined the application or the potential impact when the deferred AASB 15 becomes effective from 1 January 2019.	01 Jan 2018
AASB 2016-7	*Amendments to Australian Accounting Standards – Deferral of AASB 15 for Not-for-Profit Entities* This Standard defers, for not-for-profit entities, the mandatory application date of AASB 15 to 1 January 2019, and the consequential amendments that were originally set out in AASB 2014-5. There is no financial impact arising from this standard.	01 Jan 2018
AASB 2016-8	*Amendments to Australian Accounting Standards – Australian Implementation Guidance for Not for Profit Entities* This Standard inserts Australian requirements and authoritative implementation guidance for not-for-profit entities into AASB 9 and AASB 15. This guidance assists not-for-profit entities in applying those Standards to particular transactions and other events. There is no financial impact.	01 Jan 2019

Notes to the Financial Statements
For the year ended 30 June 2018

9.3 Key management personnel

WA Country Health Service has determined that key management personnel include cabinet ministers, board members and senior officers of WA Country Health Service. WA Country Health Service does not incur expenditures to compensate Ministers and those disclosures may be found in the *Annual Report on State Finances*.

Compensation of members of the accountable authority

Compensation Band	2018	2017
$ 0 - $ 10,000	1	1
$ 40,001 - $ 50,000	7	7
$ 70,001 - $ 80,000	1	1
	9	9

	2018 $000	2017 $000
Short-term employee benefits	344	342
Post-employment benefits	33	32
Other long-term benefits	-	-
Termination benefits	-	-
Total remuneration of members of the accountable authority	377	374

The short-term employee benefits includes salary and travel allowances incurred by WA Country Health Service in respect of the accountable authority.

Compensation 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, falling within the following bands are:

Compensation Band ($)	2018	2017
$ 10,001 - $ 20,000	1	-
$ 60,001 - $ 70,000	1	1
$120,001 - $130,000	-	1
$140,001 - $150,000	-	1
$150,001 - $160,000	-	1
$160,001 - $170,000	-	1
$170,001 - $180,000	1	1
$180,001 - $190,000	-	3
$190,001 - $200,000	2	-
$200,001 - $210,000	4	2
$210,001 - $220,000	2	1
$220,001 - $230,000	1	1
$230,001 - $240,000	4	-
$240,001 - $250,000	-	1
$250,001 - $260,000	-	1
$260,001 - $270,000	3	-
$290,001 - $300,000	-	1
$320,001 - $330,000	-	1
$440,001 - $450,000	1	-
$460,001 - $470,000	1	1
$480,001 - $490,000	-	1
	21	19

	2018 $000	2017 $000
Short-term employee benefits	3,888	3,529
Post-employment benefits	421	355
Other long-term benefits	434	247
Termination benefits	-	173
Total remuneration of senior officers	4,743	4,304

The short-term employee benefits includes salary, motor vehicle benefits, district and travel allowances incurred by WA Country Health Service in respect of senior officers.

Financial statements

Notes to the Financial Statements
For the year ended 30 June 2018

Note 9 Other disclosures (continued)

9.4 Related party transactions

WA Country Health Service is a wholly owned public sector entity that is controlled by the State of Western Australia.

Related parties of WA Country Health Service include:

- all cabinet ministers and their close family members, and their controlled or jointly controlled entities;
- all senior officers and their close family members, and their controlled or jointly controlled entities;
- other departments and statutory authorities, including related bodies, that are included in the whole of government consolidated financial statements (i.e. wholly-owned public sector entities);
- associates and joint ventures of a wholly-owned public sector entity; and
- the Government Employees Superannuation Board (GESB).

Significant transactions with Government-related entities

In conducting its activities, WA Country Health Service is required to transact with the State and entities related to the State. These transactions are generally based on the standard terms and conditions that apply to all agencies. Significant transactions include:

	2018 $000	2017 $000
Income from State Government - Service appropriations (Note 4.1)	948,805	943,451
Equity contribution (Note 9.9):		
- capital appropriations from State Government	27,781	20,439
- equity injections from Royalties for Regions Fund	206,831	94,506
Services received free of charge (Note 4.1):		
- corporate services from Health Support Services	31,799	26,536
- pathology services from North Metropolitan Health Service (PathWest)	23,482	29,491
Income from Royalties for Regions Fund (Note 4.1)	71,723	86,489
Commonwealth grant funding received under the National Health Reform Agreement (Note 4.2):		
- via the Department of Health	376,330	369,449
- via Mental Health Commission	24,909	21,839
Other grant funding received from the Mental Health Commission (Note 4.3)	82,127	73,638
Insurance payments to the Insurance Commission and Riskcover fund	20,195	20,375
Remuneration for services provided by the Auditor General (Note 9.8)	570	604

Material transactions with other related parties

Superannuation payments to GESB	70,741	69,823

Transactions with key management personnel

Outside of normal citizen type transactions with WA Country Health Service, there was no other related party transactions that involved key management personnel and/or their close family members and/or their controlled (or jountly controlled) entities.

9.5 Related bodies

A related body is a body which receives more than half its funding and resources from WA Country Health Service and is subject to operational control by WA Country Health Service.

WA Country Health Service had no related bodies during the financial year.

9.6 Affiliated bodies

An affiliated body is a body which receives more than half its funding and resources from WA Country Health Service but is not subject to operational control by WA Country Health Service.

WA Country Health Service had no affiliated bodies during the financial year.

Notes to the Financial Statements
For the year ended 30 June 2018

Note 9 Other disclosures (continued)

	2018 $000	2017 $000

9.7 Special purpose accounts

Mental Health Commission Fund (WA Country Health Service) Account

The purpose of the special purpose account is to receive funds from the Mental Health Commission, to fund the provision of mental health services as jointly endorsed by the Department of Health and the Mental Health Commission, in the WA Country Health Service, in accordance with the annual Service Agreement and subsequent agreements.

The special purpose account has been established under section 16(1)(d) of the Financial Management Act.

Balance at start of period	955	1,013
Add Receipts:		
Service delivery agreement		
State contributions	82,127	74,257
Commonwealth contributions	24,909	21,839
	107,036	96,096
Less Payments	(107,757)	(96,154)
Balance at end of period	234	955

9.8 Remuneration of auditors

Remuneration paid or payable to the Auditor General in respect of the audit for the current financial year is as follows:

Auditing the accounts, financial statements controls, and key performance indicators	570	604

9.9 Equity

The Western Australian Government holds the equity interest in WA Country Health Service on behalf of the community. Equity represents the residual interest in the net assets of WA Country Health Service.

Contributed equity

Balance at start of period	2,310,640	-
Transfer of net assets from owners	-	2,196,393
Contributions by owners		
Capital appropriations (a)	27,781	20,439
Royalties for Regions Fund – Regional Infrastructure and Headworks Account	206,831	94,506
Transfer of net assets from other agencies (b):		
Land transferred from Department of Land	695	2
	235,307	114,947
Distributions to owners		
Transfer of net assets to other agencies (b):		
Land transferred to the Health Ministerial Body	(2,951)	-
Residential buildings transferred to the Health Ministerial Body	(1,072)	-
Land in Wickham transferred to the City of Karratha	-	(700)
	(4,023)	(700)
Balance at end of period	2,541,924	2,310,640

(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.

TI 955 designates 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.

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Notes to the Financial Statements
For the year ended 30 June 2018

Note 9 Other disclosures (continued)

9.10 Supplementary financial information

(a) Write-offs

During the financial year, $ 6.306 million (2017: $ 1.397 million) was written off WA Country Health Service's receivables under the

	2018 $000	2017 $000
The accountable authority	6,306	1,397
The Minister	-	-
Executive Council	-	-
	6,306	1,397

(b) Losses through theft, defaults and other causes

Losses of public money and property through theft or default	-	4
Amount recovered		
Net losses	-	4

(c) Gifts of public property

Gifts of public property provided by WA Country Health Service	-	8

Notes to the Financial Statements
For the year ended 30 June 2018

Note 9 Other disclosures (continued)

9.11 Explanatory statement

All variances between estimates (original budget) and actual results for 2018, and between the actual results for 2018 and 2017 are shown below. Narratives are provided for key major variances, which are generally greater than:

- 5% and **$25.0** million for the Statements of Comprehensive Income and Cash Flows, and
- 5% and **$25.0** million for the Statement of Financial Position.

9.11.1 Statement of Comprehensive Income variances

	Variance note	Estimate 2018 $000	Actual 2018 $000	Actual 2017 $000	Variance between estimate and actual $000	Variance between actual results for 2018 and 2017 $000
COST OF SERVICES						
Expenses						
Employee benefits expense	(a)	947,890	1,002,713	958,399	54,823	44,314
Fees for visiting medical practitioners		82,349	85,859	84,071	3,510	1,788
Patient support costs	(b)	339,678	381,124	398,039	41,446	(16,915)
Finance costs		149	138	199	(11)	(61)
Depreciation and amortisation expense		74,050	74,005	77,016	(45)	(3,011)
Asset revaluation decrement	(c)	-	17,566	54,218	17,566	(36,652)
Loss on disposal of non-current assets		-	3,406	1,338	3,406	2,068
Repairs, maintenance and consumable equipment		37,219	49,200	48,147	11,981	1,053
Other expenses	(d)	211,438	165,559	161,643	(45,879)	3,916
Total cost of services		**1,692,773**	**1,779,570**	**1,783,070**	**86,797**	**(3,500)**
Income						
Patient charges		66,045	67,187	68,996	1,142	(1,809)
Commonwealth grants and contributions	(e)	426,525	484,181	467,570	57,656	16,611
Other grants and contributions		99,184	95,652	102,849	(3,532)	(7,197)
Donation revenue		519	551	637	32	(86)
Other revenue		33,637	22,589	23,738	(11,048)	(1,149)
Total Revenue		**625,910**	**670,160**	**663,790**	**44,250**	**6,370**
Total income other than income from State Government		**625,910**	**670,160**	**663,790**	**44,250**	**6,370**
NET COST OF SERVICES		**1,066,863**	**1,109,410**	**1,119,280**	**42,547**	**(9,870)**
INCOME FROM STATE GOVERNMENT						
Service appropriations		934,426	948,805	943,451	14,379	5,354
Assets assumed		-	(67)	43	(67)	(110)
Services received free of charge	(f)	29,739	55,373	56,107	25,634	(734)
Royalties for Regions Fund	(g)	102,698	71,723	86,489	(30,975)	(14,766)
Total income from State Government		**1,066,863**	**1,075,834**	**1,086,090**	**8,971**	**(10,256)**
DEFICIT FOR THE PERIOD		**-**	**(33,576)**	**(33,190)**	**(33,576)**	**(386)**
OTHER COMPREHENSIVE INCOME/(LOSS)						
Items not reclassified subsequently to profit or loss						
Total other comprehensive income		**-**	**-**	**-**	**-**	**-**
TOTAL COMPREHENSIVE INCOME/(LOSS) FOR THE PERIOD		**-**	**(33,576)**	**(33,190)**	**(33,576)**	**(386)**

Financial statements

Notes to the Financial Statements
For the year ended 30 June 2018

Note 9 Other disclosures (continued)

9.11 Explanatory statement (continued)

9.11.2 Statement of Financial Position variances

	Variance note	Estimate 2018 $000	Actual 2018 $000	Actual 2017 $000	Variance between estimate and actual $000	Variance between actual results for 2018 and 2017 $000
ASSETS						
Current Assets						
Cash and cash equivalents		14,958	18,173	18,949	3,215	(776)
Restricted cash and cash equivalents		37,520	25,342	37,369	(12,178)	(12,027)
Receivables		19,227	23,647	23,752	4,420	(105)
Inventories		5,269	5,157	5,270	(112)	(113)
Prepayments		5,067	4,328	5,067	(739)	(739)
Total Current Assets		**82,041**	**76,647**	**90,407**	**(5,394)**	**(13,760)**
Non-Current Assets						
Restricted cash and cash equivalents		7,680	7,463	3,840	(217)	3,623
Amounts receivable for services	(h)	748,471	748,497	674,420	26	74,077
Property, plant and equipment	(i)	2,002,976	1,916,214	1,777,418	(86,762)	138,796
Intangible assets		13,941	17,338	13,941	3,397	3,397
Total Non-Current Assets		**2,773,068**	**2,689,512**	**2,469,619**	**(83,556)**	**219,893**
Total Assets		**2,855,109**	**2,766,159**	**2,560,026**	**(88,950)**	**206,133**
LIABILITIES						
Current Liabilities						
Payables		114,283	116,019	119,198	1,736	(3,179)
Borrowings		1,779	1,779	1,701	-	78
Provisions		131,607	143,401	131,606	11,794	11,795
Other current liabilities		22	52	22	30	30
Total Current Liabilities		**247,691**	**261,251**	**252,527**	**13,560**	**8,724**
Non-Current Liabilities						
Borrowings		1,865	1,865	3,644	-	(1,779)
Provisions		26,405	27,885	26,405	1,480	1,480
Total Non-Current Liabilities		**28,270**	**29,750**	**30,049**	**1,480**	**(299)**
Total Liabilities		**275,961**	**291,001**	**282,576**	**15,040**	**8,425**
NET ASSETS		**2,579,148**	**2,475,158**	**2,277,450**	**(103,990)**	**197,708**
EQUITY						
Contributed equity		2,611,949	2,541,924	2,310,640	(70,025)	231,284
Accumulated deficit		(32,801)	(66,766)	(33,190)	(33,965)	(33,576)
TOTAL EQUITY		**2,579,148**	**2,475,158**	**2,277,450**	**(103,990)**	**197,708**

Notes to the Financial Statements
For the year ended 30 June 2018

Note 9 Other disclosures (continued)

9.11 Explanatory statement (continued)

9.11.3 Statement of Cash Flows variances

	Variance note	Estimate 2018 $000	Actual 2018 $000	Actual 2017 $000	Variance between estimate and actual $000	Variance between actual results for 2018 and 2017 $000
CASH FLOWS FROM STATE GOVERNMENT						
Service appropriations		860,227	874,584	855,497	14,357	19,088
Capital appropriations	(j)	59,681	26,080	18,815	(33,601)	7,265
Royalties for Regions Fund	(k),(l)	342,625	278,554	180,995	(64,071)	97,559
Net cash provided by State Government		**1,262,533**	**1,179,218**	**1,055,307**	**(83,315)**	**123,911**
Utilised as follows:						
CASH FLOWS FROM OPERATING ACTIVITIES						
Payments						
Employee benefits	(a), (m)	(947,891)	(997,236)	(938,947)	(49,345)	(58,288)
Supplies and services	(n), (o)	(640,944)	(604,092)	(636,892)	36,852	32,800
Receipts						
Receipts from customers		66,045	64,412	70,696	(1,633)	(6,284)
Commonwealth grants and contributions	(e)	426,525	484,181	467,570	57,656	16,611
Other grants and contributions		99,184	95,653	102,849	(3,531)	(7,197)
Donations received		519	521	622	2	(101)
Other receipts		33,637	26,532	21,795	(7,105)	4,738
Net cash used in operating activities		**(962,925)**	**(930,029)**	**(912,307)**	**32,896**	**(17,722)**
CASH FLOWS FROM INVESTING ACTIVITIES						
Payments						
Purchase of non-current physical assets	(p), (q)	(299,608)	(258,369)	(149,067)	41,239	(109,302)
Receipts						
Proceeds from sale of non-current physical assets		-		-		-
Net cash used in investing activities		**(299,608)**	**(258,369)**	**(149,067)**	**41,239**	**(109,302)**
Net increase / (decrease) in cash and cash equivalents		-	(9,180)	(6,067)	(9,180)	(3,113)
Cash and cash equivalents at the beginning of the period		60,158	60,158	-	-	60,158
Cash and cash equivalents transferred from other sources		-	-	66,225	-	(66,225)
CASH AND CASH EQUIVALENTS AT THE END OF PERIOD		**60,158**	**50,978**	**60,158**	**(9,180)**	**(9,180)**

Financial statements

Notes to the Financial Statements
For the year ended 30 June 2018

Note 9 Other disclosures (continued)

9.11 Explanatory statement (continued)

Significant variances between estimates and actuals for 2018 and/or between actuals for 2018 and 2017

(a) Employee benefits expense

The variance between current year estimate and actual is primarily attributable to various new and ongoing services for which funding was not included in the initial estimates but were the subject of subsequent budget allocations throughout the year and at Mid-Year Review. These included increased funding for Commonwealth funded programs ($37.6m) including multi purpose services, trachoma services, aged, respite and home care for which funding agreements had not been finalised at the time of the initial 2017-18 budget, as well as additional $8.6m for mental health, drug and alcohol programs.

(b) Patient support costs

The variance between current year estimate and actual is primarily due to expenditure associated with various continuing and new services that were not included in the initial Estimates but were the subject of subsequent budget adjustments, including various Commonwealth funded programs for which funding agreements had not been finalised at the time of the initial 2017-18 budget. In addition, actual patient support costs include the value of services received at less than full cost from Pathwest, which had not been included in the initial budget, but was the subject of a budget adjustment during the financial year ($23.0m).

(c) Asset revaluation decrement

The variance between current and last year actuals in asset revaluation decrement is a direct result of changes in land and building valuation undertaken by the Western Australian Land Information Authority (Valuation and Property Analytics).

(d) Other expenses

The variance between current year estimate and actual is largely due to approved budgets in the initial estimates held pending reallocation to other Health entities, and budget adjustments throughout the year and at Mid Year Review.

(e) Commonwealth grants and contributions

The variance between current year estimate and actual is primarily due to revenues for various continuing and new Commonwealth funded services that were not included in the initial Estimates but were the subject of subsequent budget adjustments ($37.6m) such as multi purpose services, trachoma services, aged, respite and home care, for which funding agreements had not been finalised at the time of the initial 2017-18 budget. In addition, $19.0m of Commonwealth capital grants were received during the year for renal dialysis, cancer care and Newman Health Redevelopment projects, with a corresponding budget Adjustment received at Mid Year Review.

(f) Services received free of charge

The variance between current year estimate and actual is due to revised estimates of the value of services received free of charge from Health Support Services ($2.3m) with a corresponding budget adjustment received during the year, and the recognition of the value of services received at less than full cost from Pathwest which had not been included in the initial budget but was the subject of a budget adjustment during the financial year ($23.0m).

(g) Royalties for regions fund (Income)

The variance between current year estimate and actual is due to reconfiguration and recashflowing of Royalties for Regions programs during the financial year. Variances included reprofiling and recashflowing for Southern Inland Health Initiative's medical workforce and residential aged care programs ($14.8m), Turquoise Coast Health Initiative ($4.0m), Goldfields Emergency Telehealth ($2.7m) North West Health Initiative ($3.3m) and various other programs ($6.2m) as detailed in the 2017-18 Mid Year Review and the 2018-19 State budget documentation .

(h) Amounts receivable for services

Amounts receivable for services represents the non-cash component of service appropriations that support asset replacement or the payment of leave liability. The variance between current and last year actuals is attributable to the increase in accrual appropriation for depreciation and amortisation expenses.

(i) Property, plant and equipment

The variance between current and last year actuals is due to additions to capital projects including major infrastructure such as Karratha Health Campus, Onslow Redevelopment and various Southern Inland Health Initiative capital projects, offset by reduction through depreciation ($72.1m) and asset revaluation decrement ($17.6m).

(j) Capital appropriations

The variance between current year estimate and actual is due to delays in construction and achievement of project milestones for various capital works projects which have been recashflowed during the 2017-18 Mid Year Review and the 2018-19 State Budget.

(k) Royalties for regions fund (cash flow)

The variance between current year estimate and actual is due to reconfiguration and recashflowing of the Royalties for Regions programs during the financial year. Variances included reprofiling and recashflowing for Southern Inland Health Initiative 's medical workforce and residential aged care programs ($14.8m), Turquoise Coast Health Initiative ($4.0m) and Goldfields Emergency Telehealth ($2.7m), Karratha Health Campus development ($22.1m) and various other programs ($10m) as detailed in the 2017-18 Mid Year Review and the 2018-19 State budget documentation.

Notes to the Financial Statements
For the year ended 30 June 2018

Note 9 Other disclosures (continued)

9.11 Explanatory statement (continued)

Significant variances between estimates and actuals for 2018 and/or between actuals for 2018 and 2017 (continued)

(l) Royalties for regions fund (cash flow)

The variance between current and last year actuals is due to higher funding received for various capital projects under the Southern Inland Health Initiative ($79.7m) and the Karratha Health Campus development ($45m). This is offset by lower amounts received in 2017-18 for various hospital investment programs, residential aged and dementia care services, as well as a one-off payment to the Royal Flying Doctor Services for the purchase of an aeroplane in 2016-17 ($5.1m).

(m) Employee expenses (cash flow)

The variance between current and last year actuals is due to the combined effect of increased FTE associated with new and expanded services and changes to industrial awards for which budgets were provided in the initial 2017-18 Service Agreement or during the financial year.

(n) Supplies and Services

The variance between current year estimate and actual is due to a combination of:
(i) the reconfiguration and recashflowing of the Royalties for Regions programs during the financial year. Variances included reprofiling and recashflowing for Southern Inland Health Initiative 's medical workforce and residential aged care programs ($14.8m), Turquoise Coast Health Initiative ($4.0m) and Goldfields Emergency Telehealth ($2.7m), North West Health Initiative ($3.3m) and various other programs ($6.2m) as detailed in the 2017-18 Mid Year Review and the 2018-19 State budget documentation,
(ii) lower than budgeted expenditures on Hepatitis C antiviral drugs ($4.7m), and
(iii) the net effect of various other factors ($1.2m).

(o) Supplies and services

The variance between current and last year actuals is attributable to a combination of one off expenditures in 2016-17, including Southern Inland Health Initiative [projects, grants to Royal Flying Doctor Service for replacement aircraft and medical equipment replacements], together with reduced expenditures on drugs (particularly Hepatitis C antivirals).

(p) Payments for purchase of non-current physical assets

The variance between current year estimate and actual is due to the recashflow of Karratha Health Campus development ($22.1m), and delays in construction and achievement of project milestones, adjustments to the Asset Investment Program and recashflowing of various capital projects during the 2017-18 Mid Year Review and 2018-19 State Budget.

(q) Payment for purchase of non-current physical assets

The variance between current and last year actuals is primarily due to increased payments for various infrastructure projects including the Karratha Health Campus development, Onslow Redevelopment and various Southern Inland Health Initiative capital projects.

9.12 Administered trust accounts

Funds held in these trust accounts are not controlled by WA Country Health Service and are therefore not recognised in the financial statements.

WA Country Health Service administers trust accounts for the purpose of holding patients' private moneys.

A summary of the transactions for these trust accounts is as follows:

	2018 $000	2017 $000
Balance at the start of period	1,187	1,205
Add Receipts	891	1,270
	2,078	2,475
Less Payments	(1,075)	(1,288)
Balance at the end of period	1,003	1,187

Certification of key performance indicators

WA COUNTRY HEALTH SERVICE
CERTIFICATION OF THE KEY PERFORMANCE INDICATORS FOR THE YEAR ENDED 30 JUNE 2018

We hereby certify the key performance indicators are based on proper records, are relevant and appropriate for assisting users to assess the WA Country Health Service's performance and fairly represent the performance of the Health Service for the financial year ending 30 June 2018.

PROFESSOR NEALE FONG
CHAIR
WA COUNTRY HEALTH SERVICE BOARD

MR ALAN FERRIS
BOARD MEMBER
WA COUNTRY HEALTH SERVICE BOARD

19 September 2018

Key performance indicators

Outcome 1: Public hospital based services that enable effective treatment and restorative healthcare for Western Australians	PAGE
Unplanned hospital readmissions of public hospital patients within 28 days for selected surgical procedures	102
Proportion of elective wait list patients waiting over boundary for reportable procedures	104
Hospital infection rates	105
Survival rates for sentinel conditions	106
Percentage of admitted Aboriginal and Non-Aboriginal patients who discharged against medical advice	108
Percentage of live-born term infants with an Apgar score of less than seven at five minutes post delivery	109
Rate of total hospital readmissions within 28 days to an acute designated mental health inpatient unit	110
Percentage of contacts with community-based public mental health non-admitted services within seven days post discharge from and acute public mental health inpatient unit	111
Average admitted cost per weighted activity unit	112
Average Emergency Department cost per weighted activity unit	113
Average non-admitted cost per weighted activity unit	114
Average cost per bed-day in specialised mental health inpatient units	115
Average cost per treatment day of non-admitted care provided by public clinical mental health services	116

Outcome 2: Prevention, health promotion and aged and continuing care services that help Western Australians to live healthy and safe lives	PAGE
Response times for emergency air-based patient transport services	117
Percentage of patients who access emergency services at a small rural or remote Western Australian hospital and are subsequently discharged home	118
Average cost per bed-day for specialised residential care facilities, flexible care (hostels) and nursing home type residents	119
Average cost per person of delivering population health programs by population health units	120
Cost per trip of patient emergency air-based transport, based on the total accrued costs of these services per the total number of trips	121
Average cost per trip of Patient Assisted Travel Scheme (PATS)	122
Average cost per rural and remote population (selected small rural hospitals)	123

Outcome 1
Effectiveness Indicators

UNPLANNED HOSPITAL READMISSIONS WITHIN 28 DAYS FOR SELECTED SURGICAL PROCEDURES

Rationale

After successful hospital stay, the most important task for WA public hospital patients and staff is preparing for a successful discharge home. Tracking the number of patients who experience unplanned readmissions to WA health system hospitals within 28 days for selected surgical procedures, assists in assessing the quality of hospital services provided to the community. Unplanned readmissions are those readmissions where the principle diagnosis and readmission interval indicate that the readmission may be related to the care provided by the hospital in an index surgical episode of care. This indicator measures readmissions to a public hospital (the hospital of the original admission or another public hospital) or as a public patient in Contracted Health Entities (CHEs).

Readmission rate is considered a global performance measure, as it potentially points to deficiencies in the functioning of the overall healthcare system. Good intervention and appropriate treatment, together with good discharge planning will decrease the likelihood of unplanned hospital readmissions. A low unplanned readmission rate suggests that good clinical practice is in operation within our health system, and lessons can be learnt from a higher than target unplanned readmission rate through the creation of a variety of improvement strategies.

The surgeries selected to be measured by this indicator have a risk associated with post-surgery complications. Good discharge plans can help to decrease the likelihood of unplanned hospital readmissions, by providing patients with the care instructions they need after a hospital stay and by helping patients recognise symptoms that may require immediate medical attention.

Target

The 2017 targets can be seen in the below table:

Surgical Procedure	Target
a) Knee replacement	≤26.2
b) Hip replacement	≤17.2
c) Tonsillectomy & adenoidectomy	≤61.0
d) Hysterectomy	≤41.3
e) Prostatectomy	≤38.8
f) Cataract surgery	≤1.1
g) Appendicectomy	≤32.9

Outcome 1
Effectiveness Indicators

Results

The 2017 rate of unplanned readmissions within 28 days to a country hospital for selected surgical procedures can be seen in Table 13.

Table 13: Unplanned hospital readmissions within 28 days for selected surgical procedures, 2017

Surgical Procedure	2016 (per 1,000)	2017 (per 1,000)	Target
a) Knee replacement	22.6	37.9	≤26.2
b) Hip replacement	36.7	21.8	≤17.2
c) Tonsillectomy & adenoidectomy	46.2	61.6	≤61.0
d) Hysterectomy	33.8	15.8	≤41.3
e) Prostatectomy	89.3	40.4	≤38.8
f) Cataract surgery	3.9	0.4	≤1.1
g) Appendicectomy	41.2	39.2	≤32.9

Data Source: Hospital Morbidity Data System (HMDS)

WACHS has met target for Hysterectomy and Cataract Surgery, with all other procedure readmission rates not meeting target. The low number of cases may lead to significant fluctuation in year on year results as evidenced by the raw numbers of procedures followed by readmission:

- Knee Replacement = 10 readmissions from 264 procedures
- Hip Replacement = 6 readmissions from 275 procedures
- Tonsillectomy & adenoidectomy = 22 readmissions from 357 procedures
- Prostatectomy = 4 readmissions from 99 procedures
- Appendicectomy = 30 readmissions from 766 procedures

If patients experience issues or symptoms following surgery, readmission is often the safest option especially in rural or remote areas where the distance between a patient's place of residence and access to health services can be considerable. All readmission cases are individually reviewed to ensure appropriate care.

Outcome 1
Effectiveness Indicators

PROPORTION OF ELECTIVE WAIT LIST PATIENTS WAITING OVER BOUNDARY FOR REPORTABLE PROCEDURES

Rationale

Elective surgery refers to planned surgery that can be booked in advance as a result of specialist assessment resulting in placement on the elective surgery waiting list. Waiting lists are actively managed by hospitals to ensure all patients are treated in clinically appropriate timeframes. Patients are prioritised based on their assigned clinical urgency category:

- Category 1 – procedures that are clinically indicated within 30 days
- Category 2 – procedures that are clinically indicated within 90 days
- Category 3 – procedures that are clinically indicated within 365 days

On 1 April 2016, the WA health system introduced a new state-wide performance target for the provision of elective services. The new target requires no patient (0%) on the elective waiting lists wait longer than the clinically recommended time for their procedure, according to their urgency category.

Reportable cases are defined as all waiting list cases that are not listed on the Elective Services Wait List Data Collection (ESWLDC) Commonwealth Non-Reportable Procedure List. This list is consistent with the Australian Institute of Health and Welfare (AIHW) list of Code 2 (other) procedures that do not meet the definition of elective surgery. It is also includes additional procedure codes that are intended to better reflect the procedures identified in the AIHW Code 2 list.

Target

The 2017-18 target is 0% which is aligned to the WA state-wide performance target.

Results

In 2017-18, the proportion of elective wait list patients waiting over boundary for reportable procedures did not meet target any category (see Table 14).

Table 14: Proportion of elective wait list patients waiting over boundary for reportable procedures, 2017-18

Category	2017-18 (%)	Target (%)
Category 1 within 30 days	8.7	0
Category 2 within 90 days	9.4	0
Category 3 within 365 days	4.8	0
Total	5.5	0

Data Source: Elective Surgery Wait List (ESWL) Data Collection

WA Country Health Service identified errors in the data used to calculate this KPI in 2016-17 and part of 2017-18. Due to the extent and impact of these errors, WACHS has removed the results section for this KPI from the 2016-17 Annual Report published on the WACHS website, and therefore no comparative period reporting is provided in the 2017-18 Annual Report. An erratum for the 2016-17 Annual Report has also been tabled in Parliament. The organisation is putting stringent measures in place to ensure and maintain accurate reporting of this KPI in the future.

WA Country Health Service is currently undertaking a project involving senior clinicians and health administration staff to improve the accuracy and consistency of referral documentation, and improve the use of business intelligence tools to support the monitoring and management of the elective waiting list. A program of control self-assessment on compliance is also being undertaken across the WA Country Health Service.

Outcome 1
Effectiveness Indicators

HOSPITAL INFECTION RATES (HEALTHCARE-ASSOCIATED STAPHYLOCOCCUS AUREUS BLOODSTREAM INFECTIONS (HA-SABSI) PER 10,000 OCCUPIED BED-DAYS IN PUBLIC HOSPITALS)

Rationale

Staphylococcus aureus bloodstream infection (SABSI) is a serious infection that may be associated with the provision of healthcare. Staphylococcus aureus is a highly pathogenic organism and even with advanced medical care, infection caused by this organism is associated with prolonged hospital stays, increased healthcare costs and a marked increase in morbidity and mortality – mortality estimated at 20-25%.

HA-SABSI is generally considered to be preventable adverse events associated with the provision of healthcare.

This KPI has been selected for inclusion as it is a robust KPI of the safety and quality of WA public hospitals, and aligns to the principle of increased transparency and accountability of performance information provided to the public. A low or decreasing HA-SABSI rate is desirable and a target for WA based on historical data has been set.

Target

The 2017 target is ≤ 1.0 per 10,000 bed days.

Results

The rate of HA-SABSI Infection per 10,000 occupied bed days met target as seen in Table 15.

Table 15: Hospital infection rates (healthcare-associated Staphylococcus aureus bloodstream infections (HA-SABSI) per 10,000 occupied bed-days in public hospitals, 2017

	2017 (per 10,000)	Target (per 10,000)
Infection Rate	0.64	≤ 1.0

Data Source: HISWA

WACHS participates in the WA Health Healthcare Associated Infection Surveillance in Western Australia Healthcare Facilities (HISWA) program of mandatory surveillance of a range of healthcare associated infections (HAI), including HA-SABSI.

All instances of HA-SABSI are thoroughly investigated to determine the cause of infection. Information on infection rates is discussed at the peak WACHS infection prevention and control committee to help inform understanding of WACHS HAI risks and the need to develop or revise processes to reduce risks to patients. WACHS has standardised processes across regions for the documentation and observation of peripheral intravenous devices often associated with HA-SABSI.

Outcome 1
Effectiveness Indicators

SURVIVAL RATES FOR SENTINEL CONDITIONS

Rationale

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

These three conditions have been chosen as they are particularly significant for the healthcare of the community and are leading causes of death and hospitalisation in Australia. Patient survival after being admitted for one of these three sentinel conditions can be affected by many factors that include diagnosis, the treatment given or procedure performed, age, co-morbidities at the time of admission and complications which may have developed while in hospital.

Hospital survival indicators, including this KPI, are considered screening tools as they are not definitively diagnostic of poor quality care and/or safety.

Target

The 2017 targets can be seen in the below table:

Age Group	Stroke (%)	AMI (%)	FNOF (%)
0-49 Years	94.3	99.2	N/A
50-59 Years	92.4	98.9	N/A
60-69 Years	92.8	98.1	N/A
70-79 Years	89.5	96.1	98.9
80+ Years	80.9	91.7	95.3

Results

During 2017, survival rates for stroke met target for all age cohorts (see Table 16). Low number of cases can lead to significant fluctuation in results. Across all age cohorts, WA Country Health Service reported 50 deaths attributed to stroke out of 635 episodes. This is an overall survival rate of 92.1%.

Table 16: Survival rates for sentinel condition: Stroke, 2017

Age Group	2016 (%)	2017 (%)	Target (%)
0-49 Years	95.8	100	≥ 94.3
50-59 Years	100	97	≥ 92.4
60-69 Years	92.3	95.9	≥ 92.8
70-79 Years	92.9	96.5	≥ 89.5
80+ Years	84.1	85.2	≥ 80.9

Note: Due to low number of cases within some age categories, care should be taken when considering fluctuations in results.

Data Source: Hospital Morbidity Data System (HMDS)

WACHS has a standardised clinical care pathway for stroke, developed in line with best practice standards.

Outcome 1
Effectiveness Indicators

Survival rates for Acute Myocardial Infarction (AMI) for 2017 also met target performance for the 0-49 Years, 50-59 Years, 60-69 Years and 70-79 Years age cohorts. WACHS did not meet target for the 80+ years cohort (see Table 17). WA Country Health Service reported 16 deaths attributed to AMI out of 500 episodes, representing an overall survival rate of 96.8%.

Table 17: Survival rates for sentinel condition: Acute Myocardial Infarction (AMI), 2017

Age Group	2016 (%)	2017 (%)	Target (%)
0-49 Years	100	100	≥ 99.2
50-59 Years	100	100	≥ 98.9
60-69 Years	94.7	100	≥ 98.1
70-79 Years	94.7	96.8	≥ 96.1
80+ Years	90.7	90.1	≥ 91.7

Note: Due to low number of cases within some age categories, care should be taken when considering fluctuations in results.

Data Source: Hospital Morbidity Data System (HMDS)

WACHS has a standardised chest pain pathway, designed in line with best practice clinical standards, which promotes sound escalation processes for patients diagnosed as having an acute myocardial infarction.

Table 18: Survival rates for sentinel condition: Fractured Neck of Femur (FNOF), 2017

Age Group	2016 (%)	2017 (%)	Target (%)
70-79 Years	100	100	≥ 98.9
80+ Years	95.8	96	≥ 95.3

Note: Due to low number of cases within some age categories, care should be taken when considering fluctuations in results.

Data Source: Hospital Morbidity Data System (HMDS)

WACHS utilises a standardised Falls Risk Assessment and Management Plan (FRAMP) in which patients are clinically reviewed and assessed for potential falling, and appropriate mitigation strategies are employed to reduce the likelihood of a fall occurring.

Patients presenting with a FNOF are at greater risk of developing delirium whilst an inpatient which adversely affects health outcomes. In 2018 WACHS is implementing a comprehensive cognitive impairment project which includes increasing the awareness of delirium and improving the recognition and response to patients with cognitive impairment.

Outcome 1
Effectiveness Indicators

PERCENTAGE OF ADMITTED ABORIGINAL AND NON-ABORIGINAL PATIENTS WHO DISCHARGED AGAINST MEDICAL ADVICE

Rationale

Patients who leave hospital against medical advice (also called DAMA or discharged against medical advice) have been found to cost the health system 50% more than the cost of patients who are discharged by physicians.

WA health system public hospitals employ a range of initiatives to ensure patients receive timely, understandable information regarding their treatment options and the importance of continuing to receive care in the hospital setting, if clinically appropriate. These initiatives include supporting the delivery of culturally secure health services to Aboriginal people.

This new KPI will assist in measuring the success of these initiatives and provides a measure of the safety, quality and cultural security of the services provided.

Monitoring this indicator will enable identification of performance improvement opportunities, as well as the collaborative and effective addressing of the underlying factors in achieving an equitable treatment outcome for Aboriginal patients.

Target

The 2017 target is ≤ 0.77%.

Results

The 2017 Discharge Against Medical Advice (DAMA) rate did not meet target (see Table 19).

Table 19: Percentage of admitted Aboriginal and Non-Aboriginal patients who discharged against medical advice (DAMA), 2017

Cohort	2017 (%)
Aboriginal	5.2
Non-Aboriginal	0.8
Total	1.7
Overall target:	≤ 0.77

Data Source: Hospital Morbidity Data System (HMDS)

WACHS revised and updated clinical guidance on DAMA in June 2018 (the Discharge Against Medical Advice Policy and associated medical record form). This has provided increased information for clinicians to support reducing the occurrence of DAMA, in particular among Aboriginal and Mental Health patients (who are statistically more likely to DAMA). The Policy includes a risk based approach to managing follow up with patients who DAMA.

Outcome 1
Effectiveness Indicators

PERCENTAGE OF LIVE-BORN TERM INFANTS WITH AN APGAR SCORE OF LESS THAN SEVEN AT FIVE MINUTES POST DELIVERY

Rationale

This indicator provides an outcome measure of a baby's physical health immediately after birth.

The Apgar score is an assessment of an infant's health at birth based on breathing, heart rate, colour, muscle tone and reflex irritability. An Apgar score is applied at one, five and possibly ten minutes after delivery to determine how well the infant is adapting outside the mother's womb. Apgar scores range from zero to two for each condition with a maximum total score of ten. The higher the Apgar score the better the health of the newborn infant.

The outcome measure can lead to the development and delivery of improved care pathways and interventions to improve the health outcomes of Western Australian infants.

The indicator also aligns to the National Core Maternity Indicators (2016) Health, Standard 02/02/2018.

Target

The 2017 target is ≤ 1.8%.

Results

In 2017, the percentage of live-born term infants with an Apgar score of less than seven, five minutes post-delivery met target, seen in Table 20.

Table 20: Percentage of live-born term infants with an Apgar score of less than seven at five minutes post delivery, 2017

	2016 (%)	2017 (%)	Target (%)
Liveborn Term Infants Apgar <7 at 5 minutes	1.5	1.6	≤ 1.8

Data Source: Midwives Notification System

The WA Country Health Service Midwifery Advisory Forum, in collaboration with the WA Country Health Service Clinical Advisory and Patient Safety Obstetrics and Gynaecology group, has updated the policy for Recognition and Response of Acute Deterioration in the Newborn at Clinical Risk. This policy now includes newly identified risk factors which contribute to newborn compromise at birth. The policy includes clear pathways for the ongoing management of newborns known to be at clinical risk at birth and at risk of clinical deterioration after birth. WACHS has also recently established a Neonatal and Paediatric Leadership group across rural and remote WA to address newborn and neonatal clinical care delivery issues. This will support staff and patients within WA to ensure the best outcomes for mothers and newborns.

Outcome 1
Effectiveness Indicators

RATE OF TOTAL HOSPITAL READMISSIONS WITHIN 28 DAYS TO AN ACUTE DESIGNATED MENTAL HEALTH INPATIENT UNIT

Rationale

A designated metal health inpatient unit or acute mental health inpatient unit may see patients readmitted after completion of a previous admission. Readmission rate is considered to be a global performance measure as it potentially points to deficiencies in the functioning of the overall mental healthcare system.

While multiple hospital admissions over a lifetime may be necessary for someone with ongoing illness, a high proportion of readmissions shortly after discharge may indicate that inpatient treatment was either incomplete or ineffective, or that follow-up care was not adequate to maintain the patient's recovery out of hospital. These readmissions mean that patients spend additional time in hospital and utilise additional resources. A low readmission rate suggests that good clinical practice is in operation. This indicator is reported at the facility at which the initial admission occurred rather that the facility at which the patient was readmitted.

By measuring and monitoring this indicator key areas for improvements can be identified. This in turn can facilitate the development and delivery of targeted care pathways and interventions, which can aim to improve mental health and quality of life of Western Australians.

Target

The 2017 target is ≤ 12%.

Results

In 2017, the rate of total readmissions within 28 days to an acute designated mental health inpatient unit did not meet target (see Table 21).

Table 21: Rate of total hospital readmissions within 28 days to an acute designated mental health inpatient unit, 2017

	2017 (%)	Target (%)
Total Hospital Readmissions	17.2	≤ 12

Data Source: Hospital Morbidity Data System (HMDS)

WACHS has identified that due to limited options for supported step down or sub-acute accommodation in rural and remote WA, readmissions may be in the only option for some patients. People with an Emotionally Unstable Personality Disorder (EUPD), also known as borderline personality disorder, experience repeated crises. They are encouraged to return to Emergency Departments and receive short term re-admissions prior to the emotional crises escalating (which may otherwise result in increased self-harming behaviours).

WACHS Mental Health ensures that readmissions are monitored closely and occur where clinically appropriate and not as the first solution. Intensive post discharge follow up continues to be offered to patients however readmission will occur for highly complex patients, including those with a mood disorder.

Outcome 1

Effectiveness Indicators

PERCENTAGE OF CONTACTS WITH COMMUNITY-BASED PUBLIC MENTAL HEALTH NON-ADMITTED SERVICES WITHIN SEVEN DAYS POST DISCHARGE FROM AN ACUTE PUBLIC MENTAL HEALTH INPATIENT UNIT

Rationale

In 2014-15 there were 4 million Australians (17.5%) who reported having a mental or behavioural condition. Therefore, it is crucial to ensure effective and appropriate care is provided not only in a hospital setting but also in the community.

Discharge from hospital is a critical transition point in the delivery of mental health care. People leaving hospital after an admission for an episode of mental health illness have heightened levels of vulnerability and, without adequate follow up, may relapse or be readmitted. This KPI measures the performance of the overall health system in providing continuity of mental health care.

A responsive community support system for persons who have experienced a psychiatric episode requiring hospitalisation is essential to maintain their clinical and functional stability and to minimise the need to 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 avoidable readmissions.

The standard underlying the measure is that continuity of care involves prompt community follow-up in the vulnerable period following discharge from hospital. Overall, the variation in post-discharge follow up rates suggest important differences between mental health systems in terms of their practices.

Target

The 2017 target is ≥ 75%.

Results

In 2017, contacts with community-based public mental health non-admitted services within seven days post discharge from an acute public mental health inpatient unit met target (see Table 22).

Table 22: Percentage of contacts with a community-based mental health non-admitted service within seven days post discharge, 2017

	2016 (%)	2017 (%)	Target (%)
Post-discharge community-based contacts	67.5	75.6	≥75

Data Sources: Mental Health Information System, Hospital Morbidity Data System (HMDS)

Throughout the last twelve months the WACHS regions have consistently met the target of 75 percent. Improved communication between the Mental Health Inpatient Units and the Community Mental Health teams has contributed to increased rates of follow up. The Mental Health services attempt to follow up all patients discharged but not all patients can be contacted within the seven day time frame. Patients may be difficult to contact for various reasons. Some patients when discharged do not want further contact and refuse to engage with the Mental Health Service. Others may decline to attend or not show up for appointments. Consumers may be lost to the service, not contactable or may have moved out of the area.

Outcome 1
Efficiency Indicators

AVERAGE ADMITTED COST PER WEIGHTED ACTIVITY UNIT

Rationale

This indicator is a measure of the cost per weighted activity unit compared with the Health Service Provider's Health Service Allocation Price (HSAP) set each year in the WA Activity Based Funding (ABF) Operating Model.

The measure ensures that a consistent methodology is applied to calculating and then measuring the performance of Health Service Providers (HSPs) against the funding they receive through the Government Budget Statement and subsequent Service Agreements and the activity delivered by each Hospital site (reported at an aggregate entity level). It is imperative that efficiency of this service delivery is accurately monitored and reported.

Target

The target for average admitted cost per weighted activity unit is $7,285.

This target differs from the state (aggregated) target of $6,868 as outlined in the 2017-18 Budget Statements Budget Paper No. 2-Volume 1. The target set in Budget Paper 2 excluded Teaching, Training and Research (TT&R) Programs and PathWest Resources received free of charge (RRFoC) (excluding direct charges to HSPs captured under the existing fee for service model). The 2017-18 WACHS Annual Report target of $7,285 reflects the target published in Budget Paper 2, adjusted for these items.

Results

In 2017-18, the average admitted cost per weighted activity unit (WAU) met target, as can be seen in Table 23.

Table 23: Average admitted cost per weighted activity unit (WAU), 2017-18

	2017–18 ($)	Target ($)
Average admitted cost / WAU	$6,119	$7,285

Data Sources: OBM Allocation Application, Oracle 11i Financial System, Hospital Morbidity Data System (HMDS)

WA Country Health Service inpatient activity is generally less acute and specialised, as more complex patients are typically referred to metropolitan health services. This results in a lower cost per nWAU result for inpatient activity.

Outcome 1
Efficiency Indicators

AVERAGE EMERGENCY DEPARTMENT COST PER WEIGHTED ACTIVITY UNIT

Rationale

This indicator is a measure of the cost per weighted activity unit compared with the Health Services Provider's Health Service Allocation Price (HSAP) set each year in the WA Activity Based Funding (ABF) Operating Model.

The measure ensures that a consistent methodology is applied to calculating and then measuring the performance of Health Service Providers (HSPs) against the funding they receive through the Government Budget Statements and subsequent Service Agreements and the activity delivered by each hospital site (reported at an aggregated entity level). It is imperative that Emergency Department service provision is continually monitored to ensure the efficient delivery of safe and high quality care.

Target

The target for average Emergency Department (ED) cost per weighted activity unit is $7,043.

This target differs from the state (aggregated) target of $6,642 as outlined in the 2017-18 Budget Statements Budget Paper No. 2-Volume 1. The target set in Budget Paper 2 excluded Teaching, Training and Research (TT&R) Programs and PathWest Resources received free of charge (RRFoC) (excluding direct charges to HSPs captured under the existing fee for service model). The 2017-18 WACHS Annual Report target of $7,043 reflects the target published in Budget Paper 2, adjusted for these items.

Result

In 2017-18, the average emergency department cost per weighted activity unit (WAU) did not meet target, as seen in Table 24.

Table 24: Average Emergency Department (ED) cost per weighted activity unit (WAU), 2017-18

	2017–18 ($)	Target ($)
Average ED cost / WAU	$7,292	$7,043

Data Sources: OBM Allocation Application, Oracle 11i Financial System, Emergency Department Data Collection (EDDC)

Outcome 1
Efficiency Indicators

AVERAGE NON-ADMITTED COST PER WEIGHTED ACTIVITY UNIT

Rationale

The indicator is a measure of the cost per weighted activity unit compared with the Health Service Provider's Health Service Allocation Price (HSAP) set each year in the WA Activity Based Funding (ABF) Operating Model.

The measure ensures that a consistent methodology is applied to calculating and then measuring the performance of Health Service Providers (HSPs) against the funding they received through the Government Budget Statements and subsequent Service Agreements and the activity delivered by each hospital site (reported at an aggregated entity level). It is imperative that efficiency of this Service delivery is accurately monitored and reported.

The indicator is a measure of the cost per weighted activity unit compared with the Health Service Provider's Health Service Allocation Price (HSAP) set each year in the WA Activity Based Funding (ABF) Operating Model.

Target

The target for average non-admitted cost per weighted activity unit is $7,160.

This target differs from the state (aggregated) target of $6,738 as outlined in the 2017-18 Budget Statements Budget Paper No. 2-Volume 1. The target set in Budget Paper 2 excluded Teaching, Training and Research (TT&R) Programs and PathWest Resources received free of charge (RRFoC) (excluding direct charges to HSPs captured under the existing fee for service model). The 2017-18 WACHS Annual Report target of $7,160 reflects the target published in Budget Paper 2, adjusted for these items.

Result

In 2017-18, the average non-admitted cost per weighted activity unit (WAU) met target (see Table 25).

Table 25: Average Non-Admitted cost per weighted activity unit (WAU), 2017-18

	2017–18 ($)	Target ($)
Average Non-Admitted cost / WAU	$6,035	$7,160

Data Sources: OBM Allocation Application, Oracle 11i Financial System, Non-Admitted Patient Activity and Wait List (NAPAAWL) Data Collection

Outpatient activity is predominately allied health and nursing services, with less specialist outpatient services, resulting in a lower cost per nWAU.

Outcome 1

Efficiency Indicators

AVERAGE COST PER BED-DAY IN SPECIALISED MENTAL HEALTH INPATIENT UNITS

Rationale

Specialised mental health inpatient units provide patient care in authorised hospitals and designated mental health units located within hospitals. In order 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 healthcare and enable the reallocation of funds to appropriate alternative non admitted care.

Target

The target for average cost per bed-day in specialised mental health inpatient units is $1,713.

This target differs from the target of $1,646 as outlined in the 2017-18 Budget Statements Budget Paper No. 2. The target set in Budget Paper 2 excluded Teaching, Training and Research (TT&R) Programs and PathWest Resources received free of charge (RRFoC) (excluding direct charges to HSPs captured under the existing fee for service model). The 2017-18 WACHS Annual Report target of $1,713 reflects the target published in Budget Paper 2, adjusted for these items.

Result

In 2017-18, average cost per bed-day in specialised mental health inpatient units did not meet target, as seen in Table 26.

Table 26: Average cost per bed-day in specialised mental health inpatient units, 2017-18

	2016–17 ($)	2017–18 ($)	Target ($)
Average cost / bed-day in specialised mental health inpatient unit	$2,186	$1,728	$1,713

Data Sources: OBM Allocation Application, Oracle 11i Financial System, BedState

Changes to the Outcome Based Management (OBM) allocations for Mental Health services have resulted in refinement of overhead costs to inpatient mental health services, resulting in a decrease in average cost compared to 2016-17.

Outcome 1
Efficiency Indicators

AVERAGE COST PER TREATMENT DAY OF NON-ADMITTED CARE PROVIDED BY PUBLIC CLINICAL MENTAL HEALTH SERVICES

Rationale

Efficient functioning of public community mental health services is critical to ensure that finite funds are used effectively to deliver maximum community benefit. Services provided by public community-based mental health services include assessment, treatment and continuing care.

Community mental health services consist of a range of community-based services such as emergency assessment and treatment, case management, day programs, rehabilitation, psychosocial, and residential services. The aim is to provide the best health outcomes for the individual through the provision of accessible and appropriate community mental health care. This indicator gives a measure of the cost effectiveness of treatment for public psychiatric patients under public community mental healthcare (non-admitted / ambulatory patients).

Target

The 2017-18 WA Country Health Service Target is $542.

Result

In 2017-18, WA Country Health Service average cost per treatment day of non-admitted care provided by public clinical mental health service did not meet the target as can be seen in Table 27.

Table 27: Average cost per treatment day of non-admitted care provided by public clinical mental health services, 2017-18

	2017–18 ($)	Target ($)
Average cost / treatment day of non-admitted care provided by public clinical mental health services	$591	$542

Data Sources: OBM Allocation Application, Oracle 11i Financial System, Mental Health Information Data Collection

Outcome 2

Effectiveness Indicators

RESPONSE TIMES FOR EMERGENCY AIR-BASED PATIENT TRANSPORT SERVICES (PERCENTAGE OF EMERGENCY AIR-BASED INTER-HOSPITAL TRANSFER MEETING THE STATEWIDE CONTRACT TARGET RESPONSE TIME FOR PRIORITY 1 CALLS)

Rationale

To ensure Western Australians receive the care and medical transport services they need, when they need it, WA Country Health Service has entered into a contractual relationship to deliver emergency air-based patient transport services to the WA public. This collaboration ensures that patients have access to an effective aeromedical and inter-hospital patient transfer service to ensure the best possible health outcomes for patients requiring urgent medical treatment through rapid response.

Response times for patient transport services have a direct impact on the speed with which a patient receives appropriate medical care and provide a good indication of the efficiency and effectiveness of patient transport services. Adverse effects on patients and the community are reduced if response times are reduced.

Calls are assigned a priority (1 to 3) by the service provider, to ensure that conflicting flight requests are dealt with in order of medical need and to allow operations coordinators to task aircraft and crews in the most efficient means possible to meet these needs. The priority system in place is as follows:

- Priority 1 refers to life-threatening emergencies, where the flight departs in the shortest possible time (subject to weather and essential safety requirements).
- Priority 2 refers to urgent medical transfer, where the flight departs promptly with flight planning requirements met on the ground.
- Priority 3 refers to elective transfer, where flight tasked to make best use of resources and crew hours.

Through surveillance of this measure over time, the effectiveness of patient transport services can be determined. This facilitates further development of targeted strategies and improvements to operational management practices aimed at ensuring optimal restoration to health for patients in need of urgent medical care.

Target

The 2017-18 target is ≥ 80% sourced from the WA Health System Service Agreement.

Results

In 2017-18, WA Country Health Service did not meet the target as can be seen in Table 28.

Table 28: Response times for emergency air-based patient transport services, 2017-18

	2017–18 (%)	Target (%)
Percentage of priority 1 calls meeting target response time	78.9	≥ 80

Data Source: Service Agreement Reports provided to WACHS

In 2017-18, there was an increase in the total number of patients transported state-wide, which had an impact on response times given available service resources.

WA Country Health Service continues to actively engage with the contracted provider in emergency air-based inter-hospital transfers to ensure the best care is provided to rural and remote communities.

Outcome 2

Effectiveness Indicators

PERCENTAGE OF PATIENTS WHO ACCESS EMERGENCY SERVICES AT A SMALL RURAL OR REMOTE WESTERN AUSTRALIAN HOSPITAL AND ARE SUBSEQUENTLY DISCHARGED HOME

Rationale

Small country hospitals provide emergency care services, residential aged care services and limited acute medical and minor surgical services in locations 'close to home' for country residents and the many visitors to the regions.

The ability to access emergency services in line with the WA Health Clinical Services Framework at these facilities is a clear community expectation. Accessing services with the outcome of returning home, where clinically justified, rather than transferring to another facility, demonstrates effective service delivery closer to home.

Target

The 2017-18 target is 92%.

Results

In 2017-18, WA Country Health Service did not meet the target as can be seen in Table 29.

Table 29: Percentage of patients who access emergency services at a small rural or remote WA hospital and are subsequently discharged home, 2017-18

	2017–18 (%)	Target (%)
Percentage of patients discharged home	90.4	92

Data Source: Emergency Department Data Collection (EDDC)

Increases in admissions and transfer to other health services from small hospitals occurred in 2017-18, contributing to the lower than target result. The health needs of the patient are the top priority in any decision on treatment location.

Outcome 2
Efficiency Indicators

AVERAGE COST PER BED-DAY FOR SPECIALISED RESIDENTIAL CARE FACILITIES, FLEXIBLE CARE (HOSTELS) AND NURSING HOME TYPE RESIDENTS

Rationale

The WA Country Health Service provides long-term care facilities for rural patients requiring 24 hour nursing care. This healthcare service is delivered to high and low dependency residents in nursing homes, hospitals, hostels and flexible care facilities, and constitutes a significant proportion of the activity within WA Country Health Service jurisdictions where access to non-government alternatives is limited.

Target

2017-18 target is $321.

Results

In 2017-18, average cost per bed-day for specialised residential care facilities, flexible care (hostels) and nursing home type residents did not meet target as seen in Table 30.

Table 30: Average cost per bed-day for specialised residential care facilities, flexible care (hostels) and nursing home type residents, 2017-18

	2016–17 ($)	2017–18 ($)	Target ($)
Average cost per bed-day	$526	$557	$321

Data Sources: OBM Allocation Application, Oracle 11i Financial System, Occupied Bed Day (OBD) Data Warehouse

Performance in this indicator can be variable based on demand for aged care residential placements. There is a community expectation that residential aged care facilities operated by the WA Country Health Service will remain open and maintained, regardless of occupancy. In 2017-18, WA Country Health Service led residential care facilities reported over 10,000 less bed days compared to 2016-17, which impacted on the unit (bed day) cost of service delivery.

Outcome 2
Efficiency Indicators

AVERAGE COST PER PERSON OF DELIVERING POPULATION HEALTH PROGRAMS BY POPULATION HEALTH UNITS

Rationale

Population health units support individuals, families and communities to increase control over and improve their 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 by utilising the WA Health Promotion Strategic Framework 2017–2021. This is based on the growing understanding of the social, cultural and economic factors that contribute to a person's health status.

Target

The 2017-18 WA Country Health Service target is $233.

Results

In 2017-18, average cost per person of delivering population health programs by population health units did not meet target as per Table 31.

Table 31: Average cost per person of delivering population health programs by population health units, 2017-18

	2016–17 ($)	2017–18 ($)	Target ($)
Average cost per person for population health	$294	$374	$233

Data Sources: OBM Allocation Application, Oracle 11i Financial System, EpiCalc

Refinement to the WA Health Outcome Based Management (OBM) structure has resulted in a change to the allocation of costs to this area, including the inclusion of nursing post costs which were previously reported under a separate Key Performance Indicator. This has resulted in an increase in population health program reported expenditure for 2017-18.

Outcome 2

Efficiency Indicators

COST PER TRIP OF PATIENT EMERGENCY AIR-BASED TRANSPORT, BASED ON THE TOTAL ACCRUED COSTS OF THESE SERVICES PER THE TOTAL NUMBER OF TRIPS

Rationale

To ensure Western Australians receive the care they need, when they need it, strong partnerships have been forged within the healthcare community through a collaborative agreement between the WA Country Health Service and the contracted service provider. This collaboration ensures that patients have access to an effective emergency air-based transport service that aims to ensure the best possible health outcomes for patients requiring urgent medical treatment and transport services.

Target

The 2017-18 target is $7,235.

Results

In 2017-18, the cost per trip of patient emergency air-based transport based on the total accrued costs of these services per the total number of trips met the target, as seen in Table 32.

Table 32: Cost per trip of patient emergency air-based transport, 2017-18

	2017–18 ($)	Target ($)
Cost per trip of emergency air-based transport	$7,121	$7,235

Data Sources: OBM Allocation Application, Oracle 11i Financial System, Service Agreement Reports provided to WACHS

Outcome 2
Efficiency Indicators

AVERAGE COST PER TRIP OF PATIENT ASSISTED TRAVEL SCHEME (PATS)

Rationale

The WA health system aims to provide safe, high-quality healthcare to ensure healthier, longer, and better quality lives for all Western Australians.

The Patient Assisted Travel Scheme provides a subsidy towards the cost of travel and accommodation for eligible patients travelling long distances to seek certain categories of specialised medical care. The aim of the Patient Assisted Travel Scheme is to help ensure that all Western Australians can access safe, high-quality healthcare when needed.

Target

The 2017-18 target is $377.

Results

In 2017-18 the average cost per trip of Patient Assisted Travel Scheme (PATS) did not meet target, as per Table 33.

Table 33: Average cost per trip of Patient Assisted Travel Scheme (PATS), 2017-18

	2016–17 ($)	2017–18 ($)	Target ($)
Average Cost per trip of PATS	$438	$440	$377

Data Sources: OBM Allocation Application, Oracle 11I Financial System, Secure Health Record Exchange (SHaRE) PATS On Line

The 2017-18 target was based on realisation of non-hospital savings, including in PATS expenditure. While maintaining costs at levels relatively consistent with prior years, WACHS was unable to achieve these savings. WACHS remains committed to supporting access to specialist care for rural and remote patients, including where patients may be required to travel long distances to receive specialist medical services.

Outcome 2

Efficiency Indicators

AVERAGE COST PER RURAL AND REMOTE POPULATION (SELECTED SMALL RURAL HOSPITALS)

Rationale

The WA health system aims to provide safe, high-quality healthcare to ensure healthier, longer and better quality lives for all Western Australians.

Small rural hospitals provide an essential level of access to services for rural and remote communities. These hospitals have relatively low patient activity and have high fixed costs therefore it is appropriate to measure efficiency based on population numbers as opposed to unit of patient activity.

In the calculation of this indicator, 'rural and remote' population has been calculated using the total WA Country Health Service population.

Target

The 2017-18 target is $390.

Results

In 2017-18, average cost per rural and remote population (selected small rural hospitals) did not meet target (see Table 34).

Table 34: Average cost per rural and remote population (selected small rural hospitals), 2017-18

	2017–18 ($)	Target ($)
Average Cost per rural and remote population	$401	$390

Data Sources: OBM Allocation Application, Oracle 11i Financial System, EpiCalc

Ministerial Directives

Treasurer's Instruction 903 (12) requires disclosing information about Ministerial directives relevant to the setting of desired outcomes or operational objectives, the achievement of desired outcomes or operational objectives, investment activities and financial activities.

The WA Country Health Service did not receive any Ministerial directives related to this requirement.

Summary of Board and committee remuneration

The total annual remuneration for each Board or committee is listed below in Table 35. For details of individual Board or committee members, please refer to Appendix 2.

Table 35: Summary of State Government Boards and committees within the WA County Health Service in 2017-18

Board/committee name	Total remuneration ($)
WA Country Health Service Board	$376,254
SUB TOTAL	$376,254
Medical Advisory Committees	
Albany Hospital Medical Advisory Committee	$0
Blackwood Hospital Medical Advisory Committee	$600
Bunbury Hospital Medical Advisory Committee	$4,288
Busselton Hospital Medical Advisory Committee	$1,667
Central Great Southern Medical Advisory Committee	$2,970
Denmark Medical Advisory Committee	$1,584
Donnybrook Hospital Medical Advisory Committee	$0
Eastern Medical Advisory Committee (Wheatbelt)	$2,986
Geraldton Medical Advisory Committee	$0
Margaret River Medical Advisory Committee	$1,260
Plantagenet-Cranbrook Medical Advisory Committee	$1,210
Southern District Medical Advisory Committee	$1,277
Warren District Hospital Medical Advisory Committee	$818
Western Medical Advisory Committee (Wheatbelt)	$0
SUB TOTAL	$18,661
District Health Advisory Councils	
Blackwood District Health Advisory Council	$1548
Broome District Health Advisory Council	$0
Bunbury District Health Advisory Council	$870
Central Great Southern District Health Advisory Council	$5682
East Kimberley District Health Advisory Council	$1980
East Pilbara District Health Advisory Council	$678
Eastern District Health Advisory Council (Wheatbelt)	$2694
Gascoyne District Health Advisory Council	$0
Geraldton District Health Advisory Council	$940
Goldfields District (Kalgoorlie) Health Advisory Council	$2970
Kununurra / Wyndham and Surrounding Communities District Health Advisory Council	$3060
Leschenault District Health Advisory Council	$204
Lower Great Southern District Health Advisory Council	$900
Midwest District Health Advisory Council	$1320
Naturaliste District Health Advisory Council	$0
South East (Goldfields) District Health Advisory Council	$0
Southern Wheatbelt District Health Advisory Council	$0
Warren District Health Advisory Council (Wheatbelt)	$3379
West Pilbara District Health Advisory Committee	$0
Western Wheatbelt District Health Advisory Committee	$6783
SUB TOTAL	$33,008
TOTAL	$427,923

Other financial disclosures

PRICING POLICY

The National Health Reform Agreement sets the policy framework for the charging of public hospital fees and charges. Under the Agreement, an eligible person who receives public hospital services as a public patient in a public hospital or a publicly contracted bed in a private hospital is treated 'free of charge'. This arrangement is consistent with the Medicare principles which are embedded in the *Health Services Act 2016 (WA)*.

The majority of hospital fees and charges for public hospitals are set under Schedule 1 of the Health Services (Fees and Charges) Order 2016 and are reviewed annually. The following informs WA public hospital patients fees and charges for:

Nursing Home Type Patients

The State charges public patients who require nursing care and/or accommodation after the 35th day of their stay in hospital, providing they no longer need acute care and they are deemed to be Nursing Home Type Patients. The total daily amount charged is no greater than 87.5 per cent of the current daily rate of the single aged pension and the maximum daily rate of rental assistance.

Compensable or ineligible patients

Patients who are either 'private' or 'compensable' and Medicare ineligible (overseas residents) may be charged an amount for public hospital services as determined by the State. The setting of compensable and ineligible hospital accommodation fees is set close to, or at, full cost recovery.

Private patients (Medicare eligible Australian residents)

The Commonwealth Department of Health regulates the Minimum Benefit payable by health funds to privately insured patients for private shared ward and same day accommodation. The Commonwealth also regulates the Nursing Home Type Patient 'contribution' based on March and September pension increases. To achieve consistency with the *Commonwealth Private Health Insurance Act 2007*, the State sets these fees at a level equivalent to the Commonwealth Minimum Benefit.

Other financial disclosures

Veterans

Hospital charges of eligible war service veterans are determined under a separate Commonwealth-State agreement with the Department of Veterans' Affairs. Under this agreement, the Department of Health does not charge medical treatment to eligible war service veteran patients, Instead, medical charges are fully recouped from the Department of Veterans' Affairs.

The following fees and charges also apply:

- The Pharmaceutical Benefits Scheme regulates and sets the price of pharmaceuticals supplied to outpatients, patients on discharge and for day admitted chemotherapy patients. Inpatient medications are supplied free of charge.
- The Dental Health Service charges to eligible patients for dental treatment are based on the Department of Veterans' Affairs Fee Schedule of dental services for dentists and dental specialists. Eligible patients are charged the following co-payment rates:
  - 50 per cent of the treatment fee if the patient holds a current Health Care Card or Pensioner Concession Card
  - 25 per cent of the treatment fee if the patient is the current holder of one of the above cards and receives a near full pension or an allowance from Centrelink or the Department of Veterans' Affairs.

There are other categories of fees specified under Health Regulations through Determinations, which include the supply of surgically implanted prostheses, Magnetic Resource Imaging services and pathology services. The pricing for these hospital services is determined according to their cost of service.

CAPITAL WORKS

Completed

Table 36: Capital works completed in 2017-18

Project Name	Estimated Total Cost in 2017–18 ($ '000)
Albany Regional Resource Centre- Redevelopment Stage 1	168,262
Enhancing Health Services for the Pilbara in Partnership With Industry	7,338
Point of Care Network for Pathology Testing	771
Regional Health Administrative Accommodation	1,534

Other financial disclosures

In Progress

Table 37: Capital works in progress in 2017-18

Project Name	Estimated Total Cost in 2017–18 ($ '000)	Reported in 2016–17 ($ '000)	Variance ($ '000)	Expected Completion Date	2016–17 and 2017-18 variation to cost explanation (>=10%)
Albany Hospice Car Park [4]	748	815	- 67	Completed	
Broome Regional Resource Centre - Redevelopment Stage 1	42,000	42,000	-	Completed	
Bunbury, Narrogin and Collie Hospitals - Pathology Laboratories Redevelopment [4]	6,851	6,924	- 73	December 2018	
Busselton Health Campus [4]	115,202	115,233	- 31	Completed	
Carnarvon Aged Care [2]	11,577	16,577	- 5,000	TBA	See footnotes
Carnarvon Health Campus Redevelopment	25,666	25,666	-	Completed	
Country - Staff Accommodation- Stage 3 [1,4]	27,422	26,972	450	Completed	
Country - Staff Accommodation- Stage 4 [1,4]	8,128	8,513	- 385	Completed	
Country - Transport Initiatives	3,228	3,228	-	TBA	
District Hospital Upgrade - Paraburdoo, Roebourne, Derby Community Health	3,700	-	3,700	TBA	New project
District Hospital Upgrade - Tom Price Hospital Redevelopment	5,250	-	5,250	TBA	New project
East Kimberley Development Package [4]	38,597	38,593	4	Completed	
Eastern Wheatbelt District (Including Merredin) Stage 1	7,881	7,881	-	December 2018	
Esperance Health Campus Redevelopment [1,4]	31,871	32,841	- 970	Completed	
Harvey Health Campus Redevelopment [4]	12,858	12,855	3	Completed	
Hedland Regional Resource Centre - Stage 2 [4]	136,215	136,308	- 93	Completed	
Kalgoorlie Regional Resource Centre - Redevelopment Stage 1 [4]	57,461	57,086	375	August 2018	
Karratha Health Campus - Development [4]	207,131	206,892	239	July 2018	
Newman Health Service Redevelopment [2, 4]	47,433	59,570	- 12,137	April 2019	See footnotes
Onslow Health Service Redevelopment [4]	41,723	41,798	- 75	November 2018	
Remote Indigenous Health [4]	24,053	20,736	3,317	May 2019	See footnotes
Renal Dialysis and Support Services [4]	46,796	47,390	- 594	Various	

Other financial disclosures

Table 37: Capital works in progress in 2017-18 (continued)

Project Name	Estimated Total Cost in 2017–18 ($ '000)	Reported in 2016–17 ($ '000)	Variance ($ '000)	Expected Completion Date	2016–17 and 2017-18 variation to cost explanation (>=10%)
Southern Inland Health Initiative - Integrated District Health Campuses Stream 2 [2,4]	163,743	153,728	10,015	Various	
Southern Inland Health Initiative - Primary Health Centres [2,4]	32,659	38,664	- 6,005	Various	See footnotes
Southern Inland Health Initiative - Small Hospitals & Nursing Posts	102,444	102,445	- 1	Various	
Southern Inland Health Initiative - Telehealth	5,530	5,530	-	Various	
Strengthening Cancer Services - Geraldton Cancer Centre [4]	3,930	4,062	- 132	Completed	
Strengthening Cancer Services - Narrogin Cancer Centre	2,000	2,000	-	December 2018	
Strengthening Cancer Services - Northam Cancer Centre	3,500	3,500	-	December 2018	
Strengthening Cancer Services - Regional Cancer Patient Accommodation [4]	4,392	4,498	- 106	Various	
Upper Great Southern District (including Narrogin) Stage 1	10,497	10,497	-	December 2018	
WA Country Health Service Picture Archive Communication System - Regional Resource Centre	6,273	6,273	-	Completed	
Wheatbelt Renal Dialysis [4]	1,950	1,967	- 17	December 2018	

Notes:

a) The above information is based upon the:
- *i 2017-18 published budget papers.*
- *ii 2016-17 published budget papers.*

b) Completion timeframes are based upon a combination of known dates at the time of reporting.

c) Projects listed above as 'completed' may still be in the defects period.

d) The footnotes that apply to individual projects are:
1. *Transfer of funding between projects.*
2. *Royalties for Regions Funding changes.*
3. *Impacted as part of Whole of Government Capital Audit.*
4. *2017/18 Budget excludes amounts that will not be capitalised, therefore the ETC may vary from that reported in the 2016/17 Budget.*

Other financial disclosures

EMPLOYMENT PROFILE

Government agencies are required to report a summary of the number of employees by category compared with the preceding financial year. Table 38 shows the year-to-date (June 2018) number of WA Country Health Service full-time equivalent employees for 2016–17 and 2017-18.

Table 38: WA Country Health Service total full-time employees by category

Category	Definition	2016–17	2017–18
Administration and clerical	Includes all clerical-based occupations together with patient-facing (ward) clerical support staff.	1,596	1,633
Agency	Includes full-time equivalent employees associated with the following occupational categories: administration and clerical, medical support, hotel services, site services, medical salaried (excludes visiting medical practitioners) and medical sessional.	128	127
Agency nursing	Includes workers engaged on a 'contract for service' basis. Does not include workers employed by NurseWest.	158	142
Assistants in nursing	Support registered nurses and enrolled nurses in delivery of general patient care.	69	73
Dental nursing	Includes registered dental nurses and dental clinic assistants.	0	0
Hotel services	Includes catering, cleaning, stores/supply, laundry and transport occupations.	1,242	1,226
Medical salaried	Includes all salary-based medical occupations including interns, registrars and specialist medical practitioners.	407	429
Medical sessional	Includes specialist medical practitioners that are engaged on a sessional basis.	11	13
Medical support	Includes all allied health and scientific/ technical related occupations.	797	851
Nursing	Includes all nursing occupations. Does not include agency nurses.	2,913	2,990
Site services	Includes engineering, garden and security-based occupations.	159	155
Other categories	Includes Aboriginal and ethnic health worker related occupations.	126	133
	Total	7,606	7,772

Notes:

1. *Data Source: HR Data Warehouse.*
2. *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 and Workers Compensation.*
3. *FTE figures provided are based on Actual (Paid) month to date FTE.*

Other financial disclosures

STAFF DEVELOPMENT

The WA Health Recruitment, Selection and Appointment Policy and Procedure is contained within the WA Health Employment Framework and provides the requirements and standard processes specific to recruitment, selection and appointment, secondment, transfer and temporary deployment. WA Country Health Service is committed to ensuring the timely recruitment of skilled candidates to vacancies in regional areas.

WA Country Health Service is committed to building a strong, skilled and growing Aboriginal health workforce across all levels in the organisation. A key strategy to increase the Aboriginal workforce in the WA health system is through the application of Section 51 (s.51) of the *Equal Opportunity Act 1984*. WA Country Health Service has applied the s.51 provision to advertising and recruitment strategies throughout the trial period from March 2017 – December 2018.

WA Country Health Service provides a learning and development framework that ensures the delivery of safe, high quality and consumer-centred care services. This is achieved by supporting and facilitating learning programs that enables the development and maintenance of professional skills. Ongoing skills development and learning assists us to attract and retain a competent workforce that is aligned with service needs. Strategies implemented during 2017-18 include a review of mandatory training requirements. Learning Frameworks are now available that provide the workforce with role specific training and skill development. The Framework areas include Nursing and Midwifery, Healthcare Support staff, Managers, Allied Health and Emergency Management roles. The use of a consistent Learning Management System enables an organisation wide governance approach to the management, publication and reporting of training and development. Enhancement to governance practices ensures cost effective delivery of training of programs.

The WA Country Health Service continues to expand its use of the innovative Statewide Telehealth Service to provide staff in regional and remote locations access to metropolitan specialists delivering training to support clinical skills development.

INDUSTRIAL RELATIONS

Responsibility for industrial relations is delineated by an Industrial Relations Policy MP 0025/16 established under the Employment Policy Framework issued by the System Manager (the Chief Executive Officer of the Department of Health) pursuant to section 26 of the *Health Services Act 2016.*

The Department of Health as System Manager is responsible for WA health system-wide industrial relations matters including negotiation and registration of industrial instruments. WA Country Health Service is responsible for the application of the WA Public Sector legislative and regulatory frameworks regulating employment and industrial relations, management of misconduct matters, representation and advocacy in industrial tribunals and courts, engagement with unions and other external stakeholders in industrial matters.

A new industrial agreement for hospital support workers was negotiated and in-principle agreement reached for hospital salaried officers. There was no significant industrial disputation in the year under review.

Other financial disclosures

WORKERS COMPENSATION

The WA Workers' Compensation system is a scheme established by the State Government and exists under the statute of the *Workers' Compensation and Injury Management Act 1981*.

The WA Country Health Service has an injury management system to assist employees who are injured in the workplace. This system has an early intervention focus within an environment where it is normal practice for employees to return to productive duties as soon as medically appropriate.

In 2017-18, a total of 296 workers' compensation claims were made (see Table 39)

GOVERNMENT BUILDING CONTRACTS

WA Health Works Procurement Policy stipulates that all works over $2 million are coordinated by the Department of Finance, Building Management and Works (BMW).

In collaboration with a number of Group Training Organisations, the Apprentice management program (a business unit of BMW) manages the placement of apprentices with host employers undertaking government building and construction. BMW reports compliance with the Government building training policy in their annual report.

Table 39: Number of WA Country Health Service workers' compensation claims in 2017-18

Employee category	Number of claims in 2017–18
Nursing Services/Dental Care Assistants	114
Administration and Clerical	44
Medical Support	17
Hotel Services	106
Medical (salaried)	0
Site Services	15
Total	296

Note: For the purposes of the Annual Report, Employee categories are defined as:

- *administration and clerical – includes administration staff and executives, ward clerks, receptionists and clerical staff*
- *medical support – includes physiotherapists, speech pathologists, medical imaging technologists, pharmacists, occupational therapists, dieticians and social workers*
- *hotel services – includes cleaners, caterers, and patient service assistants*
- *site services – includes handypersons, security officers, store people and electricians.*

Other financial disclosures

CONTRACTS WITH SENIOR OFFICERS

At the date of reporting, no senior officer or Board member, or firms of which senior officers or Board members are members, or entities in which senor officers or Board members have substantial interest, had any interests in existing or proposed contracts with the WA Country Health Service other than normal contracts of employment service.

UNAUTHORISED USE OF CREDIT CARDS

WA Health uses Purchasing Cards for purchasing goods and services to achieve savings through improved administrative efficiency and more effective cash management. The Purchasing Card is a personalised credit card that provides a clear audit trail for management.

WA Health credit cards are provided to employees who require it as part of their role. Credit cards are not for personal use by the cardholder. Should a cardholder use a credit card for personal purposes, they are required to submit a Notice of Non-Compliance (Form 625-3) to the accountable authority within five working days of becoming aware of the transaction and refund the total amount of expenditure.

There were 30 transactions in the period where credit cards were inadvertently used for personal purposes. All transactions were refunded before the end of the reporting period.

Table 40: Credit card personal use expenditure in 2017–18

Credit card personal use expenditure	1 July 2017 to 30 June 2018
Aggregate amount of personal use expenditure for the reporting period	$2,084.47
Aggregate amount of personal use expenditure settled by the due date (within five working days)	$1,906.14
Aggregate amount of personal use expenditure settled after the period (after five working days)	$178.33
Aggregate amount of personal use expenditure outstanding at the end of the reporting period.	$0.00

Other financial disclosures

ANNUAL ESTIMATES

In accordance with Section 40 of the *Financial Management Act 2006*, the WA Country Health Service has submitted Annual Estimates to the Minister at an appropriate time during the financial year, as determined by the Treasurer.

ADVERTISING

In accordance with section 175Z of the *Electoral Act 1907*, WA Country Health Service incurred a total advertising expenditure of $72,432 in 2017-18 (see Table 41). There was no expenditure in relation to advertising agencies, polling or direct mail organisations.

Table 41: Summary of WA Country Health Service advertising for 2017-18

Summary of advertising	Amount ($)
Advertising agencies	$0
Market research organisations	$5,500.00
Polling organisations	$0
Direct mail organisations	$0
Media advertising organisations	$66,932.16
Total advertising expenditure	$72,432.16

The organisations that provided advertising services and the amount paid to each are detailed in Table 42.

Table 42: Organisations that provided advertising services

Person, agency or organisation name	Amount ($)
Advertising agencies	
Total	$0
Market research organisations	
West Coast Field Services	$5,500.00
Total	$5,500.00
Polling organisations	
Total	$0
Direct mail organisations	
Total	$0
Media advertising organisations	
Adcorp Australia Ltd	$9,898.29
Advanced Traffic Management Pty Ltd	$2852.00
Carat Australia Media Services	$39,319.41
Crana Plus	$4,090.91
Health Communication resources Ltd	$3,649.00
Total	$63,333.64

Note: Values of less than $2,500 are not listed although the amount is included in the total.

Other financial disclosures

DISABILITY ACCESS AND INCLUSION PLAN

Our Disability Access and Inclusion Plan 2015-2020 was developed in consultation with our consumers, staff and key stakeholders to provide strategies for the WA Country Health Service to support increased independence, opportunities and inclusion for people with disability.

The plan outlines our priorities over a five-year period and builds upon our past achievements. WA Country Health Service continues to meet our commitment to ensuring that people with disability have the same opportunities to fully access the range of health services, facilities and information available in the public health system, and to participate in public consultation. Amongst a range of inclusion activities, we do this by:

- ensuring that all capital works projects comply with the minimum access, egress and amenity levels set out in the Building Code of Australia, and all infrastructure improvements and redevelopments are undertaken with a view to universal access.
- providing information to staff who are arranging events that will ensure that events are accessible to people with disabilities.
- providing disability awareness training as a recommended module of the WA Country Health Service induction program for all staff.
- ensuring people can provide feedback in a range of ways, including by the Patient Opinion website, an independent online consumer feedback platform which has accessibility functions.
- ensuring that information on patient rights and responsibilities, and feedback options are displayed at WA Country Health Service sites and that information can be made available in alternative formats.
- facilitating the use of interpreters to improve access to information for people who have difficulty speaking, hearing, seeing and/or reading, or who speak limited English.

In accordance with the *Disability Services Act 1993*, a progress report has been submitted to the Disability Services Commission outlining our progress against the priorities set out in the plan.

You can download a copy of our Disability Access and Inclusion Plan 2015-2020 from our website.

2015-2020 Disability Access and Inclusion Plan

VIEW ONLINE >

Other financial disclosures

COMPLIANCE WITH PUBLIC SECTOR STANDARDS AND ETHICAL CODES

The WA Country Health Service values and encourages quality, integrity and justice, and we strive to ensure these values are represented in all that we do.

The WA Country Health Service is committed to complying with the Public Sector Standards in Human Resource Management (the Standards), the Western Australian Public Sector Commission's Code of Ethics and WA Health Code of Conduct. WA Country Health Service raises awareness of these Standards and Code of Conduct and Ethics by providing information to new employees as part of induction and orientation programs; by including a compliance statement in all Job Description Forms; through mandatory training in Accountable and Ethical Decision Making, Aboriginal Cultural Awareness eLearning programs and the Management Development Program; through policies and procedures; and by publishing information in newsletters, on Notice Boards and on our intranet.

Human resource officers provide a range of consultancy and advisory services to managers and employees to ensure they are aware of and manage their responsibilities in relation to the Standards, together with processing services provided by Health Support Services (payroll and recruitment). Centralised oversight of the recruitment and selection process, including notification of the outcome of recruitment processes ensures that all applicants are provided information about their rights to claim a breach of the Standards.

Complaints alleging non-compliance with the Code of Ethics or Code of Conduct are reviewed, investigated and monitored by WA Country Health Service Industrial Relations in consultation with Human Resources.

Applications made for breach of Standards review, the outcome of claims, and number of complaints relating to non-compliance with the ethical codes is provided in Table 43 (next page).

Other financial disclosures

Table 43: Summary of Breach of Standards Claims 2017-18

(i) Total claims (include all claims lodged whether resolved internally or referred to the Public Sector Commission)

	Recruitment selection and appointment	Transfers	Secondment	Performance management	Redeployment	Termination	Temporary deployment (acting)	Grievance Resolution	Total
Claims lodged 2017-18	10							3	13
Claims carried over from previous financial year	1								1
Total claims handled in 2017-18	11							3	14

(ii) Outcome of claims handled

Withdrawn in agency	3							2	5
Resolved in agency	1								1
Still pending in agency	1							1	2
Referred to OPSSC	6								6
Total claims handled in 2017-18	11							3	14

Other financial disclosures

FREEDOM OF INFORMATION

The Western Australian *Freedom of Information Act 1992* gives all Western Australians a right of access to information held by the WA Country Health Service. The types of information held by the organisation include:

- reports on health programs and projects
- briefings for Minister for Health, Board and executive staff
- health circulars, policies, standards and guidelines
- health articles and discussion papers
- newsletters, magazines, bulletins and pamphlets
- health research and evaluation reports
- epidemiological, survey and statistical data/information
- publications relating to health planning and management
- committee meeting minutes
- administrative correspondence
- legislative reporting and compliance documents
- health infrastructure records
- financial and budget reports
- staff personnel records
- patient records created from episodes of care

Members of the public can access some of the above information from the WA Country Health Service website. Members of the public who do not have internet access can obtain hard copy documents for free or a nominal fee outside of the Freedom of Information process.

Access to information under the *Freedom of Information Act 1992* must be made in writing and can be lodged via email, sent by post or delivered in person. The written request must provide sufficient detail to enable the application to be processed, including contact details and an Australian address for correspondence.

In the case of an application for amendment or annotation of personal information it is required that the request include:

- detail of the matters in relation to which the applicant believes the information is inaccurate, incomplete, out-of-date or misleading
- the applicant's reasons for holding that belief
- detail of the amendment that the applicant wishes to have made.

For applications seeking non-personal information there is a fee payable at the time of submission.

The WA Country Health Service has a Freedom of Information coordinator for each region. Contact details, including postal and email addresses can be sourced from this site.

All requests for information can be granted, partially granted or may be refused in accordance with the Western Australian Freedom of Information Act 1992. The applicant can appeal if dissatisfied with the process, the reasons provided and in the event of an adverse access decision.

Other legal disclosures

For the year ended 30 June 2018, WA Country Health Service dealt with 3,207 applications for information, of which 2,887 applications were granted full or partial access and 86 were refused (Table 44).

Table 44: Applications for information under the Freedom of Information Act 1992 (WA)

Applications for information under the Freedom of Information Act 1992 (WA)	
Number of applications carried over from 2016-17	145
Number of applications received in 2017-18	3,062
Total applications active in 2017-18	3,207
Number of applications granted – full access	1,031
Number of applications granted – partial or edited access	1,856
Number of applications withdrawn by applicant	69
Number of applications refused	86
Number of applications in progress	154
Other applications	11
Total applications dealt with for 2017-18	3,207

RECORDKEEPING PLANS

WA Country Health Service has an agency-specific Recordkeeping Plan and supporting framework approved by the State Records Commission, which address the geographic challenges of country WA. This includes information on the recordkeeping system(s), record archiving and disposal arrangements, policies, practices and processes that comply with the *State Records Act 2000*.

Resources, advice and guidance regarding corporate recordkeeping are made available to all staff through the intranet, staff newsletters and training sessions. Strategies to ensure employees are aware and comply with the Recordkeeping Plan include online recordkeeping and awareness and systems training. In 2017-18, 3500 employees completed the mandatory online Recordkeeping Awareness training course, which is included in the WA Country Health Service induction program. The efficiency and effectiveness of the training program is reviewed on a regular basis via trainee feedback and assessments. Regular communication with end users of recordkeeping system is maintained through targeted training sessions including 'tip of the week' emails and ‘master classes’ for specific user groups. In addition, improved reporting has been implemented to ensure that managers have timely access to compliance information.

In 2017-18 a review of the WA Country Health Service Recordkeeping Plan commenced and is due for submission to the State Records Office in August 2018. The review will include findings on the programs evaluation, including organisation-wide survey, individual site assessments, adoption analysis and learning program surveys.

Across the WA Country Health Service, over 750,000 records were created in the Electronic Documents and Records Management Systems (EDRMS) during 2017-18. Over 600 users completed the EDRMS training program in 2017-18.

Other legal disclosures

SUBSTANTIVE EQUALITY

The WA Country Health Service is committed to substantive equality for Western Australians living in the regions through the implementation of the WA Health Policy Framework for Substantive Equality. Our commitment to recognising the diversity of our employees, consumers and other stakeholders is reflected in our organisational values, and reflected in our policies and procedures.

WA Country Health Service is committed to ensuring people with disability, their families and carers are not discriminated against. This includes providing strategies to increase independence, opportunities and inclusion for people with disability and detailed strategies are outlined in the WA Country Health Service Disability Access and Inclusion Plan 2015–2020.

A key focus for the organisation in contributing towards substantive equality is improving the health outcomes of Aboriginal people through a coordinated approach to the planning, funding and delivery of Aboriginal health programs, and the development of a workplace environment that values the employment and retention of Aboriginal employees.

An exciting achievement this year has been the State Government's commitment to long term funding of Aboriginal health programs that are improving the health and wellbeing of Aboriginal people. The investment provides certainty of funding for programs across the state that support child and maternal health; sexual health education and support; tackling smoking; cancer screening; chronic disease prevention and treatment; improving access to mental health services; as well as promoting a healthy lifestyle and wellbeing. The commitment offers welcomed security for the Aboriginal health workforce and safeguards the long-term sustainability of Aboriginal health programs delivered in partnership with communities, non-government organisations, Aboriginal Community Controlled Health Organisations and other specialist providers.

A key focus for the organisation is to contribute towards substantive equality for Aboriginal people. In 2017-18 we have contributed to substantive equality in the following ways:

- Continuing to implement the Aboriginal Mentorship Program.
- Appointment of Regional Aboriginal Health Consultants in the Midwest and Kimberley, and currently recruiting Regional Aboriginal Health Consultants to the remaining five regions.
- Continued implementation of the WA Country Health Service Aboriginal Entry Level Employment Program.
- Provided face to face cultural awareness training for executive and other staff located in WA Country Health Service central office.
- Implemented the Aboriginal Health Practitioner pilot project in the Kimberley region.
- Produced a promotional video to promote Aboriginal employment within the WA Country Health Service.
- Employed 413 Aboriginal people (as at the end of April 2018), equating to 4.4% of our workforce. This is above the 3.2% target set by the Public Sector Commission for WA Health.
- As of 30 June 2018, 84% of WA Country Health Service employees had completed the Department of Health's mandatory Aboriginal Cultural eLearning Package.

Other legal disclosures

- Expanded the Country Health Connection Meet and Greet service to provide services from 6.00am to 10.00pm Monday to Friday and as required on the weekends.
- Commenced development of a WA Country Health Service Aboriginal Health Strategy which will outline how the organisation will work across all regions, directorates and departments to improve service access and delivery for Aboriginal people to reduce health inequities.
- Continued our longstanding participation and support of a range of state and national forums such as the Statewide Aboriginal Health Network and WA Aboriginal Health Partnership Forum and continued our engagement with key agencies and partners such as the Commonwealth Department of Health, WA Primary Health Alliance, Rural and Remote West and the Aboriginal Health Council of WA.

OCCUPATIONAL SAFETY, HEALTH AND INJURY MANAGEMENT

Commitment to occupational safety, health and injury management

The WA Country Health Service is committed to providing a safe workplace and achieving high standards in safety and health for its employees, contractors and visitors. To achieve this the organisation has in place an integrated risk management approach to occupational safety and health that is underpinned by policies and procedures in accordance with the *Occupational Safety and Health Act 1984*, the *Occupational Safety and Health Regulations 1996* and the Code of Practice on Occupational Safety and Health in the Western Australian Public Sector 2007. WA Country Health Service has a published Occupational Safety and Health Statement of Commitment and an Occupational Safety and Health Policy.

The WA Country Health Service takes a proactive approach to “best practice” occupational safety and health by establishing clear policies, goals and strategies and monitoring systems, developing preventative programs, and articulating employee responsibilities. Occupational safety and health objectives, policies, strategies and staff responsibilities are available to all staff through HealthPoint and occupational safety and health intranet pages.

Hazard and risk management processes include the use of Safety Risk Report forms, workplace inspections, risk assessments and job hazard analysis. Consultation on safety and health matters occurs with safety and health representatives and the formation of safety and health committees and OSH performance is improved by establishing measurable objectives and targets through OSH planning activities.

Compliance with occupational safety, health and injury management

WA Country Health Service provides a comprehensive injury management service to support injured workers and facilitate the development and implementation of return to work programs. This service is guided by the requirements of both the *Workers’ Compensation and Injury Management Act 1981* and the Workers’ Compensation Code of Practice (Injury Management) 2005.

Injury Management Coordinators manage the injury management systems and are accessible to staff and managers. They develop and assist in the implementation of return to work programs, and report on recovery progress. Claims management processes including claims lodgment and processing, early intervention, and ongoing claims supervision is conducted by both occupational safety and health staff and Injury Management Coordinators to ensure high levels of support are provided to injured workers and their managers.

Other legal disclosures

Employee consultation

All regions within the WA Country Health Service facilitate occupational safety and health management and consultation through:

- the election of occupational safety and health representatives;
- the establishment of regional occupational safety and health committees and strategic occupational safety and health groups;
- hazard/incident reporting and investigation;
- routine workplace inspections;
- resolution of issues process; and
- the implementation of regular audits, risk assessments and control measures to prevent incidents occurring.

Regional occupational safety and health committees meet regularly to discuss and resolve occupational safety and health issues. These processes facilitate communication with management on occupational safety and health issues and support hazard and incident reporting. This ensures issues are formally recognised and actions are communicated back to the employee and occupational safety and health representative.

Employee rehabilitation

WA Country Health Service has a dedicated injury management system which enables systematic management of workers' compensation claims and the provision of injury management services that are administered in accordance with the *Workers' Compensation and Injury Management Act 1981*.

Injury management services are provided to support the development of return to work programs for staff with a work-related injury or illness. The organisation adopts a case management approach involving the WA Country Health Service Injury Management Coordinator, the injured worker and their treating medical provider to facilitate the early and safe return to work of injured workers.

Return to work performance is reported to the WA Country Health Service Executive on a quarterly basis. Employee rehabilitation programs also extend to non-compensable injuries where there is a risk of exacerbating factors and/or a requirement to provide expert advice to facilitate the employee's safe return to work.

Other legal disclosures

Occupational safety, health assessment and performance indicators

The annual performance reported for the WA Country Health Service in relation to occupational safety, health and injury for 2017-18 is summarised in Table 45.

Table 45: Occupational safety, health and injury performance 2015-16 to 2017-18

	Actual Results			Results against target	
Measure	2015-16	2016-17	2017-18	Target	Comments
Number of Fatalities	0	0	0	0	Target achieved
Lost time injury (LTI) and/or disease incidence rate	2.35	2.56	2.73	0 or 10% reduction	Target not achieved
Lost time injury and/or disease severity rate	39.32	32.98	42.00	0 or 10% reduction	Target not achieved
Percentage of injured workers returned to work:					
i) Within 13 weeks	N/A	57.2%	47%	70%	Target not achieved
ii) Within 26 weeks	69.80%	69.40%	51%	80%	Target not achieved
Percentage of managers trained in occupational safety, health and injury management responsibilities	30.60%	86%	88%	Greater than or equal to 80%	Target achieved

In the 2017/18 period there was a decrease in the number of Workers' Compensation claims lodged, however of those lodged, there was an increase in severe cases compared to the prior period. WACHS will undertake proactive risk mitigation in the areas of Manual Handling and Stress incidents to achieve LTI and Severity rate improvement.

Note: Performance is based on a three-year trend and as such the comparison base year is two years prior to the current reporting year (ie. current year is 2017/18 and comparison base year is 2015/16).

Other legal disclosures

SENIOR OFFICERS

Senior officers and their area of responsibility for the WA Country Health Service as at 30 June 2018 are listed in Table 46.

Table 46: WA Country Health Service senior officers

Area of responsibility	Title	Name	Basis of appointment
WA Country Health Service	Chief Executive	Mr Jeffrey Moffet	Term contract
Operations	Chief Operating Officer	Mr Shane Matthews	Term contract
*Innovation and Development	Executive Director	Ms Melissa Vernon	Acting
Nursing and Midwifery	Executive Director	Ms Marie Baxter	Term contract
Medical Services	Executive Director	Dr Anthony Robins	Term contract
Business Services	Executive Director	Mr Jordan Kelly	Term contract
Mental Health	Executive Director	Ms Paula Chatfield	Term contract
Health Programs	Executive Director	Ms Margaret Denton	Acting
Regional Operations	Regional Director Goldfields	Ms Geraldine Ennis	Substantive
Regional Operations	Regional Director Great Southern	Mr David Naughton	Term contract
Regional Operations	Regional Director Kimberley	Ms Rebecca Smith	Term contract
Regional Operations	Regional Director Midwest	Mr Jeffrey Calver	Term contract
**Regional Operations	Regional Director Pilbara	Ms Margi Faulkner	Term contract
Regional Operations	Regional Director Southwest	Ms Kerry Winsor	Substantive
Regional Operations	Regional Director Wheatbelt	Mr Sean Conlan	Term contract
Office of the Chief Executive	Director	Ms Tracy Rainford	Substantive
Finance	Director	Mr John Arkell	Substantive
Infrastructure	Director	Mr Robert Pulsford	Substantive
Aboriginal Health Strategy	Area Director	Mr Russell Simpson	Substantive

Note:

**Ms Melissa Vernon was Acting Chief Operating Officer Strategy and Reform until 31/12/2017 and is no longer filled.*

***The position of Regional Director Pilbara was held by Mr Ron Wynn up until 14/07/2017. Margi Faulkner was appointed to the role on 07/08/2017.*

****The position Executive Director Workforce was filled by Mr Marshall Warner until 18/08/2017 and is no longer filled (the position has been abolished). The position of Executive Director Public Health and Ambulatory Care was temporarily held by Ms Margaret Denton until 22/07/2018 and is no longer filled*

07 APPENDICES

Appendix 1: WA Country Health Service contact details

WA COUNTRY HEALTH SERVICE (WACHS)

Street address: 189 Wellington Street, Perth WA 6000
Postal address: PO Box 6680, East Perth Business Centre WA 6892
Phone: (08) 9223 8500 **Fax:** (08) 9223 8599
Email: centralofficereception.WACHS@health.wa.gov.au
Web: www.wacountry.health.wa.gov.au

WACHS – GOLDFIELDS

Street address: The Palms, 68 Piccadilly Street, Kalgoorlie WA 6430
Postal address: PO Box 716, Kalgoorlie WA 6430
Phone: (08) 9080 5710 **Fax:** (08) 9080 5724
Email: WACHS-GoldfieldsExec@health.wa.gov.au

WACHS – GREAT SOUTHERN

Street address: 84 Collie Street, Albany WA 6330
Postal address: PO Box 252, Albany WA 6331
Phone: (08) 9892 2672 **Fax:** (08) 9842 2643
Email: gs.ces@health.wa.gov.au

WACHS – KIMBERLEY

Street address: 29 Coghlan Street, Broome WA 6725
Postal address: Locked Bag 4011, Broome WA 6725
Phone: (08) 9195 2450 **Fax:** (08) 9192 5757
Email: KHS.ExecSecretary@health.wa.gov.au

WACHS – MIDWEST

Street address: 45 Cathedral Avenue, Geraldton WA 6530
Postal address: PO Box 22, Geraldton WA 6531
Phone: (08) 9956 2209 **Fax:** (08) 9956 2421
Email: CES.WACHS-Midwest@health.wa.gov.a

WACHS – PILBARA

Street address: Level 2, State Government Building Corner Brand and Tonkin Street, South Hedland WA 6722
Postal address: PMB 12, South Hedland WA 6722
Phone: (08) 9174 1600 **Fax:** (08) 9172 4167
Email: wachspb_execservices@health.wa.gov.au

WACHS – SOUTH WEST

Street and postal address: 5th floor, Bunbury Tower, 61 Victoria Street, Bunbury WA 6230
Phone: (08) 9781 2350 **Fax:** (08) 9781 2385
Email:execservices.wachssw@health.wa.gov.au

WACHS – WHEATBELT

Street address: Shop 4, 78 Wellington Street, Northam WA 6401
Postal address: PO Box 690, Northam WA 6401
Phone: (08) 9621 0700 **Fax:** (08) 9621 0701
Email: wheatbeltreception@health.wa.gov.au

Appendix 2: Boards and committee remuneration

WA COUNTRY HEALTH SERVICE BOARD

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Chair	Professor Neale Fong	Annual	Full year	$72,356
Deputy Chair	Wendy Newman	Not eligible	Full year	Not eligible
Member	Dr Daniel Heredia	Annual	Full year	$43,414
Member	Dr Kim Isaacs	Annual	Full year	$43,414
Member	Joshua Nisbet	Annual	Full year	$43,414
Member	Michael Hardy	Annual	Full year	$43,414
Member	Mary Anne Stephens	Annual	Full year	$43,414
Member	Meredith Waters	Annual	Full year	$43,414
Member	Alan Ferris	Annual	Full year	$43,414
Total				$376,254

Appendix 2: Boards and committee remuneration

MEDICAL ADVISORY COMMITTEES

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Albany Hospital Medical Advisory Committee				
Chairperson	Dr Frans Cronje	Per meeting	12 months	$0
Member	Dr Paul Salmon	Not eligible	12 months	$0
Member	Dr Russell Young	Not eligible	12 months	$0
Member	Dr David Ingram	Not eligible	12 months	$0
Member	Dr Peter Kendall	Not eligible	12 months	$0
Member	Dr Alice Poon	Not eligible	12 months	$0
Member	Dr George du Toit	Not eligible	12 months	$0
Member	Dr Anju Mahesh Reddy	Not eligible	12 months	$0
Member	Dr Ian Leggett	Not eligible	12 months	$0
Member	Dr James Turner	Not eligible	12 months	$0
Ex-Officio member	Juan Clark	Not eligible	12 months	$0
Ex-Officio member	Barbara Marquand	Not eligible	12 months	$0
Ex-Officio member	Dr Thomas Moodie	Not eligible	12 months	$0
Ex-Officio member	Dr Brendan Carson	Not eligible	12 months	$0
Ex-Officio member	Mr David Naughton	Not eligible	12 months	$0
Ex-Officio member	Dr Rofi Pillai	Not eligible	12 months	$0
Total				$0

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Blackwood Hospital Medical Advisory Committee				
Chair	Dr Michael Hoar	Per meeting	12 months	$600
Member	Dr Mick Dewing	Not eligible	12 months	$0
Member	Dr Nigel Jones	Not eligible	12 months	$0
Member	Dr Neil Wells	Not eligible	12 months	$0
Member	Dr Jonathan Morling	Not eligible	12 months	
Member	Dr Allison Johns	Not eligible	4 months	$0
Member	Jeremy Higgins	Not eligible	12 months	$0
Member	Anne-Maree Martino	Not eligible	12 months	$0
Member	Helen Stuart	Not eligible	6 months	$0
Member	Sally Shaw	Not eligible	12 months	$0
Member	Tamsen Robertson	Not eligible	12 months	$0
Total				$600

Appendix 2: Boards and committee remuneration

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Bunbury Hospital Medical Advisory Committee				
Chair	Dr Stephen Hinton	Per meeting	12 Months	$4,288
Member	Dr A Chauhan	Not Eligible	10 Months	$0
Member	Dr Ravi Krishnamurthy	Not Eligible	2 Months	$0
Member	Dr Adam Coulson	Not Eligible	12 Months	$0
Member	Dr Emma Crampin	Not Eligible	12 Months	$0
Member	Dr Benjamin Cunningham	Not Eligible	12 Months	$0
Member	Dr Peter English	Not Eligible	12 Months	$0
Member	Dr Iain Gilmore	Not Eligible	12 Months	$0
Member	Dr Harvey Graham	Not Eligible	12 Months	$0
Member	Dr Ivan Jansz	Not Eligible	12 Months	$0
Member	Dr Nicholas Newman	Not Eligible	12 Months	$0
Member	Dr Jacinta Cover	Not Eligible	12 Months	$0
Member	Dr Koula Pratsis	Not Eligible	12 Months	$0
Member	Dr Esther Knight-Terlouw	Not Eligible	4 Months	$0
Member	Dr Lila Stephens	Not Eligible	12 Months	$0
Member	Dr Ramesh Parthasarathy	Not Eligible	12 Months	$0

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Bunbury Hospital Medical Advisory Committee				
Agency Representative	Kerry Winsor	Not Eligible	12 Months	$0
Agency Representative	Dr Allison Johns	Not Eligible	12 Months	$0
Agency Representative	Dr Geoffrey Williamson	Not Eligible	12 Months	$0
Agency Representative	Jan Cook	Not Eligible	11 Months	$0
Member	Glen Matters	Not Eligible	1 Month	$0
Member	Marianne Slattery	Not Eligible	12 Months	$0
Committee Member	Yvonne Bagwell	Not Eligible	12 Months	$0
Member	Ceri Elliott	Not Eligible	12 Months	$0
Member	Naomi Lillywhite	Not Eligible	12 Months	$0
Member	Dr Naru Pal	Not Eligible	6 Months	$0
Total				$4,288

Appendix 2: Boards and committee remuneration

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Busselton Hospital Medical Advisory Committee				
Chair	Dr Sarah Moore	Per meeting	12 months	$1,667
Deputy Chair	Dr Patrick Mulhern	Not Eligible	12 months	$0
Ex-Officio Member -	Dr Mark Monaghan	Not Eligible	5 months	$0
Ex-Officio Member -	Daniel Anderson	Not Eligible	12 months	$0
Ex-Officio Member	Dr Phil Chapman	Not Eligible	12 months	$0
Ex-Officio Member -	Jo Moore	Not Eligible	3 months	$0
Ex-Officio Member -	Chris Love	Not Eligible	12 months	$0
Ex-Officio Member -	Brian Tucker	Not Eligible	12 months	$0
Ex-Officio Member -	Kerry Winsor	Not Eligible	12 months	$0
Ex-Officio Member	Dr Allison Johns	Not Eligible	12 months	$0
Member	Dr Anne Giele	Not Eligible	12 months	$0
Member	Dr Donna Hill	Not Eligible	12 months	$0
Member	Dr V Pushpalingam	Not Eligible	12 months	$0
Member	Dr Miles Earl	Not Eligible	12 months	$0
Member	Dr Francis Loutsky	Not Eligible	12 months	$0
Member	Dr Geoff Hunt	Not Eligible	12 months	$0
Member	Dr Martin Ibach	Not Eligible	12 months	$0
Member	Dr Rachel Jackson	Not Eligible	12 months	$0
Member	Dr Chris Kruk	Not Eligible	12 months	$0
Member	Dr Mark Holloway	Not Eligible	12 months	$0
Member	Dr Sandra Rennie	Not Eligible	12 months	$0
Member	Dr Maria O'Shea	Not Eligible	12 months	$0
Member	Dr Gerhard Erasmus	Not Eligible	12 months	$0
Member	Dr Trent Healy	Not Eligible	12 months	$0
Total				$1,667

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Central Great Southern Medical Advisory Committee				
Chair	Dr Nicholas Du Preez	Per Meeting	12 months	$2,970
Member	Dr Bilal Ahmad	Not Eligible	12 months	$0
Member	Dr Deepak Panneerselvam	Not Eligible	12 months	$0
Member	Dr Saleem Hafees	Not Eligible	12 months	$0
Member	Dr Samantha Weaver	Not Eligible	12 months	$0
Member	Dr Agit Chaurasia	Not Eligible	12 months	$0
Member	Dr Oluwole Oluyede	Not Eligible	12 months	$0
Member	Dr Adewale Olatunji	Not Eligible	12 months	$0
Member	Dr Kamran Malick	Not Eligible	5 months	$0
Member	Dr Saweela Sarwar	Not Eligible	5 months	$0
Member	Dr Moeen Ahmed	Not Eligible	5 months	$0
Member	Dr Emily Webb	Not Eligible	12 months	$0
Total				$2,970

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Denmark Medical Advisory Committee				
Chair	Dr Peter Faulkner	Per Meeting	12 months	$1,584
Member	Dr Brett Lamb	Not Eligible	12 months	$0
Member	Dr Virginia Longley	Not Eligible	12 months	$0
Member	Dr Pieter Austin	Not Eligible	12 months	$0
Member	Dr Prathalingam	Not Eligible	2 months	$0
Member	Dr Jane James	Not Eligible	3 months	$0
Member	Dr Sharon Jackson	Not Eligible	7 months	$0
Member	Dr Christine Archer	Not Eligible	7 months	$0
Total				$1,584

Appendix 2: Boards and committee remuneration

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Donnybrook Hospital Medical Advisory Committee				
Chair	Dr Wiestke van Der Velden Schuijling	Per meeting	12 months	$0
Ex Officio Member	Jeremy Higgins	Not Eligible	12 months	$0
Ex Officio Member	Lucy Murphy	Not Eligible	12 months	$0
Member	Dr Peter Rae	Not Eligible	12 months	$0
Member	Dr Loryn Geyer	Not Eligible	12 months	$0
Member	Dr Andrew Luc	Not Eligible	12 months	$0
Member	Robin Armstrong	Not Eligible	12 months	$0
Total				$0

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Eastern Medical Advisory Committee				
Chair	Dr Peter Lines	Per Meeting	12	$2,986.59
Member	Dr Andrew Van Ballegooyen	Not Eligible	12	$0
Member	Dr Adenola Adeleye	Not Eligible	12	$0
Member	Dr Brian Walker	Not Eligible	12	$0
Member	Dr Caleb Chow	Not Eligible	12	$0
Member	Dr Mirielsa Ruiz	Not Eligible	12	$0
Member	Dr Jonathan Ruiz	Not Eligible	12	$0
Member	Dr Infeanyi-Chukwu Nwoko	Not Eligible	12	$0
Member	Dr Modupe Olanrewaju	Not Eligible	12	$0
Member	Robert Amm	Not Eligible	12	$0
Member	Dr Peter Barratt	Not Eligible	12	$0
Member	Jacinta Herbert	Not Eligible	12	$0
Member	Karen Horsley	Not Eligible	12	$0
Member	Lyn Tutt	Not Eligible	12	$0
Total				$2,986.59

Appendix 2: Boards and committee remuneration

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Geraldton Medical Advisory Council				
Chairperson	Dr Ian Taylor	Not Eligible	12	$0
Ex Officio Member	Dr Allan Pelkowitz	Not Eligible	12	$0
Member	Dr Katherine Templeman	Not Eligible	12	$0
Member	Dr Jacques Perry	Not Eligible	12	$0
Member	Dr Helko Schenk	Not Eligible	12	$0
Member	Dr Roy Varhgese	Not Eligible	12	$0
Member	Dr Sara Armitage	Not Eligible	12	$0
Member	Dr Anita Banks	Not Eligible	6	$0
Member	Dr Jonah Chieza	Not Eligible		$0
Member	Dr Stefan Schutte	Not Eligible	12	$0
Member	Dr Yusuf Nagree or Dr Jenne Love	Not Eligible	6	$0
Member	Dr Lorcan McGonagle	Not Eligible	12	$0
Total				$0

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Margaret River Medical Advisory Committee				
Chair	Dr Verelle Roocke	Per meeting	12 Months	$1,260
Ex Officio Member	Dr Allison Johns	Not Eligible	12 Months	$0
Ex Officio Member	Jo Moore	Not Eligible	12 Months	$0
Ex Officio Member	Dr Mark Monaghan	Not Eligible	12 Months	$0
Ex Officio Member	Marie Tweedie	Not Eligible	12 Months	$0
Ex Officio Member	Sandy Znidarsich	Not Eligible	12 Months	$0

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Margaret River Medical Advisory Committee				
Ex Officio Member	Bernard Feenan	Not Eligible	12 Months	$0
Ex Officio Member	Chris Love	Not Eligible	12 months	
Ex Officio Member	Dr Peter English	Not Eligible	12 Months	$0
Member	Dr Peter Durey,	Not Eligible	12 Months	$0
Member	Dr Ray Clarke,	Not Eligible	12 Months	$0
Member	Dr Cathy Milligan,	Not Eligible	12 Months	$0
Ex Officio Member	Dr Adam Bancroft	Not Eligible	12 Months	$0
Member	Dr Bob Bucat,	Not Eligible	12 Months	$0
Member	Dr John Collis,	Not Eligible	12 Months	$0
Member	Dr Marigold Jones,	Not Eligible	12 Months	$0
Member	Dr Kirsty MacGregor	Not Eligible	12 Months	$0
Member	Dr Graham Velterop	Not Eligible	12 Months	$0
Member	Dr Shaun O'Rourke	Not Eligible	12 Months	$0
Member	Dr Sharyn Bennier	Not Eligible	12 Months	$0
Member	Dr Peter Carroll	Not Eligible	12 Months	$0
Member	Dr Martin Ibach	Not Eligible	12 Months	$0
Member	Dr Nathalie Maron	Not Eligible	12 Months	$0
Member	Dr Louise Marsh	Not Eligible	12 Months	$0
Ex Officio Member	Dane Hendry	Not Eligible	12 Months	$0
Member	Dr Alan Walley	Not Eligible	12 Months	$0
Member	Dr Gareth Mann	Not Eligible	12 Months	$0
Member	Dr Katina Koukourou	Not Eligible	12 Months	$0
Member	Dr Richard Roddy	Not Eligible	12 Months	$0

Appendix 2: Boards and committee remuneration

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Margaret River Medical Advisory Committee				
Member	Dr Rebecca Vernon	Not Eligible	12 Months	$0
Member	Dr Gary Wilson	Not Eligible	12 Months	$0
Member	Dr Emma Stephenson	Not Eligible	12 Months	$0
Member	Dr Archana Ratna	Not Eligible	12 Months	$0
Member	Dr Fintan Andrews	Not Eligible	12 Months	$0
Member	Dr Chris Thexton	Not Eligible	12 Months	$0
Member	Dr Jaimie Drysdale	Not Eligible	12 Months	$0
Total				$1,260

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Plantagenet Cranbrook Health Service - Medical Advisory Committee				
Chair	Dr Victor Seah	Per Meeting	12 months	$806.76
Member	Dr Carol Fitzpatrick	Not Eligible	12 months	$0.00
Member	Dr Ligia Galvez	Per Meeting	12 months	$201.69
Member	Dr Elaine Sabin	Not Eligible	12 months	$0.00
Member	Dr Amanda Villis	Per Meeting	12 months	$201.69
Member	Dr Yelal	Not Eligible	12 months	$0.00
Total				$1,210.14

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Southern District Medical Advisory Committee				
Chair	Dr Peter Maguire	Per Meeting	5 months	$1,277.10
Member	Dr Peter Smith	Not eligible	12 months	Nil
Member	Dr Wynand Breytenbach	Not eligible	12 months	Nil
Member	Dr Gina Sherry	Not eligible	1 month	Nil
Member	Dr Alan Kerrigan	Not eligible	12 months	Nil
Member	Dr Peter Barratt	Not eligible	12 months	Nil
Member	Jenny Menasse	Not eligible	12 months	Nil
Member	Kerry Fisher	Not eligible	12 months	Nil
Member	Dr Kath Comparti	Not eligible	12 months	Nil
Member	Dr Ian Swingler	Not eligible	4 months	Nil
Member	Dr Jean Paul Lalonde	Not eligible	1 month	Nil
Member	Dr Nigel Chikolwa	Not eligible	12 months	Nil
Member	Dr Brendan Parmar	Not eligible	8 months	Nil
Member	Dr Rhonda Marques	Not eligible	8 months	Nil
Total				$1,277.10

Appendix 2: Boards and committee remuneration

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Warren District Medical Advisory Committee				
Chairperson	Dr John Rosser Davies	Per Meeting	12 months	$818
Member	Dr Alison Turner	Not Eligible	12 months	$0
Member	Dr James Bowie	Not Eligible	12 months	$0
Member	Dr Lucas Vesely	Not Eligible	12 months	$0
Member	Dr Mildred Chiwara	Not Eligible	12 months	$0
Member	Dr Paul Griffiths	Not Eligible	12 months	$0
Member	Dr Peter Wutchak	Not Eligible	12 months	$0
Member	Cr Jan Van Vollenstee	Not Eligible	12 months	$0
Member	Dr Lillian Daniels	Not Eligible	12 months	$0
Member	Dr Utara White	Not Eligible	12 Months	$0
Total				$818

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Western District Medical Advisory Committee				
Chair	Dr Anna Varone	Not eligible	12 months	$0
Member	Dr Peter Barratt	Not eligible	12 months	$0
Member	Dr Shahi Patel	Not eligible	12 months	$0
Member	Dr Kate Saunders	Not eligible	12 months	$0
Member	Dr Damien Zilm	Not eligible	12 months	$0
Member	Dr Marion Davies	Not eligible	12 months	$0
Member	Dr Marie Fox	Not eligible	12 months	$0
Member	Dr Duncan Steed	Not eligible	12 months	$0
Member	Dr Sam Al Mur	Not eligible	12 months	$0
Member	Dr Gavin Osgarby	Not eligible	12 months	$0
Member	Dr Oladapo Alegbe	Not eligible	12 months	$0
Member	Dr Colin Smyth	Not eligible	12 months	$0
Member	Dr Tony Mylius	Not eligible	12 months	$0
Member	Dr Peter Smith	Not eligible	12 months	$0
Member	Dr Wes Abujalala	Not eligible	12 months	$0
Member	Dr Paul Gallacher	Not eligible	12 months	$0
Member	Dr Marion Rae	Not eligible	12 months	$0
Member	Dr Smriti Shah	Not eligible	12 months	$0
Total				$0

Appendix 2: Boards and committee remuneration

DISTRICT HEALTH ADVISORY COMMITTEES

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Blackwood District Health Advisory Council				
Chair	Philippe Kaltenrieder	Per meeting	12 months	$585
Deputy Chair	Max Barrington	Per meeting	12 months	$532
Member	Cate Stevenson	Per meeting	12 months	$0
Member	Pat Twiss	Per meeting	12 months	$431
Member	Terry Linz	Per meeting	12 months	$0
Total				$1,548

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Broome and Surrounding Communities District Health Advisory Council				
Agency Representative	Wendy McKinley	Not Eligible	4 months	$0
Agency Representative	Chris Mitchell	Not Eligible	10 months	$0
Community representative	Tracey Chamberlain	Not Eligible	10 months	$0
Agency Representative	Karen Fitzpartick	Not Eligible	10 months	$0
Community representative	Margaret Moore	Not Eligible	10 months	$0
Agency Representative	Cheryl Ozies	Not Eligible	12 months	$0
Community representative	Justine Young	Not Eligible	12 months	$0
Agency Representative	Laura Handscombe	Not Eligible	12 months	$0
Agency Representative	Adam Vincent	Not Eligible	10 months	$0
Total				$0

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Bunbury District Health Advisory Council				
Chair	John Gardyne	Per Meeting	12 months	$330
Deputy Chair	Margaret Smith	Per Meeting	12 months	$0
Member	Fay Thompson	Per Meeting	5 months	$0
Member	Joan Birkett	Per Meeting	12 months	$540
Member	Lynne King	Per Meeting	8 months	$0
Agency Representative	Robyn Jones	Not Eligible	6 months	$0
Member	Robert Blakeman	Per Meeting	3 months	$0
Member	Saswati Pal	Per Meeting	9 months	$0
Member	Stephen Leggett	Per Meeting	4 months	$0
Agency Representative	Wendy Botha	Not Eligible	12 months	$0
Agency Representative	Maria Fitzgerald	Not Eligible	12 months	$0
Agency Representative	Dianne Ritson	Not Eligible	12 months	$0
Agency Representative	Jasmin Brown	Not Eligible	12 months	$0
Agency Representative	Kate Cross	Not Eligible	3 months	$0
Community Representative	Zahara Castles	Not Eligible	5 months	$0
Community Representative	Liam Oaky	Not Eligible	5 months	$0
Community Representative	Kage Geyer	Not Eligible	4 months	$0
Community Representative	Aimee Adams	Not Eligible	1 month	$0
Community Representative	Wyatt Goff	Not Eligible	1 month	$0
Agency Representative	Glen Matters	Not Eligible	1 month	$0

Appendix 2: Boards and committee remuneration

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Bunbury District Health Advisory Council				
Agency Representative	Jan Cook	Not Eligible	11 months	$0
Agency Representative	Dr Geoffrey Williamson	Not Eligible	12 months	$0
Agency Representative	M A Slattery	Not Eligible	3 months	$0
Agency Representative	Yvonne Bagwell	Not Eligible	8 months	$0
Agency Representative	Peter Davies-Sage	Not Eligible	2 months	$0
Agency Representative	Kirsten Bosich	Not Eligible	9 months	$0
Agency Representative	Rachel Parsons	Not Eligible	12 months	$0
Total				$870

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Central Great Southern District Health Advisory Council				
Chair	Hilary Harris	Per Meeting	12 months	$1,118
Deputy Chair	Gladys Wells	Per Meeting	12 months	$824
Member	Norma Hersey	Per Meeting	12 months	$1,475
Member	Pauline Roosendaal	Per Meeting	12 months	$694
Member	Jill Mathwin	Per Meeting	12 months	$974
Member	Gabrielle Hansen	Per Meeting	12 months	$165
Member	Deanne Noakes	Per Meeting	12 months	$433
Total				$5,682

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Derby and Surrounding Communities District Health Advisory Council				
Chair	Susan Murphy	Per Meeting	10 months	$1,980.00
Chair	Rachele Humbert	Not Eligible	2 months	$0
Agency representative	Rachele Humbert	Not Eligible	11 months	$0
Agency representative	Annette Kogolo	Not Eligible	3 months	$0
Community representative	Elsia Archer	Not Eligible	1 month	$0
Agency representative	Elsia Archer	Not Eligible	10 months	$0
Agency representative	Lyn Henderson Yates	Not Eligible	11 months	$0
Agency representative	Joanne Moore	Not Eligible	11 months	$0
Agency representative	Jeannie Roberts	Not Eligible	11 months	$0
Agency representative	Ruth Southern	Not Eligible	11 months	$0
Community representative	Robyn Bowcock	Not Eligible	11 months	$0
Agency representative	Linda Royce	Not Eligible	11 months	$0
Ex Officio	Andrew McGaw	Not Eligible	11 months	$0
Agency representative	Kylie Lawsen	Not Eligible	1 month	$0
Agency representative	Peter McCumstie	Not Eligible	3 months	$0
Total				$1,980

Appendix 2: Boards and committee remuneration

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Eastern Wheatbelt District Health Advisory Council				
Chair	Onida Truran	Per Meeting	12 months	$0
Member	Alan McAndrew	Per Meeting	8 months	$849
Member	Lynne White	Per Meeting	11 months	$1,174
Member	Sandra Waters	Per Meeting	12 months	$671
Member	Mary Cowan	Per Meeting	12 months	$0
Member	Adrian Wesley	Per Meeting	12 months	$0
Total				$2,694

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Eastern Wheatbelt District Health Advisory Council				
Chair	Onida Truran	Per Meeting	12 months	$0
Member	Alan McAndrew	Per Meeting	8 months	$849
Member	Lynne White	Per Meeting	11 months	$1,174
Member	Sandra Waters	Per Meeting	12 months	$671
Member	Mary Cowan	Per Meeting	12 months	$0
Member	Adrian Wesley	Per Meeting	12 months	$0
Total				$2,694

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
East Pilbara District Health Advisory Committee				
Chair	Ms Gloria Jacob	Per Meeting	12 months	$678
Total				$678

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Gascoyne District Health Advisory Council				
Member	Jackie Cameron	Not eligible	5 months	$0
Member	Alex Maslen	Not eligible	5 months	$0
Member	Joan Sedgwick	Not eligible	5 months	$0
Member	Trevor Halls	Not eligible	5 months	$0
Member	Merle Dann	Not eligible	5 months	$0
Member	Joan Mitchell	Not eligible	5 months	$0
Total				$0

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Geraldton District Health Advisory Council				
Chair	Donald Rolston	Per Meeting	12 months	490.00
Member	Margaret Pike	Per Meeting	12 months	300.00
Member	Debra Buckle	Per Meeting	12 months	150.00
Member	Merrilyn Agnew	Not Eligible	12 months	0.00
Member	Glenn Jones	Not Eligible	12 months	0.00
Total				940.00

Appendix 2: Boards and committee remuneration

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Goldfields District Health Advisory Council				
Acting Chair	Margaret Christie	Per Meeting	12 Months	$180
Member	Hayley Dowson	Per Meeting	6 Months	$270
Member	Dianne Paddon	Per Meeting	12 Months	$540
Member	Greg Baxter	Per Meeting	12 Months	$450
Member	Keith Cowan	Per Meeting	12 Months	$540
Member	Debbie Van Luxemborg	Per Meeting	12 Months	$450
Member	Kirsty McCluskey	Per Meeting	12 Months	$360
Member	Natasha Edgecombe	Per Meeting	12 Months	$180
Total				$2,970

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Kununurra Wyndham and Surrounding Communities District Health Advisory Council				
Chair	Maxine Middap	Per Meeting	12 months	$3,060
Agency Representative	Donna Hindmarsh	Not Eligible	12 months	$0
Agency Representative	Dr James Harris	Not Eligible	12 months	$0
Agency Representative	Terry Howe	Not Eligible	12 months	$0
Community Representative	Robyn Long	Not Eligible	12 months	$0
Community Representative	Sister Marcella Hegarty	Not Eligible	12 months	$0
Community Representative	Virginia O'Neil	Not Eligible	12 months	$0
Community Representative	Peter Frewen	Not Eligible	12 month	$0
Agency Representative	Andrew McGaw	Not Eligible	6 months	$0
Total				$3060

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Leschenault District Health Advisory Council				
Chair	Amanda Lovitt	Per Meeting	12 months	$204
Member	Colin Beauchamp	Not Eligible	12 months	$0
Member	Derrick Simpson	Not Eligible	2 months	$0
Member	Lesley Ugle	Not Eligible	12 months	$0
Member	William Adans	Not Eligible	10 months	$0
Total				$204

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Lower Great Southern District Health Advisory Council				
Chair	Irene Montefiore	Not Eligible	12 months	0.00
Deputy Chair	Rodger Bull	Per Meeting	12 months	540.00
Member	Elizabeth Hamilton	Per Meeting	12 months	360.00
Member	Dorothy Price	Not Eligible	12 months	0.00
Member	Denise Kaye	Not Eligible	12 months	0.00
Member	Ann Dunlop	Not Eligible	12 months	0.00
Member	Ruth McLean	Not Eligible	12 months	0.00
Total				900.00

Appendix 2: Boards and committee remuneration

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Naturaliste District Health Advisory Council				
Chair	Elizabeth Jones	Per Meeting	12 months	$0
Deputy Chair	Max Kewish	Per Meeting	12 months	$0
Member	David McDonald	Per Meeting	3 months	$0
Member	Gaye Hargreaves	Per Meeting	12 months	$0
Member	Tanya Gillett	Not Eligible	12 months	$0
Member	Jennifer Richards	Per Meeting	12 months	$0
Agency Representative	Lorrae Loud	Not Eligible	12 months	$0
Member	Naomi Grimshaw	Per Meeting	6 months	$0
Total				$0

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
South East District Health Advisory Council				
Chair	Meredith Waters	Not Eligible	12 Months	$0
Member	Kathleen Fowler	Not Eligible	12 Months	$0
Member	Pam Gardner	Not Eligible	12 Months	$0
Member	Pamela Kerr	Not Eligible	12 Months	$0
Member	Sue Meyer	Not Eligible	12 Months	$0
Member	Ellen Saltmarsh	Not Eligible	12 Months	$0
Member	Jennifer Woods	Not Eligible	3 months	$0
Member	Rachel McGrinder	Not Eligible	12 months	$0
Member	Gabrielle Lilley	Not Eligible	12 Months	$0
Member	Thuriyya Ibrahim	Not Eligible	12 Months	$0
Member	Lynette Whitby	Not Eligible	2 months	$0
Total				$0

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Southern Wheatbelt District Health Advisory Council				
Chair	Stan Sherry	Not Eligible	12 months	$0
Member	Bronwen O'Sullivan	Not Eligible	12 months	$0
Member	Geoff Hodgson	Not Eligible	12 months	$0
Member	Moya Carne	Not Eligible	12 months	$0
Member	Frank Heffernan	Not Eligible	12 months	$0
Member	Amanda Milton	Not Eligible	12 months	$0
Member	Debrah Clarke	Not Eligible	12 months	$0
Member	Lindsay Smoker	Not Eligible	12 months	$0
Member	Alan McAndrew	Not Eligible	12 months	$0
Total				$0

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Warren District Health Advisory Council				
Chair	Ray Curo	Per meeting	12 months	$2830
Member	Elizabeth Bartholomaeus	Per meeting	12 months	$0
Member	Gordon Smith	Per meeting	12 months	$549
Member	Kathy Yovkoff	Per meeting	12 months	$0
Member	Lesley Polley	Per meeting	12 months	$0
Member	Sue Harris	Per meeting	12 months	$0
Member	Sue Priddis	Per meeting	12 months	$0
Member	Sydney Brunalli	Per meeting	12 months	$0
Total				$3379

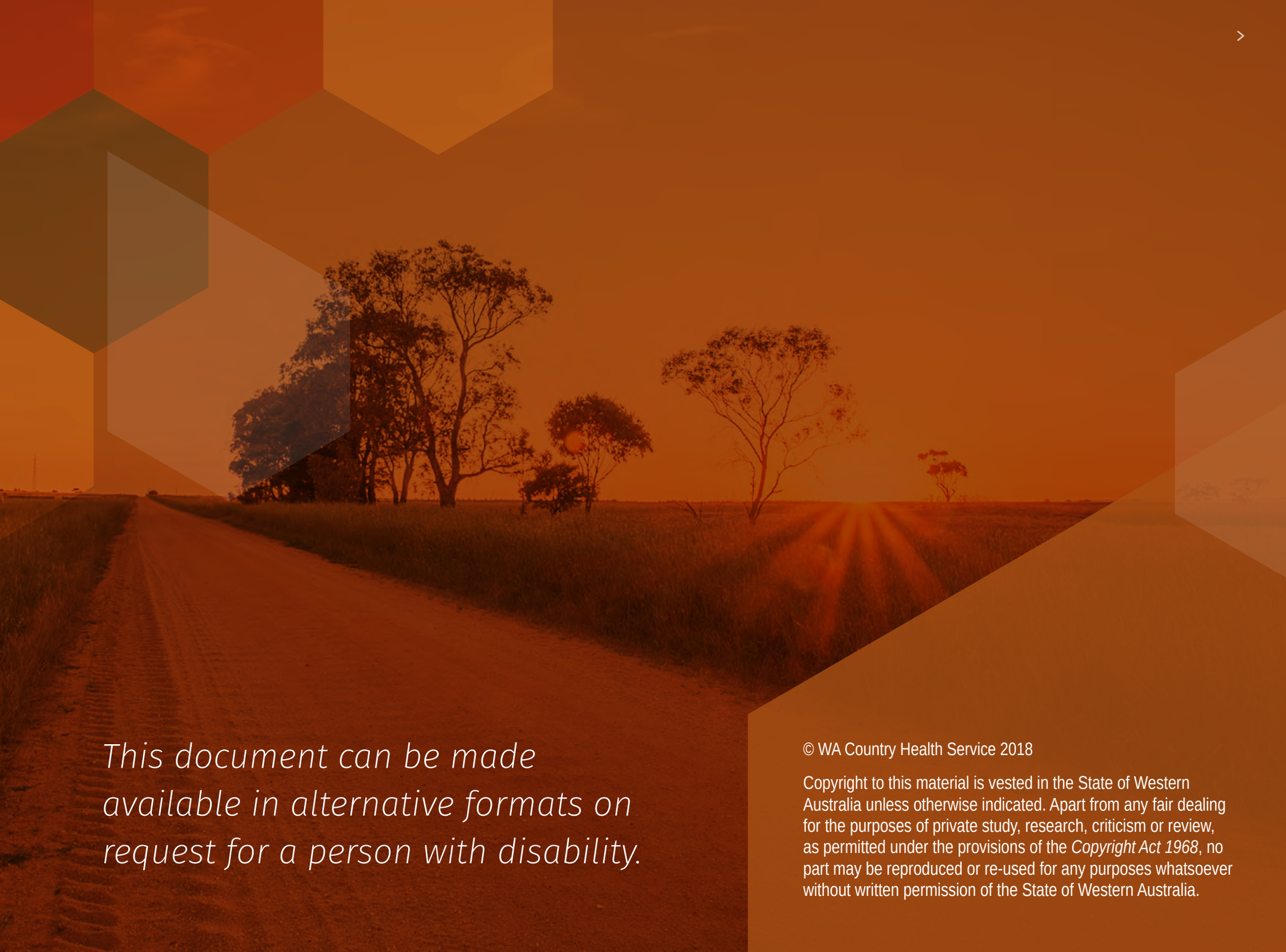
Appendix 2: Boards and committee remuneration

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
West Pilbara District Health Advisory Committee				
Chair	Jo Halpin	Per Meeting	12 months	$0
Member	Casey Mitchell	Per Meeting	12 months	$0
Member	Jo Van-Dyke	Per Meeting	12 months	$0
Member	Courtney Wellington	Per Meeting	12 months	$0
Member	Winny Henry	Per Meeting	12 months	$0
Member	Dee Van Beek	Per Meeting	12 months	$0
Member	Phaedra Fenner	Per Meeting	12 months	$0
Total				$0

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Western Wheatbelt District Health Advisory Council				
Chair	Irene Mills	Per Meeting	12 months	$1,159
Deputy Chair	Jan Court	Per Meeting	12 months	$0
Member	Georgina Mackintosh	Per Meeting	12 months	$1,712
Member	Dianne Hooper	Per Meeting	12 months	$180
Member	Sandra Randell	Per Meeting	12 months	$0
Member	Cynthia Mcmorran	Per Meeting	12 months	$526
Member	Keith Murray	Per Meeting	12 months	$1,193
Member	Patricia Walters	Per Meeting	12 months	$141
Member	Dianne Kelly	Per Meeting	12 months	$0
Member	Michelle Cockman	Per Meeting	12 months	$393
Member	Kerrie Roberts	Per Meeting	12 months	$1,527
Member	Michelle Thompson	Per Meeting	12 months	$1,110
Total				$6,783

Appendix 3: Data sources

Page	Source
11	Executive Summary - Year in Review: Emergency Department presentations per day 2017 - Emergency Department Data Collections (EDDC); Emergency Department 2017-18 emergency department presentations EDDC extracted 9 July 2018; Admission and discharges (separations data) 2017 Hospital Morbidity Data System (HDMS) extracted 9 July 2018; people living with an acute mental health or alcohol and drug condition in 2017 HDMS; births 2017-18 Midwives Notification System and Birth Notification Database WACHS extracted 9 July 2018, KEMH extracted 17 July 2018; Elective Surgery numbers: Elective Services Wait List Data Collection, Inpatient Data Collections, Data Collections Directorate extracted 20 July 2018; Aboriginal patients provided care discharges (separations data) 2017 Hospital Morbidity Data System (HDMS) extracted 9 July 2018; Telehealth Data: ETS and STS activity data source MMEx and extracted on the 10 May 2018 (MMEx data does not include case conference or chart reviews where the patient is not in attendance. It does not include Mental Health activity, educational events or any other activity that is scheduled outside of the MMEx system. Activity through external videoconferencing applications such as Lync, Skype and VideoCall are not included in MMEx reporting. MH data source PSOLIS AdHoc Reporting module (PAHR) and extracted on 11 May 2018. MH data includes both consults and case conferences where the patient is not in attendance. This data reflects attended appointments only from 1 January 2014 to 31 December 2017).
12	Executive Summary - WACHS in Country Communities: Employee Establishment snapshot as at the end of March 2018; Number of Aboriginal employees headcount HR Data Warehouse April 2018.
13	WA Country Health Service at a glance: Australian Bureau of Statistics Estimated Resident Population data 2016.
16	Patient Opinion: Patient Opinion Online as at 30 June 2018.
24	Aboriginal Health: Australian Bureau of Statistics Estimated Resident Population data 2016; Life expectancy at birth from the Australian Bureau of Statistics 2010-2012 for WA state; WA Country Health Service Health Profile Summary March 2017; WA Country Health Service Sustainable Health Review Submission; Otitis media statistic from Department of Prime Minister and Cabinet (2014) Health Performance Framework 2014, Report available at https://www.pmc.gov.au/sites/default/files/publications/indigenous/Health-Performance-Framework-2014/tier-1-health-status-and-outcomes/115-ear-health.html
25	Aboriginal Health: Chronic Diseases Australian Bureau of Statistics. 2014. Australian Aboriginal and Torres Strait Islander Health Survey: Biomedical Results, 2012–13; Australian Institute of Health and Welfare. Chronic Kidney Disease in Aboriginal and Torres Strait Islander people 2011.
52	Clinical governance and performance: SAC 1 data Datix Clinical Incident Management System.
54	Clinical governance and performance: Healthcare Associated Infection data – Healthcare Infection Surveillance Western Australia.
55	Patient experience and satisfaction: Patient Evaluation of Health Services, undertaken by the Western Australian Department of Health.
61	Health snapshot of country WA: Life expectancy at Birth from the ABS 3302055001DO002_2014-2016 Life tables, States, Territories and Australia, 2014-2016.
62	Health Snapshot of Country WA - Life expectancy at Birth from the ABS 3302055001DO002_2014-2016 Life tables, States, Territories and Australia, 2014-2016 (data is for 2010-12 births); motor vehicle death Health Tracks June 2018; Cancer Registry 2009-10 to 2015-16; Midwives Notification System June 2018; WACHS Child and Adolescent Health Profile 2017;Obesity, drinking, smoking, chronic conditions Health Tracks 2013-16; Trachoma, diarrhoeal disease, skin infections Health Tracks 2011-2015.
63	Health Snapshot of Country WA (continued) – Avoidable hospitalisations due to chronic conditions Health Tracks, accessed June 2018; Diabetes related hospitalisations Department of Health Epidemiology, June 2018; Kimberley chronic conditions vs state rates Health Tracks 2011-2015.
64	Significant Issues: WACHS Sustainable Health Review Submission; Australian Bureau of Statistics Estimated Resident Population data 2016; WA missing out on $430 million annually due to GP shortage: Former Health Department head, Emily PIESSE, ABC News (5 Aug. 2017) (http://www.abc.net.au/news/2017-08-05/kim-snowball-offers-health-advice-to-wa-government/8776100); WA Tomorrow 2015 population projections; Ageing in the Bush 2016 (https://www.wheatbelt.wa.gov.au/files/5214/7243/6717/Ageing_in_the_Bush_Report_Highlights_290816.pdf).



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