




WA Country Health Service Annual Report 2006-07

Statement of Compliance

HON JIM MCGINTY MLA
MINISTER FOR HEALTH

In accordance with Section 61 of the *Financial Management Act 2006*, I hereby submit for your information and presentation to Parliament, the Report of the WA Country Health Service for the year ended 30 June 2007.

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

Dr Neale Fong
DIRECTOR GENERAL OF HEALTH
Accountable Authority

27th September 2007

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

Executive Summary

The 2006-07 year has seen further progress in health reform for the WA Country Health Service (WACHS) commencing with the integration of the South West Area Health Service into WACHS in July 2006. WACHS is now the principal provider of public health care in country Western Australia and this has provided an opportune time to advance the work promoted under the "Country Health Services Review 2003" and develop a strategic plan for the period 2007-2010 for all health care services in Western Australian country areas. Following extensive consultation with the community including focus groups, government agencies and clinical stakeholders, the "Foundations for Country Health Services" was released in early 2007.

"Foundations" is presented at a time when public health services across Western Australia are being re-equipped to better meet the needs of a dynamic community, to respond to new resource, capability and capacity issues, and to take timely advantage of new technologies and practices in clinical and patient care. The three strategic intentions outlined in "Foundations" of 'Networking Health Services', 'Building Healthier Communities' and 'Strengthening and modernising the country health system' affirm the distinct and unique needs and challenges facing our country health system.

During 2006-07 improving aboriginal health remained a key strategic and operational objective for WACHS, reinforced in "Foundations". WACHS has focussed on developing initiatives for the advancement and recruitment of aboriginal health workers and professionals. It has also forged partnerships with aboriginal organisations and the Office of Aboriginal Health, and facilitated aboriginal consultations and participation in health service planning and decision-making.

The year saw the completion of a number of capital infrastructure projects including Karlarra House residential care facility at Port Hedland, the Derby Hospital acute in-patient ward, the Moora Multi-purpose Centre and the Margaret River Hospital upgrade. The equipment investment program also continued with the installation of a new computed tomography scanner at Port Hedland and general upgrading of medical imaging, surgical and patient care equipment.

Telehealth is recognised as an important asset in bringing quality clinical practice and training to country areas and 2006-07 saw increased development and use of telehealth services for specialist areas such as psychiatry and neurology, and in conducting specialist clinics or programs in clinical areas such as paediatric burns, gastroenterology and pain and wound management.

WACHS is committed to providing a range of residential and community based services to the aged population of rural WA, with an emphasis on maintaining the health and independence of elderly people in the community. New initiatives and services such as the Transitional Care Program, the Long Stay Older Patients Initiative, the Residential Care Line and the ongoing Home and Community Care Program, aim to provide care and support to elderly patients through all stages of their care. Aged care management units have also been established in each regional network to improve the efficiency and coordination of aged care service delivery in rural communities and to assist staff training and skill development.

WACHS has actively addressed its elective surgery waiting lists with over 13,800 Category 1, 2 and 3 people receiving treatment in WACHS hospitals, and reducing the median waiting times and over-boundary cases in the elective surgery categories. During 2006-07 the Area Health Service has progressed the introduction of the 'Hospital in the Home' and ambulatory surgery programs and these will be expanded in 2007-08.

WACHS has been actively promoting partnership arrangements with the non-government and private sectors including provision for renal dialysis in Busselton with St John of God Hospital Bunbury, Pilbara outpatient and allied health services with BHP Billiton, the development of the Rural Clinical School in Bunbury with the University of WA, and is currently negotiating with the Royal Flying Doctor Service to develop a 5 year plan for inter-hospital transport services.

The Patient Assisted Travel Scheme is an important program for WACHS assisting country people to access specialist medical and surgical services based in regional centres and the metropolitan area. The year has seen WACHS introduce a number of program initiatives to simplify PATS for country people including flexible reimbursement options. These initiatives support a scheme that has seen increased numbers of trips and especially expenditure where there has been significant increase in transport costs.

During 2006-07 WACHS has also made some significant workforce enhancements across the Area Health Service. These include the appointment of additional medical officers under WACHS' Specialist Services Plan for the disciplines of mental health, surgery, paediatrics, gastroenterology, and obstetrics and gynaecology, the appointment of additional district medical officers and the recruitment of additional allied health staff. The introduction of the role of nurse practitioners has also been advanced as well as the ongoing work for the nursing workload project. A number of staff retention and attraction projects have progressed relating to staff accommodation and initiatives to promote staff training, work site rotations and occupational experience.

The year also saw the inaugural appointments of WACHS-wide Executive Directors for Nursing and Medical Services, along with the Nurse Director and Medical Director positions in each of the regional networks. These positions strengthen nursing and medical leadership, and in conjunction with clinical governance initiatives such as the Safety and Quality Investment in Reform (SQUIRE) program, form key elements of the clinical management enhancements pursued by WACHS. These positions are designed to provide our nursing and medical teams greater opportunity for leadership and collaboration across each regional service network with their peers.

During the year, WACHS has continued to prioritise the establishment and participation of the District Health Advisory Councils in the regional health service planning process, with 24 now operating across the Area Health Service. The Councils play an integral part in WACHS community consultation especially for such programs as 'Patient First".

WACHS has been an active participant in Disaster Planning and Emergency Management initiatives being developed for the State and has implemented its own Country Health Disaster Plan. Country based staff have volunteered for the Disaster Medical Assistance Team and have been offered opportunities for emergency management and counter terrorism training.

I would like to thank Ms Christine O'Farrell WACHS Chief Executive Officer and all WACHS staff for their leadership and initiative in delivering quality health services to the people of country Western Australia. As Christine leaves WA Health in July I would like to take this opportunity to thank her for her leadership of WACHS and in her numerous other capacities in WA Health over many years, and take this opportunity to welcome Kim Snowball as the new CEO of WACHS.

Finally I am proud to present the 2006-07 Annual Report for the WA Country Health Service signifying the Government's commitment to improving health care for all West Australians.

Dr Neale Fong

DIRECTOR GENERAL OF HEALTH

Your Health System

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Our purpose

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

Our vision

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

Service framework

Better Planning: Better Futures

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

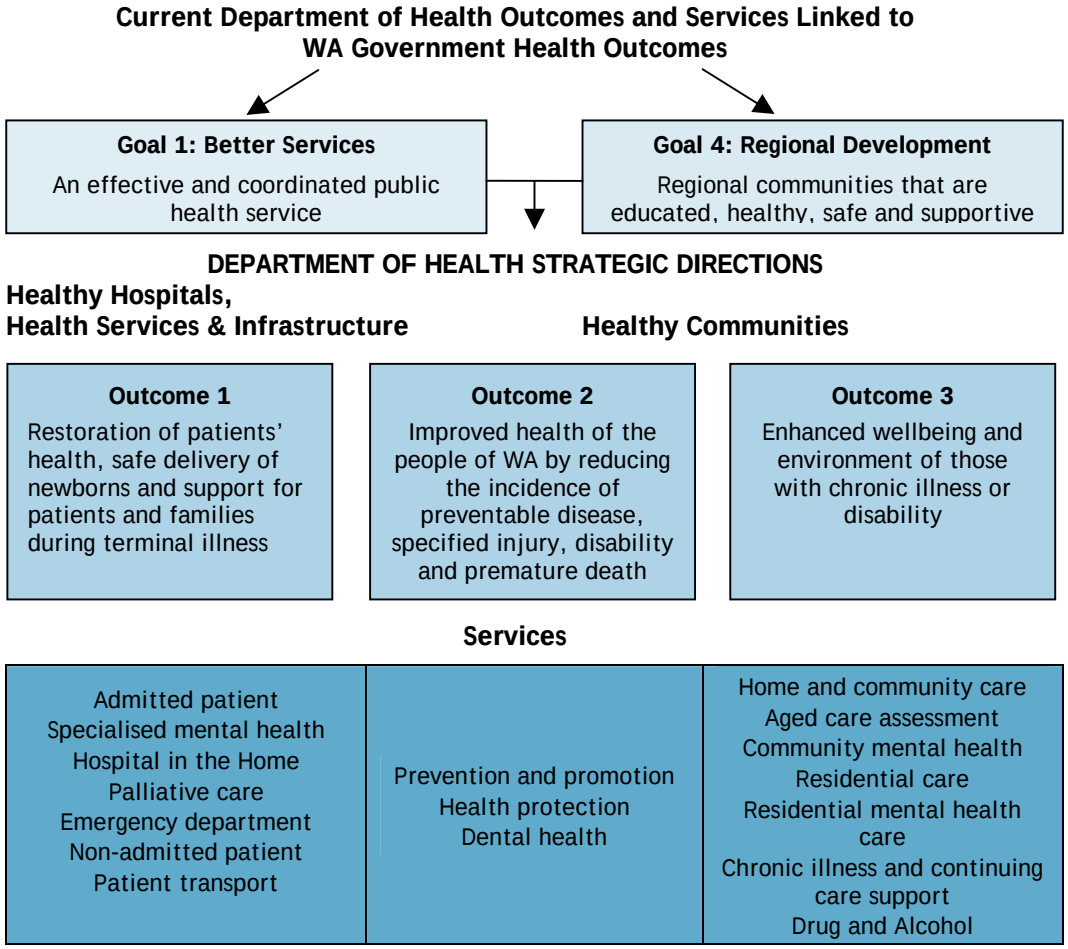
The framework states that the Western Australian public sector seeks to provide the best opportunities for current and future generations to live better, longer and healthier lives. Its vision is to promote a creative, sustainable and economically successful State that embraces the diversity of its people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

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

- *Goal 1: Better services*
  Enhancing the quality of life and wellbeing of all people throughout Western Australia by providing high quality, accessible services
- *Goal 2: Jobs and economic development*
  Creating conditions that foster a strong economy, delivering more jobs, opportunities and greater wealth for all Western Australians
- *Goal 3: Lifestyle and environment*
  Protecting and enhancing the unique Western Australian lifestyle and ensuring sustainable management of the environment
- *Goal 4: Regional development*
  Ensuring that regional Western Australia is strong and vibrant
- *Goal 5: Governance and public sector improvement*
  Developing and maintaining a skilled, diverse and ethical public sector, serving the Government with consideration of the public interest.

WA Health Outcomes and Strategic Directions

WA Health principally contributes to Better Planning: Better Futures - Goals 1 and 4.
The diagram below shows the relationship between the Government's and WA Health's desired outcomes.



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

Services provided

The 2006-07 year saw the WA Country Health Service consolidate the hospital role delineation framework which focused on improving the capacity of the Regional Resource Centres to deliver acute services, and on the development of Integrated District Health Services and network health services in smaller rural centres and towns to deliver a range of hospital and community based primary and secondary health care. This strategic initiative will strengthen the primary health care focus and enable the provision of specialised community and residential care and aged care services via regional networks.

The WACHS Regional Network Model incorporates the following facility groups:

Regional resource centres

Regional Resource Centres provide comprehensive acute care services and support major specialties and sub-specialty services based on regional requirements. Regional Resources Centres are situated in Albany, Broome, Bunbury, Geraldton, Kalgoorlie and Port Hedland.

Integrated district health services

Integrated District Health Services provide health care for towns with populations of 4,000 to 12,000 people and have an increased role in the provision of primary and secondary care. Integrated District Health Services are situated in Busselton, Esperance, Katanning, Moora, Narrogin, Merredin, Margaret River, Northam, Collie, Carnarvon, Warren (Manjimup), Newman, Nickol Bay (Karratha), Derby and Kununurra.

Small health centres

Health Centres provide health care to small populations of 1,000 to 4,000 people and are focused on emergency care, community based services and residential care. WACHS health centres are situated in Augusta, Beverley, Boddington, Bruce Rock, Boyup Brook, Bridgetown, Corrigin, Cunderdin, Dalwallinu, Denmark, Donnybrook, Dumbleyung, Exmouth, Fitzroy Crossing, Gnowangerup, Goomalling, Halls Creek, Kellerberrin, Kojonup, Kondinin, Kununoppin, Lake Grace, Laverton, Leonora, Meekatharra, Morawa, Mullewa, Nannup, Narembeen, Norseman, North Midlands (Three Springs), Northampton, Onslow, Paraburdoo, Pemberton, Pingelly, Plantagenet (Mt Barker), Quairading, Ravensthorpe, Roebourne, Southern Cross, Tom Price, Wagin, Wickham, Wongan Hills, Wyalkatchem, Wyndham, Yarloop and York. There are also three Multi-Purpose Centres at Dongara, Kalbarri and Jurien.

The WACHS administers and manages:

- 71 hospitals (including 29 MPS sites)
- 22 nursing posts
- 34 aged care facilities (including 3 Nursing Homes)
- 312 child, community, dental, alcohol and drug, mental and public health facilities and units
- 510 staff accommodation facilities
- 23 office and general service buildings and facilities
- In addition, WACHS operates 35 nursing posts and health centres where services are provided to the community under contract by the Silver Chain Nursing Association.

Services provided (continued)

Direct inpatient and medical services, community and public health, and corporate support services are provided and include:

Direct patient services
- Accident and Emergency Medicine
- Anaesthetics
- Acute, general and specialist medical and surgical
- Renal dialysis
- Paediatrics
- Gynaecology, Obstetrics and Midwifery
- Oncology (limited)
- Aged and extended care
- Psychiatry
- Mental health
- Occupational medicine
- Rheumatology
- Pain management

Medical support services
- Ambulance
- Audiology
- Clinical psychology
- Continence advice
- Medical imaging
- Occupational therapy
- Pathology
- Pharmacy
- Diabetes education
- Dietetics and nutrition
- Physiotherapy
- Podiatry
- Social work
- Sexual health, HIV/AIDS and blood borne viruses
- Speech pathology

Community and support services
- Aged care assessments
- Community, child, adolescent and maternal health
- Emergency and disaster management
- Public and environmental health, health promotion including drug and alcohol abuse prevention and management and physical activity promotion
- Chronic illness and disease surveillance and control
- Residential aged care
- Home and Community Care including home nursing
- Community Aged Care
- Carer respite
- Community, child, adolescent and adult mental health
- Injury prevention and physical activity promotion
- Palliative care
- Community aids and appliances
- Medical transport
- Remote area health

Other services
- Patient Assisted Travel
- Tele-health facilities
- General administration, medical records and service management
- Engineering and maintenance
- Hotel and catering
- Purchasing and supply and contract management

Compliance reports

Enabling legislation

The Department of Health is established by the Governor under section 35 of the *Public Sector Management Act 1994.* The Director General of Health is responsible to the Minister for Health for the efficient and effective management of the organisation. The Department of Health supports the Minister in the administration of 43 Acts and 98 sets of subsidiary legislation.

Acts administered

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

Acts passed during 2006-07

- *Nurses and Midwives Act 2006*
- *Medical Radiation Technologists Act 2006*
- *Tobacco Products Control Act 2006*

Bills in Parliament at 30 June 2007

- *Alcohol and Drug Authority Repeal Bill 2005*
- *Dental Bill 2005*
- *Food Bill 2005*
- *Human Reproductive Technology Amendment Bill 2007*
- *Medical Practitioners Bill 2005*
- *Pharmacists Bill 2005*
- *Surrogacy Bill 2006*

Amalgamation and establishment of Boards

There were no Boards amalgamated or established during 2006-07

Ministerial directives

The Minister for Health did not issue any directives on the WA Country Health Service operations during 2006-07.

Statement of compliance with public sector standards

In the administration of the WA Country Health Service, I have complied with the Public Sector Standards in Human Resources Management, the Western Australian Public Sector Code of Ethics and our Code of Conduct and instigated procedures and internal processes to ensure that compliance has been met and to satisfy myself that this statement is correct.

Human Resource Management

The WA Country Health Service has adopted procedures ensuring compliance with the requirements of the Public Sector Standards for Human Resource Management. Information on compliance requirements is included in workplace procedure manuals and is emphasised in staff training and induction programs. The WACHS has developed an agency Code of Conduct that compliments the WA Public Sector Codes of Conduct and Ethics and the Department's Code of Conduct.

The WACHS employs mechanisms to assess compliance and maintain its focus on the standards including ensuring duty statements detail compliance responsibility, conducting staff knowledge surveys and exit interviews, participating in compliance audits performed by the Internal Audit Branch and external auditing agencies such as the Office of the Auditor General and conducting training programs and workshops and when required, investigations on breaches and grievances. ACHS accreditation also includes compliance with Public Sector Standards and with the Codes of Ethics and Conduct.

In 2006-07 the WA Country Health Service received 36 claims for breach of Public Sector Standards – four for recruitment and selection practice and seven for performance management and 25 for grievance resolution. Five were referred to the Office of the Public Sector Standards Commissioner (OPSSC) with one still under review. There were no reports of substantiated breaches of the Public Sector Standards from the concluded claims.

Code of Ethics and Code of Conduct

Compliance with the Codes of Ethics and Conduct is promoted in WACHS workplaces and is included in orientation and induction courses where attendees are provided with hardcopies of the relevant documents. Copies of the relevant Codes are also available on the Intranet. Staff surveys are undertaken to assess the level of knowledge in the workplace and staff are required to acknowledge their understanding and acceptance of the Codes.

During 2006-07 the WACHS received 89 complaints alleging non-compliance with the Codes. The nature of complaints ranged from verbal abuse of fellow workers to misuse of vehicles and computer networks. Nine were initially substantiated and referred to an external agency for resolution and recommendations for action, where appropriate. The remainder were investigated and resolved internally.

The WA Country Health Service has not been investigated or audited by the Office of Public Sector Standards Commissioner for the period to 30 June 2007.

Dr Neale Fong
Director General of Health
Accountable Authority

27th September 2007

Accountable authority

The Director General of Health, Dr Neale Fong, in his capacity as Chief Executive Officer, is the accountable authority for the WA Country Health Service.

Pecuniary interests

Senior officers of the WA Country Health Service have declared no pecuniary interests in 2006-07.

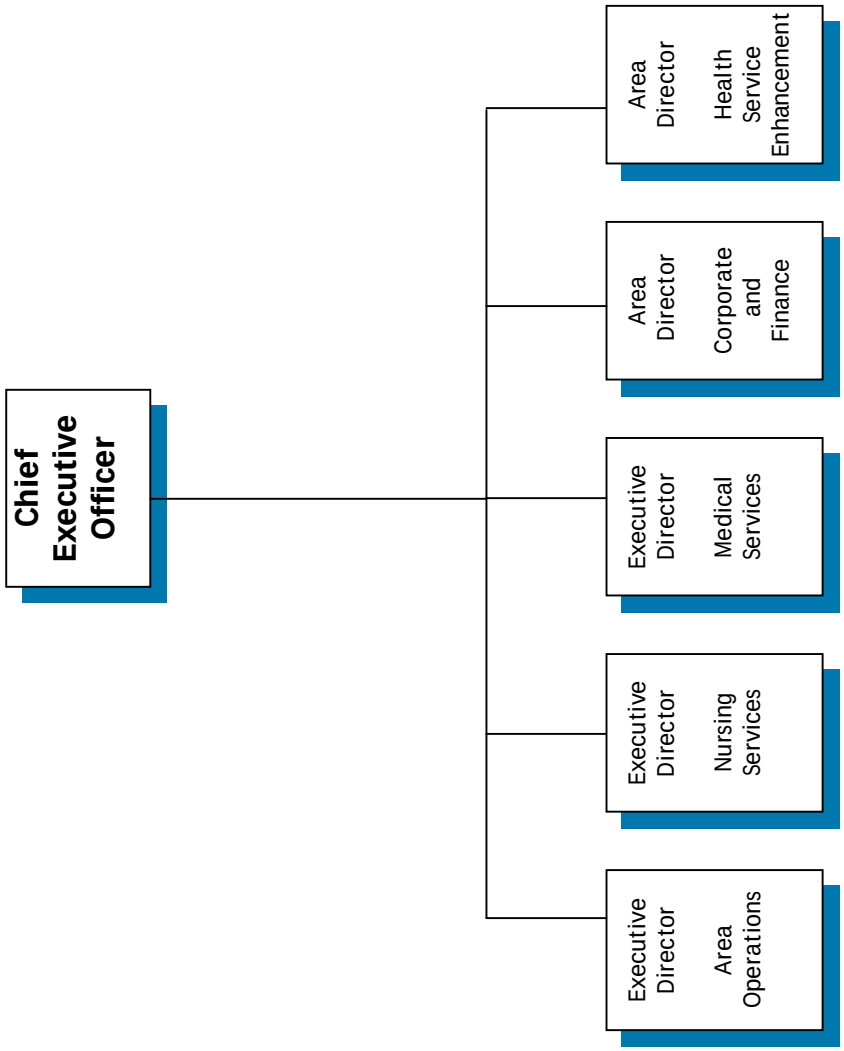
Senior officers

The senior officers as at 30 June 2007 for the WA Country Health Service and their areas of responsibility are listed below:

WACHS Senior Officers

Area of Responsibility	Title	Name
WA Country Health Service (WACHS)	Chief Executive Officer	Christine O'Farrell
WACHS Area Operations	Executive Director	Jeff Moffet
WACHS Corporate and Finance	Area Director	Ken Mills
WACHS Health Service Enhancement	Area Director	Noel Carlin
WACHS Nursing Services	Executive Director	Catherine Stoddart
WACHS Medical Services	Executive Director	Vacant

WA Country Health Service structure (June 2007)



Key Performance Indicators Certification Statement

WA COUNTRY HEALTH SERVICE
CERTIFICATION OF PERFORMANCE INDICATORS
FOR THE YEAR ENDING 30 JUNE 2007

I hereby certify the performance indicators are based on proper records, are relevant and appropriate for assisting users to assess the performance of the WA Country Health Service and fairly represent the performance of the health service for the financial year ending 30 June 2007.

Dr Neale Fong
ACCOUNTABLE AUTHORITY
Director General of Health

13 September 2007

Key Performance Indicators Audit Opinion

AUDITOR **GENERAL**

INDEPENDENT AUDIT OPINION

To the Parliament of Western Australia

WA COUNTRY HEALTH SERVICE
FINANCIAL STATEMENTS AND KEY PERFORMANCE INDICATORS
FOR THE YEAR ENDED 30 JUNE 2007

I have audited the accounts, financial statements, controls and key performance indicators of the WA Country Health Service.

The financial statements comprise the Balance Sheet as at 30 June 2007, and the Income Statement, Statement of Changes in Equity and Cash Flow Statement of WA Country Health Service for the year then ended, a summary of significant accounting policies and other explanatory Notes.

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

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

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

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

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

Key Performance Indicators Audit Opinion (continued)

WA Country Health Service
Financial Statements and Key Performance Indicators for the year ended 30 June 2007

Audit Opinion
In my opinion,

(i) the financial statements are based on proper accounts and present fairly the financial position of the WA Country Health Service at 30 June 2007 and its financial performance and cash flows for the year ended on that date. They are in accordance with Australian Accounting Standards (including the Australian Accounting Interpretations) and the Treasurer's Instructions;

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

(iii) the key performance indicators of the Health Service are relevant and appropriate to help users assess the Health Service's performance and fairly represent the indicated performance for the year ended 30 June 2007.

COLIN MURPHY
AUDITOR GENERAL
25 September 2007

Key Performance Indicators

Introduction

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

The key performance indicators outlined in the following pages address the extent to which the strategies and activities of the Health Services contribute to the broadly stated health outcome, which is, through the delivery of its health services, the improvement of the health of the Western Australian community, measured by three Outcomes:

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

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

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

Different divisions of the Area Health Services are responsible for specific areas of the three outcomes. The largest proportion of health services' activity is directed to Outcome 1. However, to ascertain the overall performance of the health system all reports must be read as all entities contribute to the 'whole of health' performance.

These reports are:

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

Table 1: Service activities in relation to the health outcomes

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

Performance Targets

Performance targets have been developed for the Effectiveness and Efficiency Key Performance Indicators wherever possible. Effectiveness indicator targets have been based on published national averages for the indicators where available, or from the analysis of previous performance results. Efficiency indicator targets are those contributing to the State-wide targets published in the 2007-08 Government Budget Statements (GBS) for estimated expenditure for 2006-07.

Please note that Capital User Charge (CUC) costs are no longer included in the construction of the GBS. In 2006-07 CUC costs contributed approximately 8.0% to the WACHS expenditure total that is not reflected in the construction of the Efficiency targets.

The development of appropriate effectiveness performance targets for country areas is continuing for future reporting. Issues such as the appropriateness of national or state-wide targets, benchmarking in a rural and remote setting, and the affect on a calculated result or rate from a small population or a small number of reported events needs to be examined.

Comparative Results

In July 2006 the South West Area Health Service was integrated into the WA Country Health Service creating a new legal entity and therefore prior year comparative results are not available.

Consumer Price Index (CPI) Deflator Series

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

Please note however that as the expanded WACHS is a new reporting entity in 2006-07, CPI adjusted efficiency indicators are not reported.

Efficiency Indicator Note

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

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

The achievement of this Outcome involves activities which:

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

Table 2: Key Performance Indicators for Outcome 1 by reporting entity.

Outcome 1	Metropolitan Health Service	Department of Health	Peel Health Service	WA Country Health Service
Restoration of patients' health	1-00 1-02 1-03	R1-50 R1-51	1-00 1-02 1-03	1-00 1-02 1-03 1-20
Timely access to admitted hospital care	1-01 1-08			1-01
Provide safe services	1-04 1-05	R1-52 R1-53		1-04 1-05
Safe delivery of newborns	1-06			1-06
Timely emergency care	1-07			1-07
Provide palliative care services		R1-54		

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

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

Rationale

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

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

An important indicator of how well patients have been restored to health (as well as survival rate) is that they are not readmitted to hospital for treatment of the same condition within a short time of discharge. This indicator should be linked with KPI 1-02 for greater insight.

Performance Target

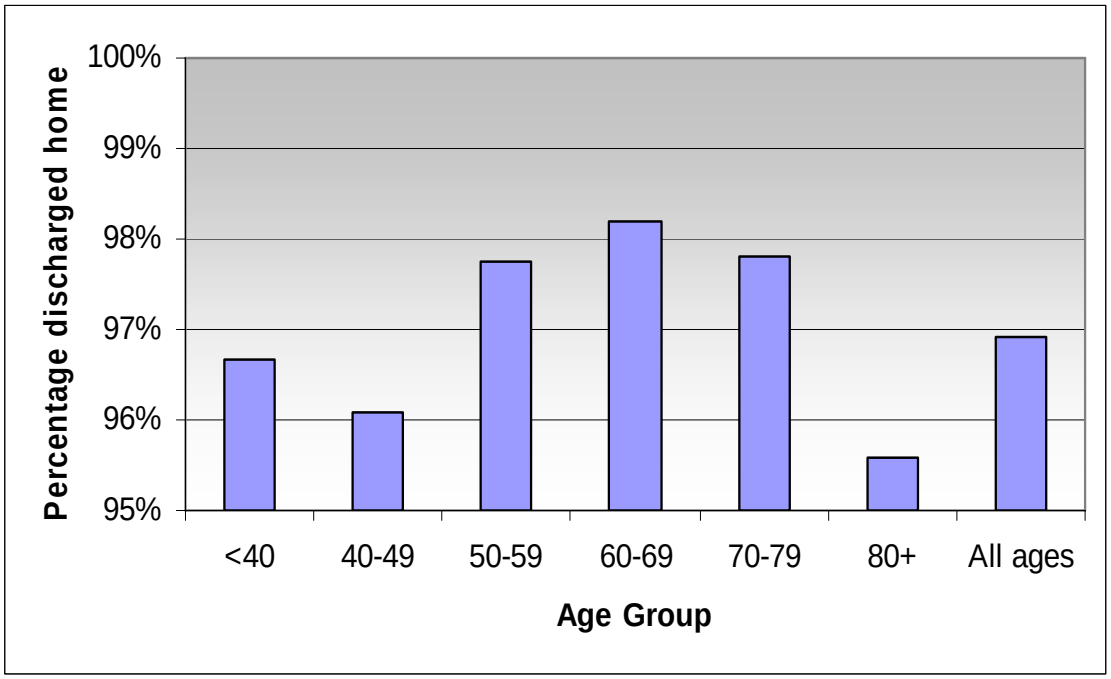
Greater than 96.8%

Results

The overall percentage for all ages of public patients discharged home from country hospitals was 96.9% within target.

The age cohort results demonstrate that the probability of being restored to health (discharged home after hospitalisation) is materially higher in the age groups under 50 yrs and reduced in the 80+ yrs age group.

Figure 1: Proportion of patients discharged to home after admitted hospital treatment



Note

This indicator has not previously been included in Annual Report Key Performance Indicators.

Data source

Hospital Morbidity Data System

1-01 (200): Elective surgery waiting times

This indicator reports the waiting times for elective surgery.

Rationale

The purpose of the Department of Health is to ensure healthier, longer and better lives for all West Australians. Health services strive to improve access to and efficiency in the provision of elective surgery as well as a range of other services. In recognition of the importance of maintaining good health, a range of initiatives has been introduced to ensure that West Australians are provided with timely access to elective surgery. Timely elective surgery ensures that patients have a better chance of being restored to health or to have the quality of their life improved.

Patients who are referred for elective surgery are classified by senior medical staff into one of the following urgency categories based on clinical need. If patients requiring admission to hospital wait for long periods of time, there is potential for them to experience an increased degree of pain, dysfunction and disability relating to their condition.

Performance targets

Category 1: Admission desirable within 30 days
Category 2: Admission desirable within 60 days
Category 3: Admission desirable within 365 days

Results

As at 30 June 2007 there were 25 over-boundary Category 1 people across WACHS while at the same time last year the number of over-boundary Category 1 was 70 (WACHS 38 and SWAHS 32). Similar improvement for over-boundary cases is evident for Categories 2 and 3.

Over the past three years WACHS has increased its elective surgery activity and improved the process for managing the elective surgery waitlist. This has enabled more people to receive treatment in country locations, and resulted in all urgency category median wait times for either those admitted from or remaining on the wait lists falling within the desirable times and a reduction in the number of over-boundary cases.

During 2006-07, WACHS hospitals admitted 1,811 Category 1 people for elective surgery with a median waiting time of 9 days where 89% were treated within boundary. For Category 2, 4,887 people were admitted with 93% treated within boundary and a median waiting time of 14 days, and 7,151 Category 3 people with 96% within boundary and a median waiting time of 29 days.

Note

- This reporting rationale conforms with the Institute of Health and Welfare reporting requirements.

Table 3: People remaining on the elective surgery waiting list – 30 June 2007

	Category 1			Category 2			Category 3		
	Cases	%	Median waiting time in days	Cases	%	Median waiting time in days	Cases	%	Median waiting time in days
People remaining within boundary	49	66	17	433	83	31	1886	97	90
People remaining over boundary	25	34		86	17		67	3	

Data source

Elective Placement Service, Department of Health

1-02 (204): Rate of unplanned hospital readmissions within 28 days to the same hospital for a related condition

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

Rationale

Good medical and/or surgical intervention together with good discharge planning will decrease the likelihood of unplanned hospital readmissions. An unplanned readmission is an unplanned return to hospital as an admitted patient for the same or a related condition as the one for which the patient had most recently been discharged. Unplanned readmissions necessitate patients spending additional periods of time in hospital as well as consuming additional hospital resources.

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

Performance target

Less than 2.8% (National average reported in the Report on Government Services 2007).

Results

The unplanned readmission rate for WACHS is 3.0%.

The WACHS is committed to ensuring that all its hospitals adopt the highest standards of clinical practice to provide the best level of care to all patients.

Note

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

Data source

Hospital Morbidity Data System

1-03 (205): Rate of unplanned hospital readmissions within 28 days to the same hospital for a mental health condition

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

Rationale

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

While it is inevitable that some patients will need to be readmitted to hospital within 28 days, in an unplanned way, a high percentage of readmissions may indicate that improvements could be made to discharge planning or to aspects of inpatient therapy protocols. Appropriate therapy, together with good discharge planning will decrease the likelihood of unplanned hospital readmissions. Unplanned readmissions necessitate patients spending additional periods of time in hospital as well as consuming additional hospital resources.

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

Performance targets

Less than 10%

Results

The WA Country Health Service has recorded an unplanned readmission rate of 5.2% and met the benchmark for readmissions for a related mental health condition.

The WACHS is committed to providing a range of mental health programs and support networks designed to provide quality mental health services delivered in the community.

Note

- The numbers of patients who receive inpatient mental health care are very low, hence small numbers of patients who have unplanned re-admissions can result in large variations to the annual percentage.
- A return to hospital is a readmission only if the reason for this admission is the same or is related to the condition treated in the previous admission. Only actual separations, not statistical discharges, are included.

Data source

Hospital Morbidity Data System

1-04 (206): Rate of post-operative pulmonary embolism

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

Rationale

Post-operative patients can develop a blood clot in the deep veins of the leg. This can travel to the lungs and cause circulatory problems. This is known as a pulmonary embolism and is one of the main preventable causes of death in fit people undergoing elective surgery.

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

This indicator measures the percentage rate of patients who underwent surgery and subsequently developed pulmonary embolism. By monitoring the incidence of post-operative pulmonary embolism, a hospital can ensure clinical protocols that minimise such risks are in place and are working. The monitoring of post-operative complications is important in ensuring the optimum recovery rate for people with acute illness.

Performance targets

The target for this indicator is few or no cases of post-operative pulmonary embolism.

Results

WACHS hospitals recorded a post-operative pulmonary embolism rate of 0.21% of surgical activity in 2006 (two cases) following surgery, demonstrating that WACHS has adopted good clinical practice in surgical treatment and patient care.

Note

- Cases are reported for pulmonary embolism if the post-operative length of stay is at least seven days. The data capture period for this key performance indicator is the 2006 calendar year.

Data source

Hospital Morbidity Data System

1-05 (208): Survival rates for sentinel conditions

This indicator reports the survival rates for sentinel conditions.

Rationale

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

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

For each of these conditions: stroke; heart attack (also known as acute myocardial infarction AMI); and fractured hip (also known as fractured neck of femur FNOF), a good recovery is more likely when there is early intervention and appropriate care. Additional co-morbid conditions are more likely to increase with age. Therefore comparing age brackets rather than the whole population can make better comparisons.

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

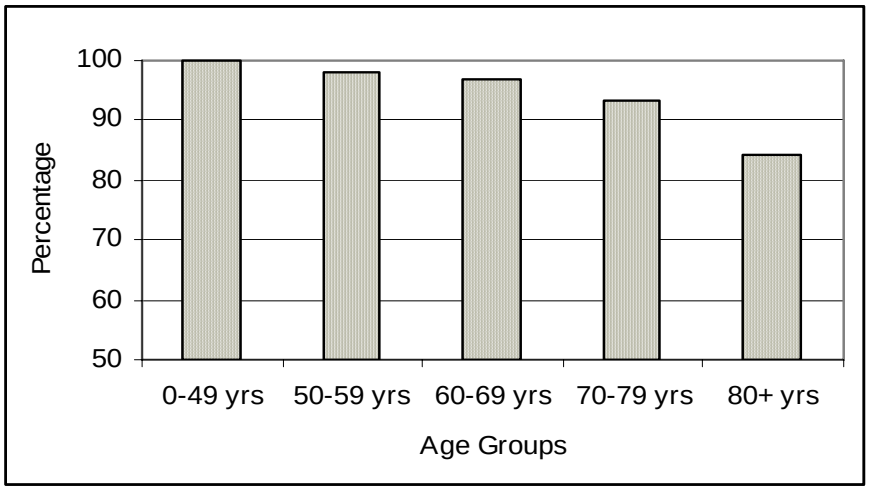
The survival rates for stroke and AMI decline as expected in the older age groups. High survival rates indicate effective clinical care.

Results

All reported survival rates for sentinel conditions met performance targets.

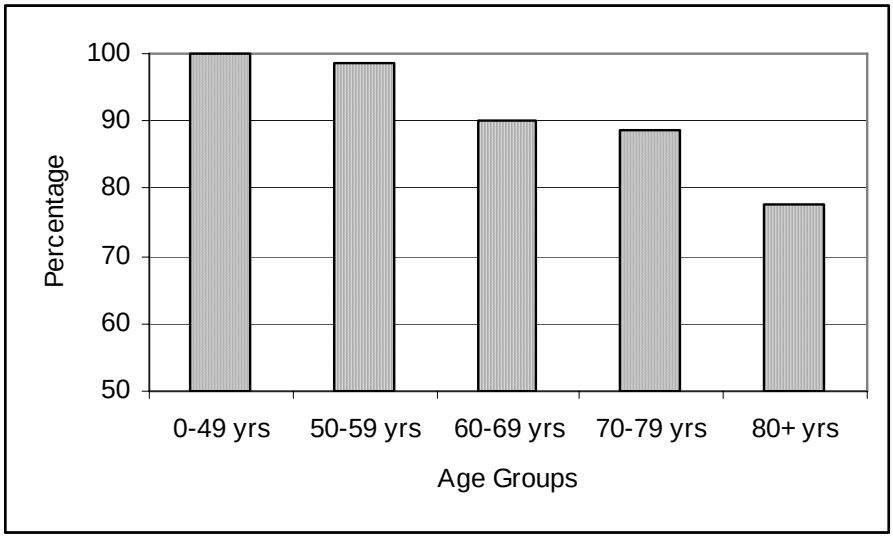
This is an indication that the clinical practice being provided in the WACHS continues to deliver appropriate outcomes for patients.

Figure 2: Survival rate for acute myocardial infarction (AMI)



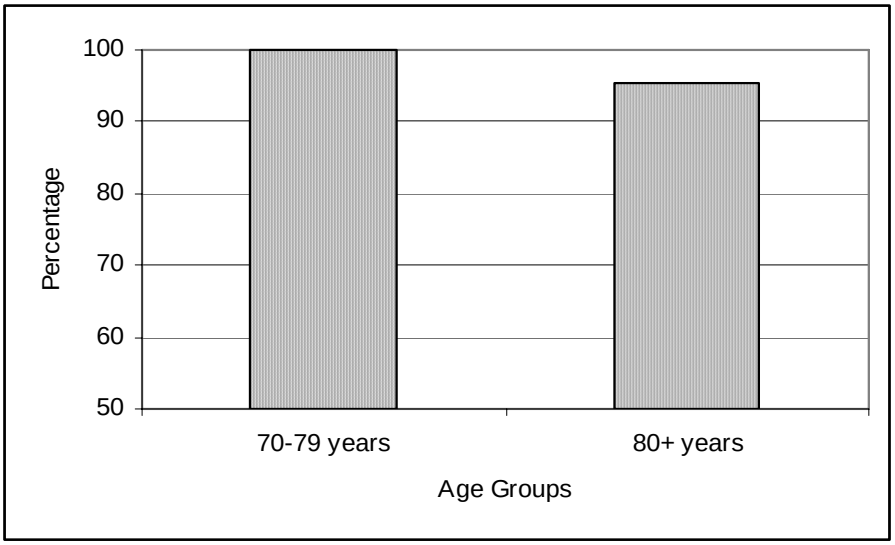
Performance Targets
0-49 years - >97%
50-59 years - >97%
60-69 years - >95%
70-79 years – >90%
80+years - >80%

Figure 3: Survival rate for stroke



Performance Targets
0-49 years - >90%
50-59 years - >85%
60-69 years - >85%
70-79 years – >85%
80+years - >75%

Figure 4: Survival rate for fractured neck of femur (FNOF)



Performance Targets
70-79 years – >95%
80+years - >90%

Data source
Hospital Morbidity Data System

1-06: Proportion of live births with an APGAR score of three or less five minutes post delivery

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

Rationale

'APGAR score at five minutes' is an outcome indicator of governments' objective to deliver maternity services that are safe and of high quality. The APGAR score is a numerical score that indicates a baby's condition shortly after birth. APGAR scores are based on an assessment of the baby's heart rate, breathing, colour, muscle tone and reflex irritability.

Low APGAR scores (defined as less than 4) are strongly associated with babies' birth weights being low.

The management of labour in hospitals does not usually affect birth weights, but can affect the prevalence of low APGAR scores for babies with similar birth weights. Within birth weight categories therefore, APGAR scores may indicate relative performance.

Performance Targets

Only state-wide performance targets are available for this indicator and may not reflect service availability in some rural locations, and remote access factors which might influence health outcomes in rural and remote areas.

Results

The recorded proportions for babies born 0-1499gms and 2000-2499gms did not meet the State-wide targets. There were 16 babies born in WACHS facilities with an APGAR score of three or less five minute post delivery across all weights.

Note

- Factors other than hospital maternity services can influence APGAR scores within birth weight categories – for example antenatal care, multiple births and socioeconomic factors.
- The small numbers of babies included in this indicator can result in large variations to recorded proportions.

Table 4: Proportion of live births with an APGAR score of 3 or lower, five minutes after delivery

Birthweight (grams)	Proportion of babies	Target (State)
0 - 1499	36.4%	≤16.6%
1500 - 1999	0.0%	≤0.7%
2000 - 2499	1.2%	≤0.5%
2500 and over	0.1%	≤0.1%

Note

This indicator has not previously been included in Annual Report Key Performance Indicators.

Data source

Midwives Notification System

Text: Report on Government Services 2007

1-07 (201): Proportion of emergency department presentations seen within recommended times

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

Rationale

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

A patient is allocated a triage code between 1 and 5, which indicates their urgency. The triage process and scores are recognised by the College of Emergency Medicine and recommended for prioritising those who present to an Emergency Department. In a busy Emergency Department when several people present at the same time, the service aims for the best outcome for all. Treatment should be within the recommended time of the triage category allocated.

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

Results

Only attendances in Triage categories 1 and 5 were reported seen within the recommended thresholds.

While there has been improvement in the percentage seen on time for Triage category 2, this triage category and categories 3 and 4 did not meet the performance thresholds. The Bunbury Regional Resource Centre has experienced an increase in emergency department workload that has contributed to the time deterioration particularly for categories 3 and 4.

Table 5: Proportion of emergency department patients seen within recommended times

	Threshold	2006-07
Triage category 1 (immediately)	100%	100%
Triage category 2 (within 10 mins)	80%	75%
Triage category 3 (within 30 mins)	75%	61%
Triage category 4 (within 60 mins)	70%	63%
Triage category 5 (within 2 hours)	70%	88%

Note

The Bunbury Regional Resource Centre emergency department is the only WACHS site that meets the criteria required for this indicator.

Data source

Emergency Department Data Collection, Information Collection and Management

1-20 (202): Rate of emergency presentations with a triage score of 4 and 5 not admitted

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

Rationale

When patients attend hospital they are initially assessed in emergency departments where treatment and a decision on whether to admit for further care takes place.

Triaging is an essential function of the emergency department where many people may present simultaneously. The aim of triage is to ensure that patients are treated in order of their clinical urgency and that patients receive timely care.

While urgency refers principally to time-critical intervention and is not synonymous with severity, more patients triaged 1 and 2 are admitted to hospital than those with a score of 4 and 5. Without care provided by staff in an emergency department, the restoration to health of people with an injury or a sudden illness may take longer or result in death.

This indicator reports the rate of people presenting to the emergency department who were given a triage score of 4 or 5 but did not need admitted hospital care, i.e. were restored to health. These emergency departments do not have 24-hour cover by doctors who are trained specifically in emergency medicine.

Presentations are the number of people attending an emergency department where the assessments include doctor-attended assessments and treatment as well as nursing assessment and treatment. Generally these are people who receive primary care in the emergency department.

Performance target

Target not appropriate. Emergency presentations will be admitted or not admitted in accordance with their clinical needs.

Result

In 2006-07 the percentage of Triage 4 and 5 emergency presentations not admitted to WACHS hospitals was 90.1% and 97.0% respectively. During this period there were 130,236 Triage 4 attendances and 103,230 Triage 5 attendances.

Note

- All WACHS hospital based emergency departments and services are included in this indicator except for the Bunbury Regional Resource Centre.

Data source

Emergency Department Data Collection, Information Collection and Management

S1-01 (221): Average cost per casemix adjusted separation for non-teaching hospitals

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

Rationale

The use of casemix in hospitals is a recognised methodology for adjusting actual activity data to reflect the complexity of service provision and the use of resources. Hence the number of separations in a hospital may not necessarily equal the number of casemix adjusted separations. The magnitude of the difference will depend on the complexity of the services provided.

Reporting country hospitals for this KPI utilise the Australian Refined National Diagnostic Related Groups (AR-DRGs) to which cost weights are allocated. A new round of case weights was applied in 2006-07.

Result

The WACHS recorded a cost per casemix adjusted separation of $4,240.

Notes

- The 2006-07 target detailed in the 2007-08 GBS process does not include Capital User Charge while expenditure in 2006-07 includes CUC allocations.
- Overhead costs for Health Corporate Network, Health Reform Implementation Taskforce and InfoHEALTH have been apportioned to this key performance indicator in 2006-07.
- Hospital sites Collie, Katanning and Carnarvon are now reported under KPI S1-20.

Table 6: Average cost per casemix adjusted separation for non-teaching hospitals

	2006-07	Target (adjusted to incl. CUC)	GBS Target
Actual cost	$4,240	$4,349	$4,024

Data sources

Hospital Morbidity Data System (HMDS)

WACHS Financial Systems

S1-20 (227): Average cost per bed-day for admitted patients selected small rural hospitals

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

Rationale

While the use of casemix is a recognised methodology for measuring the cost and complexity of admitted patients in larger hospitals where there is a wide range of different medical and surgical patients for significant volumes of activity, it is not the accepted method of costing admitted patient activity in a small rural hospital. These hospitals do not experience significant activity volumes nor is there a wide range of types of medical and surgical patients.

Small hospitals also do not have the advantage of economies of scale and minimum nursing services may have to be rostered for very few patients.

Result

The WACHS recorded a cost per small hospital bedday of $1,275 exceeding the target (see notes).

Notes

- Commencing in 2006-07 the WACHS has identified acute and non-acute bedday activity in its small hospitals and residential care facilities and reported this activity between KPIs S1-20 and S14-00. The GBS performance target was based on approximately 90,000 acute and 190,000 non-acute beddays and while the total beddays provided has proven reasonably accurate, the actual split of activity between acute (72,000) and non-acute (207,000) has varied from the estimates.
- The 2006-07 target detailed in the 2007-08 GBS process does not include Capital User Charge while expenditure in 2006-07 includes CUC allocations.
- Overhead costs for Health Corporate Network, Health Reform Implementation Taskforce and InfoHEALTH have been apportioned to this key performance indicator in 2006-07.

Table 7: Average cost per bedday for admitted patients in selected small rural hospitals

	2006-07	Target (adjusted to incl. CUC)	GBS Target
Actual cost	$1,275	$900	$832

Data sources

HCARe activity data systems

WACHS Financial Systems

S2-00 (229): Average cost per bed-day in an authorised mental health unit

This indicator reports the average cost per bed-day in an authorised mental health unit.

Rationale

The efficient use of hospital resources can help minimise the overall cost of providing health care, or allow more patients to be treated with a similar amount of resources. Variations in patient characteristics between sites and across time may result in differences in service delivery costs.

In order to ensure quality and cost effectiveness, it is important to monitor the unit cost per bed day of admitted patient care in authorised mental health units. These are hospitals or hospital wards devoted to the treatment and care of patients with psychiatric, mental or behavioural disorders that are by law able to admit people as involuntary patients for psychiatric treatment.

Result

The WACHS recorded a cost per mental health unit bedday of $982.

Notes

- The 2006-07 target detailed in the 2007-08 GBS process does not include Capital User Charge while expenditure in 2006-07 includes CUC allocations.
- Overhead costs for Health Corporate Network, Health Reform Implementation Taskforce and InfoHEALTH have been apportioned to this key performance indicator in 2006-07.
- The WA Country Health Service has three authorised units situated in the Bunbury, Albany and Kalgoorlie Regional Resource Centres. Data from each site has been combined.

Table 8: Average cost per bedday in an authorised mental health unit

	2006-07	Target (adjusted to incl. CUC)	GBS Target
Actual cost	$982	$1,143	$1,058

Data sources

Mental Health Information System

WACHS Financial Systems

S6-20 (225): Average cost per non-admitted hospital based occasion of service for rural hospitals

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

Rationale

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

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

Result

The WACHS recorded a cost per non-admitted hospital based occasion of service of $174.

Note

- The 2006-07 target detailed in the 2007-08 GBS process does not include Capital User Charge while expenditure in 2006-07 includes CUC allocations.
- Overhead costs for Health Corporate Network, Health Reform Implementation Taskforce and InfoHEALTH have been apportioned to this key performance indicator in 2006-07.

Table 9: Average cost per non-admitted hospital based occasion of service for rural hospitals

	2006-07	Target (adjusted to incl. CUC)	GBS Target
Actual cost	$174	$187	$173

Data sources

HCARe Non-admitted activity data systems

WACHS Financial Systems

S6-21 (226): Average cost per non-admitted occasion of service in a nursing post

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

Rationale

The efficient use of health service resources can help minimise the overall cost of providing health care, or provide for more patients to be treated for the same amount of resources. It is important to monitor the unit cost of the non-admitted component of health service provision in order to ensure overall quality and cost effectiveness. However, due to variations in patient characteristics and clinic types between sites and across time, there may be differences in service delivery costs.

Result

The WACHS recorded a cost per non-admitted in a nursing post occasion of service of $139.

Note

- The 2006-07 target detailed in the 2007-08 GBS process does not include Capital User Charge while expenditure in 2006-07 includes CUC allocations.
- Overhead costs for Health Corporate Network, Health Reform Implementation Taskforce and InfoHEALTH have been apportioned to this key performance indicator in 2006-07.

Table 10: Average cost per non-admitted occasion of service in a nursing post

	2006-07	Target (adjusted to incl. CUC)	GBS Target
Actual cost	$139	$146	$135

Data sources

HCARe activity data systems

WACHS Financial Systems

S7-20 (228): Average cost per trip of Patient Assisted Travel Scheme

This indicator reports the average cost per trip of the Patient Assisted Travel Scheme (PATS).

Rationale

The PATS assists permanent country residents to access the nearest medical specialist and specialist medical services.

A subsidy is provided towards the cost of travel and accommodation for patients, and where necessary, an escort for people who have to travel more than 100 kilometres one-way to attend medical appointments. Without this assistance many people would be unable to access the services needed to diagnose or treat some conditions.

Result

The WACHS recorded a cost per PATS trip of $327 exceeding the target. This result reflects increased travel costs affecting rural and remote areas.

Note

- The 2006-07 target detailed in the 2007-08 GBS process does not include Capital User Charge while expenditure in 2006-07 includes CUC allocations.
- Overhead costs for Health Corporate Network, Health Reform Implementation Taskforce and InfoHEALTH have been apportioned to this key performance indicator in 2006-07.

Table 11: Average cost per trip of PATS

	2006-07	Target (adjusted to incl. CUC)	GBS Target
Actual cost	$327	$317	$294

Data sources

Local activity data systems
WACHS Financial Systems

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

The services, or outputs, of all parts of the Department of Health contribute to the above outcome. These services include activities that reduce the likelihood of disease or injury and reduce the risk of long-term disability or premature death. Strategies include prevention, early identification and intervention and the monitoring of the incidence of disease in the population to ensure primary health measures are working.

The achievement of this outcome involves activities which:

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

Table 12: Key Performance Indicators for Outcome 2 by reporting entity.

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

Notes

- WACHS population health units deliver both health prevention and promotion services as well as health protection services.
- This section contains population-based indicators. The residential postcode of the individual receiving the service allows for epidemiological comparisons and is not the postcode of the location where the service was provided. Performance measurement for these indicators is provided for both Aboriginal and non-Aboriginal populations.

2-01 (103): Rate of hospitalisation for gastroenteritis in children (0-4 years)

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

Rationale

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

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

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

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

Performance Target

Total Population - less than 21.3 per 1000.

Results

In 2006 WACHS reported hospitalisation rates for gastroenteritis in non-Aboriginal children 0-4yrs of 13.3 per 1000 within target while a rate of 51.3 per 1000 was recorded in Aboriginal children 0-4yrs exceeded the target.

WACHS continues to work in partnership with all health providers in delivering environmental and community health programs aimed at preventing gastroenteritis and similar conditions in rural and remote locations, especially Aboriginal communities.

Note

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

Data sources

Hospital Morbidity Data System

Australian Bureau of Statistics (ABS) population figures

2-02 (104): Rate of hospitalisation for respiratory conditions

This indicator reports the rate of hospitalisation for respiratory conditions.

Rationale

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

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

Performance targets

Condition	Age	Rate per 1000 total population
Asthma	0-4 yrs	<11.2
	5-12 yrs	<3.7
	13-18 yrs	<1.7
	19-34 yrs	<1.6
	35 plus	<2.0
Bronchitis	0-4	<1.3
Bronchiolitis	0-4	<17.1
Croup	0-4	<6.4

Note

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

Results

While the recorded rates for 2006 of hospitalisation for respiratory conditions in non-Aboriginal populations met the targets, the recorded results for Aboriginal populations failed to meet the targets.

Specific programs targeting the prevention, management and treatment of respiratory conditions especially for Aboriginal populations continue to feature in community and allied health service delivery across WACHS. Programs target individuals, families, groups and communities and focus on the determinants of poor health. Services are provided locally, as a visiting or outreach service and via telehealth.

Figure 5: Rate of hospitalisation per 1000 for acute asthma (all ages)

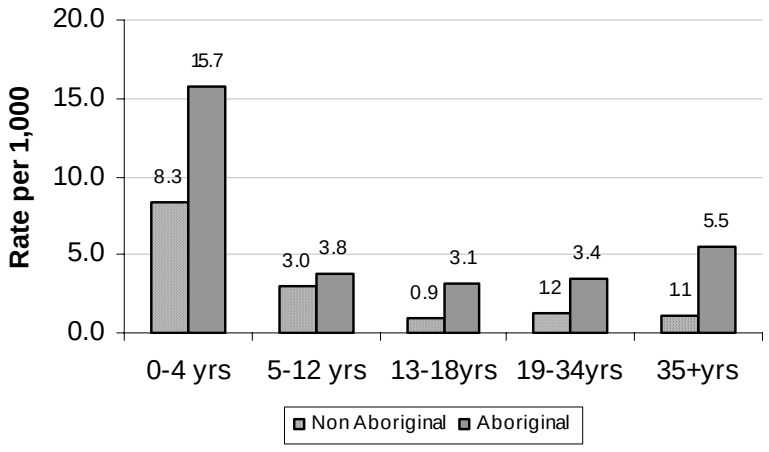


Figure 6: Rate of hospitalisation per 1000 for acute bronchitis (0 to 4 yrs)

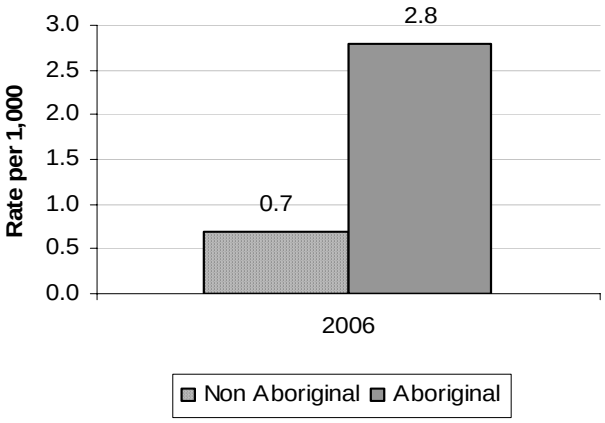


Figure 7: Rate of hospitalisation per 1000 for bronchiolitis (0 to 4yrs)

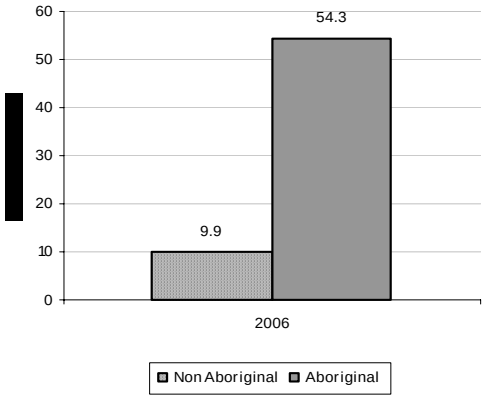
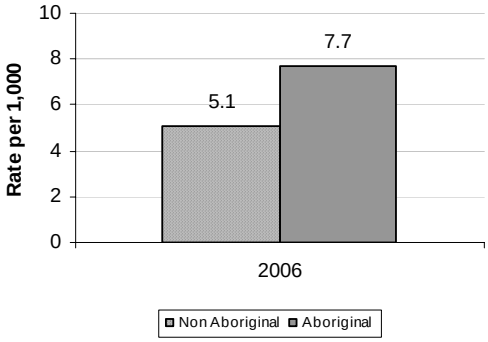


Figure 8: Rate of hospitalisation per 1000 for croup (0 to 4yrs)



Data sources

Hospital Morbidity Data System

Australian Bureau of Statistics population figures

R2-51 (101A): Percentage of fully immunised children at 12 and 24 months

This indicator reports the proportion of fully immunised children at 12 and 24 months.

Rationale

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

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

Performance targets

The agreed targets in the National Childhood Immunisation Program are as follows:

- At least 90% of children fully immunised at 12 months of age.
- At least 90% of children fully immunised at 24 months of age.

Results

Immunisation percentages achieved in 2006 across WACHS for completely immunised children at 12 months and 24 months of 92% and 93.5 % respectively exceeded the national targets for non-Aboriginal children. However the recorded immunisation percentages of 79.1% at 12 months and 86.3% at 24 months of Aboriginal children remain below the national target.

WACHS continues to promote its immunisation programs across rural communities with specific attention given to Aboriginal communities.

Data sources

Australian Childhood Immunisation Register (ACIR)

Australian Bureau of Statistics (ABS) population figures

R2-52 (101B): Rate of hospitalisations with an infectious disease for which there is an immunisation program

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

Rationale

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

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

Measles, mumps and rubella are reported for 0 to 17 year age groups while diphtheria, hepatitis B, whooping cough, poliomyelitis and tetanus are reported for 0 to 12 year age groups.

Performance targets

There should be few or no individuals hospitalised for infectious diseases when an immunisation program is effective.

Results

WACHS recorded one case of hospitalisation for pertussis in 2006 for non-Aboriginal populations realising a rate of 1 per 100,000 in the age cohort and continues to demonstrate effective vaccination and immunisation programs provided by the WACHS. There were no reported hospitalisations for immunisable infectious diseases for the WACHS Aboriginal population.

Data sources

Hospital Morbidity Data System

Australian Bureau of Statistics population figures

S8-00 (110): Cost per capita of Population Health units

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

Rationale

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

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

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

Result

The WACHS recorded a cost per capita for WACHS Population Health Units of $161.

Note

- The 2006-07 target detailed in the 2007-08 GBS process does not include Capital User Charge while expenditure in 2006-07 includes CUC allocations.
- Overhead costs for Health Corporate Network, Health Reform Implementation Taskforce and InfoHEALTH have been apportioned to this key performance indicator in 2006-07.

Table 13: Average cost per capita of population health units

	2006-07	Target (adjusted to incl. CUC)	GBS Target
Actual cost	$161	$168	$156

Data source

Australian Bureau of Statistics

WACHS Finance Systems

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

The achievement of this Outcome involves provision of services and programs that improve and maintain an optimal quality of life for people with chronic illness or disability. If a person suffers from a chronic illness they have access to services and support through a range of organisations, including a number of non-government organisations providing services under contract to the Department of Health. The effectiveness and efficiency measured for this support is reported by DOH. Services for persons with a chronic illness are also provided by the WA Country Health Service who assist people to manage their own illness and work to keep people out of hospital.

The Area Health Services in general will mainly come into contact with people with chronic illness when their condition requires acute care. When this type of care is completed they are returned to the community where they can again receive ongoing (continuing) care services either from a public health service, another agency or a non-government provider.

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

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

The significant areas of continuing care provided by the Area Health Services are in the areas of Mental Health, Community Care and Aged Care.

Mental Health Community Care consists of multi-disciplinary teams including mental health nurses providing continued and regular contact with clients to ensure, prevent or delay the onset of acuity and thereby allow them to continue to maintain as close to normal lifestyles as possible.

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

Where a person has a disability, including a younger person, they can receive support through a number of agencies including the Disability Services Commission and the Quadriplegic Centre. The DOH and Area Health Services also provide assistance to those with disabilities through the provision of Home and Community Care (HACC) services. The HACC program is administered through the DOH. The effectiveness and efficiency indicators for HACC are reported by DOH. Area Health Services will also provide acute services to those with disabilities under Outcome 1.

Table 14: Key Performance Indicators for Outcome 3 by reporting entity.

Outcome 3	Metropolitan Health Service	Department of Health	Peel Health Service	WA Country Health Service
Providing appropriate home care for frail aged		R3-50 R3-51		3-20
Providing support services for those with mental illness		R3-52		
Providing follow up in community to people with mental illness	3-00		3-00	3-00

3-00 (301): Percent of contacts with community-based public mental health non-admitted services within seven and fourteen days post discharge from public mental health inpatient units

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

Rationale

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

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

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

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

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

Performance target

There is currently no agreed benchmark for the proportion of clients to be seen within a seven-day period. However, consensus among a number of mental health clinicians in Western Australia suggest that targets of 60% threshold for seven-day post discharge contact and 75% threshold for fourteen day post discharge contact are reasonable expectations pending an empirical review of their appropriateness.

Results

In 2006, 64.1% of discharges with a principal diagnosis of schizophrenia or bipolar disorder from public mental health inpatient units received contact with a community-based public mental health non-admitted service within seven days of discharge. A further 15.0% of clients were seen within 8 to 14 days.

Approximately 6% of discharges had no contact within the year. No contact may indicate that referrals, following discharge, were made to the private sector (eg General Practitioners, Private Psychiatrists, Private Psychologists) for which data on contacts is not available.

The percentage of clients making contact with a community based public mental health non-admitted service within seven-days and 14 days was above the target thresholds for these time periods.

Data source

Mental Health Information System, Information Collection and Management

3-20: Aged care resident/carer satisfaction survey

This indicator reports resident satisfaction with the residential aged care services they receive in WACHS facilities.

Rationale

The WA Country Health Service provides care for people who require long-term care involving 24 hour nursing home and hostel care. The provision of non-acute permanent care is a significant activity provided to rural clients across the WA Country Health Service where access to local alternative private or non-government providers may be limited.

WACHS residential care services include high dependency, high dependency respite, low dependency and low dependency respite provided to nursing home residents, nursing home type residents in hospital and hostel residents.

Satisfaction with residential care, as assessed by the residents, is used to provide an indication of the quality of the services provided.

An independent survey contractor has conducted the survey under contract to the Epidemiology Branch and the WACHS. On-site resident interviews were undertaken in 30 facilities and the survey results have been combined for all WACHS residential care facilities for nursing home, nursing home type and hostel services. A possible 264 respondents were identified for the survey with a response rate of 90.2% being achieved. The questionnaire was based on previous focus group consultations and identified five major domains of importance as detailed below.

Performance Target

Scale mean scores for each of the five domains are presented as scores out of 100. For normal admitted patients, a score of 80 is considered average, while a score of 90 or better is considered best practice standard.

Results

The results of the survey indicate that the overall level of satisfaction for residential patients is in the excellent range. Residential care services are delivering high levels of satisfaction in the areas of *time and attention paid to care* as well as *meeting personal needs*, which residential care patients report are the most important areas of service provision. Areas for potential improvement include food and residential surroundings, although these still exceed average satisfaction levels.

There was no statistically significant difference in the overall satisfaction between males and females, or between the WACHS regions.

Table 15: Mean scale scores for the five satisfaction scales and overall indicator of satisfaction.

Scale	Mean Score
Time and attention paid to care	91.0
Meeting personal as well as clinical needs	94.8
The coordination and consistency of care	87.5
Information and communication between patients and carers	87.4
Residential aspects of the health care facility	85.2
Overall Indicator of Satisfaction	89.2

Note

- The WACHS residential care satisfaction survey will be an Area Health Service wide annual event commencing in 2006-07. However, for 2006-07 please note that the Kimberley, Pilbara and Goldfields residents were not included for cultural reasons or insufficient resident numbers. Also, no carers have been surveyed given a substantial percentage of residents who indicated willingness. Future surveys will include these populations.

Data source

Epidemiology Branch, Analysis and Performance Reporting, Department of Health

S12-00 (311): Average cost per completed ACAT assessment

This indicator measures the average cost per ACAT assessment.

Rationale

People within targeted age groups are at risk of experiencing a poorer quality of life because of frailty, chronic illness or disability reducing their capacity to manage their activities of daily living.

A range of services are available to people requiring support to improve or maintain their optimal quality of life.

The Commonwealth funds the Aged Care Assessment Program based on State health service assessments which determine eligibility for and the level of care required by these aged care services.

Result

The WACHS recorded a cost per completed ACAT assessment of $1,145 exceeding the target.

This result reflects the resource allocation required to provide ACAT services to rural and remote locations and includes travel and remote access costs as well as the costs of multiple contacts with small numbers of clients living in a remote setting.

Note

- The 2006-07 target detailed in the 2007-08 GBS process does not include Capital User Charge while expenditure in 2006-07 includes CUC allocations.
- Overhead costs for Health Corporate Network, Health Reform Implementation Taskforce and InfoHEALTH have been apportioned to this key performance indicator in 2006-07.

Table 16: Average cost per completed ACAT assessment

	2006-07	Target (adjusted to incl. CUC)	GBS Target
Actual cost	$1,145	$706	$653

Data sources

Aged Care Assessment Program WA Evaluation Unit Minimum Data Set Reports, July to September 2006 and October to December 2006

WACHS Financial Systems

S13-00 (303): Average cost per person receiving care from public community-based mental health services

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

Rationale

The majority of services provided by community mental health services are for people in an acute phase of a mental health problem or who are receiving post-acute care.

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

Result

The WACHS recorded a cost per person receiving community health services of $3,321 exceeding the target. This result reflects increased expenditure for community mental health services providing community-based occasions of service for mental health clients.

Note

- The 2006-07 target detailed in the 2007-08 GBS process does not include Capital User Charge while expenditure in 2006-07 includes CUC allocations.
- Overhead costs for Health Corporate Network, Health Reform Implementation Taskforce and InfoHEALTH have been apportioned to this key performance indicator in 2006-07.

Table 17: Average cost per person receiving public community based mental health services

	2006-07	Target (adjusted to incl. CUC)	GBS Target
Actual cost	$3,321	$3,034	$2,807

Data source

Mental Health Information System
WACHS Financial Systems

S14-20 (312): Average cost per bed-day for specified residential care facilities, flexible care (hostels) and nursing home type residents

This indicator reports the cost per residential aged care bedday provided in WA Country Health Service facilities.

Rationale

WACHS cares for patients who require long term care involving 24 hour nursing home and hostel care. WACHS residential care services include high dependency, high dependency respite, low dependency and low dependency respite provided to nursing home residents, nursing home type residents in hospital, and hostel and flexible care residents.

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

Residential care services are provided in specified residential aged care facilities in the Kimberley at Numbala Nunga and Kununurra, and in the Pilbara at Karlarra, and in WACHS hospitals, multi-purpose services and hostels.

Result

The WACHS recorded a cost per residential care bedday of $337 (see notes).

Notes

- The 2006-07 target detailed in the 2007-08 GBS process does not include Capital User Charge while expenditure in 2006-07 includes CUC allocations.
- Overhead costs for Health Corporate Network, Health Reform Implementation Taskforce and InfoHEALTH have been apportioned to this key performance indicator in 2006-07.
- Commencing in 2006-07 the WACHS has identified acute and non-acute bedday activity in its small hospitals and residential care facilities and reported this activity between KPIs S1-20 and S14-00. The GBS performance target was based on approximately 90,000 acute and 190,000 non-acute beddays and while the total beddays provided has proven reasonably accurate, the actual split of activity between acute (72,000) and non-acute (207,000) has varied from the estimates.
- Activity for WACHS residential aged care residents other than specified facilities in the Kimberley and Pilbara were previously included in KPI S1-20 or had not been included in annual reporting.
- Activity data for July 2006 was not available and has been projected from August – June activity.

Table 18: Average cost per residential care bedday

	2006-07	Target (adjusted to incl. CUC)	GBS Target
Actual cost	$337	$386	$357

Data sources

WACHS HCARe data warehouse

WACHS Financial Systems

Significant Issues and Trends

Overview

During 2006-07 the WA Country Health Service released its strategic plan for the period 2007-2010 "Foundations for Country Health Services". This followed extensive consultation involving community focus groups and public forums, and meetings with key stakeholders such as Commonwealth and State government agencies, local government, Divisions of General Practice, medical and other clinical specialists, and non-government organisations.

The development of the strategic plan comes at a time when public health services across Western Australia are being re-equipped to better meet the needs of a changing community, to respond to new resource, capability and capacity issues, and to take timely advantage of new technologies and practices in clinical and patient care, and encompasses the WA Country Health Service's three strategic directions:

Networking Health Services

To effectively connect people and services, whether within regions, between regions, or with metropolitan hospitals, or among the different country service providers, is vital to improving both access to health services and the efficiency and effectiveness of those services. Priority areas for achieving this direction include further advancement of the regional hospital role delineation project, implementing effective service planning and management to deliver coordinated and responsive services, develop greater collaboration between clinical and associated staff across regions, and to ensure effective emergency care across the Area Health Service.

Building Healthier Communities

To increase resource allocation for disease and injury prevention, the earlier intervention and smarter management of chronic disease, to provide more home and community based service delivery especially to maintain the health and independence of older people, to develop mental health, alcohol and drug abuse response capacity, and to improve Aboriginal health.

Strengthening and modernising the country health system

In the face of the challenges of increasing demand for high quality and accessible services combined with workforce shortages, WACHS will conduct management and system support evaluations across the health service, to highlight areas of duplication, and identify opportunities for new and innovative ways to enhance the efficiency and effectiveness of our operational management and service support systems.

Service Trends

There are a number of significant service and demographic trends that impact upon service delivery in country areas, and provide a challenge to the provision of efficient and effective health care.

Population growth and change

The country population is estimated to grow by 13% between 2001 and 2011. The rural and remote population is also being subjected to a number of change variables. These include the extensive growth in mining areas, the South West and coastal towns, an increase in our ageing population who experience a higher incidence of chronic disease and ill-health, the increasing young Aboriginal population, and the significant and persistent disparity in health status between the Aboriginal and non-Aboriginal populations.

Workforce shortages, the medical workforce specialisation, and medical technology evolution

Workforce shortages exist across most medical disciplines essential for the provision of efficient health care services. These shortages have been exacerbated by national and international competition for skilled health care workers, preferences for metropolitan and coastal locations, and the

desire by workers to access shorter hours and less demanding employment environments. The increasing preference for specialisation amongst medical professionals has also affected staff recruitment for country areas where there is a heavy reliance on a multi-skilled generalist medical workforce. In addition, an increasing number of highly specialised technologies are only available in the metropolitan area, due to their high costs and relatively low levels of activity.

The burden of disease in country WA

The health status of the people of Western Australia and the quality and availability of health services is generally high across all areas and is demonstrated by mortality rates and life expectancy. However, the WA country population carries a higher burden of disease and demonstrates a poorer health status than the State average. The poorer health status in country WA is significantly affected by the higher proportion of Aboriginal people who live in rural and remote areas, a population cohort that experiences notably poorer health outcomes compared to other Australians.

Patient safety and service quality

Ensuring patient safety and service quality in a rural and remote setting poses a special challenge to service providers. In particular, issues such as recruitment and retention of skilled staff, providing professional and peer support, distance and access factors, and managing low levels of activity in combination with community expectations for locally accessible specialised healthcare, are service delivery factors that must be considered by country health service providers.

Resourcing

State government finance policy requires WA Health to perform within its budget. This is extremely challenging for the WACHS as it addresses increasing demand for health care services from an ageing and growing population, higher workforce costs resulting from staff shortages and retention and attraction initiatives, and the increased costs of medical practice and technology, innovation, transport and isolation. An extensive program of health service and infrastructure reform including the introduction of new service innovation is being implemented to ensure the WACHS is able to operate on a sustainable financial basis while delivering an effective and efficient health care service that responds to the needs and priorities of country people either locally, within the region or in Perth.

Activity

Hospital activity profiles across the period 2000-06 support the role delineation initiatives implemented by the WA Country Health Service for country hospitals. Country hospital activity has changed significantly where WACHS' six Regional Resource Centres have experienced an increase of over 25% in the number of acute separations over the period, while Integrated District Health Services show relatively stable activity levels. However, over the same period acute separation activity in the small WACHS hospitals has declined reflecting the activity trend in these sites to delivering more non-acute, residential and primary care services.

Over the past three years, activity trends for emergency presentations and non-admitted occasions of service has grown 5% and 6.8% respectively. In the same period the number of Patient Assisted Transport Scheme (PATS) trips has increased by 6% with expenditure for the scheme increasing by 23.7% reflecting the higher costs of transport to and from most rural and remote locations.

In 2006 the WACHS hospitals delivered 4,894 live born infants, provided 8,976 same day procedures and discharged 106,516 cases for 462,536 occupied beddays. It also provided 90,157 individual consultations from a community mental health service. During 2006-07 there were 346,928 attendances to WACHS emergency departments and WACHS small hospitals provided over 170,000 occupied beddays for residential care clients.

Major Achievements 2006-07 – Healthy workforce

WACHS continues to build a skilled, stable and motivated workforce that meets the needs of the diverse country population. The Area Health Service is committed to providing and promoting a healthy working environment, providing opportunities for professional development, ensuring a high standard of knowledge and skill, and enabling the implementation of workforce planning tools to meet demand and to minimise the affects of workforce shortages and gaps. Initiatives focus on workforce planning, attraction and retention, the development of innovative new workforce models, cultivating partnerships with other employers and providers and striving to be an employer of choice.

Specialist Services

During 2006-07 WACHS continued implementation of the Specialist Services Plan, recruiting salaried medical officers and resident specialists in general medicine, general surgery, obstetrics, paediatrics and psychiatry. New and expanded visiting services have been established through the Medical Specialist Outreach Assistance Program, including a sleep apnoea service in the Great Southern, vascular surgery and expanded ophthalmology services in the Midwest, respiratory services to the Goldfields and palliative care up-skilling for regional health professionals in the Midwest, Wheatbelt and South West.

Nurse practitioners

Seventy-three sites across WACHS have been designated nurse practitioner sites for emergency care. Appointments for nurse practitioners will commence by mid-2007 with up to 25 nurse practitioners appointed by mid 2008. Scholarships are being implemented to increase the number of nurse practitioners available for recruitment. In addition, 14 scholarships have been made available to mental health nurses to complete specific mental health nurse practitioner training.

Mental health

Access to acute mental health services in WACHS has been enhanced with the appointment of additional allied health, nursing, medical, and psychiatric staff across the Area Health Service. Specifically, the Mental Health Strategy prioritised emergency service liaison nurse positions in WACHS - South West and psychiatrist positions in the WACHS - Goldfields and WACHS - Midwest.

Medical officers

Medical cover across the Area Health Service has been improved with additional medical officers in Broome, a Medical Director, a general surgeon and a obstetrician / gynaecologist in the Great Southern, a salaried medical service in Merredin and two district medical officers in the Pilbara. These appointments have made significant advancements in the management of community and hospital based medical issues, and enhanced the development of liaison networks with general and Visiting Medical Practitioners.

Aged care services

The review of the Aged Care Assessment Team (ACAT) Towards Best Practice Manual, has been completed and a framework to address training to meet these best practice and quality measures, ACAT guidelines, and the Australian Council on Healthcare Standards Evaluation and Quality Improvement Program implemented. The ACAT training framework is based on developing unit competency targets that identify competency gaps and needs.

Seven Regional National Action Plan Coordinators have been employed in major regional hospitals to work in cooperation with emergency service, allied health and other staff to improve outcomes for older patients. Aged Care Units have been established in all seven regions, consolidating all WACHS aged care programs and staff in one division streamlining service delivery and providing increased staff support. This will provide a more coordinated approach to managing rural aged care and will enhance and streamline

Major Achievements 2006-07 – Healthy workforce (continued)

service delivery while providing improved support for aged care staff

Cultural Respect

The WA Country Health Service received presentations outlining the purpose of the Cultural Respect Implementation Framework and the role of area health services in delivering these objectives. WACHS has ensured Cultural Respect training is part of all staff orientation and promote training with external agencies such as Divisions of General Practice.

Videoconferencing

WACHS has invested in additional videoconference equipment establishing a robust telehealth network for the organisation. This will provide staff with improved access to meetings and training opportunities as well as enhancing the provision of clinical services by giving patients in remote locations more opportunities to access specialists' services and clinical consultations.

Training Partnerships

During 2006-07 WACHS continued the development of partnerships with Colleges of TAFE to implement specific health industry traineeships in areas such as sterilizing services, personal care assistants, and aged care and community support workers.

Staff attraction and retention

WACHS is actively contributing to the development of community, regional, state and national initiatives for a sustainable rural health workforce. The development and delivery of new models of health care to address the expected workforce gaps and skills shortages is a priority for the Area Health Service, as is developing key organizational competencies to match workforce skills and experience with the needs of the health service and the patient.

Initiatives to attract and retain nursing staff have continued during 2006-07 with the implementation of programs such as the "Kimberley Rotation", where ten registered nurses have been employed on 12 month contracts, spending four months at three Kimberley sites, and the continuation of the "Ocean to Outback" program which supports staff through a range of nursing experiences, in both acuity and location. Further placements will occur in 2007-08.

WACHS is implementing additional initiatives to support access to further education and training for staff, particularly in small sites where low staff numbers mean staff are often unable to leave the clinical setting to attend training. During 2006-07 employees of the health service participated in the WA Health employee survey and WACHS is working to address issues raised in the survey responses.

Aboriginal health services

The 'Foundations for Country Health Services' prioritises Aboriginal health as a fundamental outcome for health care strategies and includes two significant Aboriginal workforce actions that articulate the aim of developing a WACHS Aboriginal workforce strategy and improve access to primary care, child and community health and Aboriginal health services through greater use of allied health assistants. In 2006-07 the WACHS began preliminary work on the Aboriginal workforce strategy by initiating the development of a WACHS Aboriginal Employees Network that will underpin the workforce strategy development process and by liaising with the workforce directorate of the Department of Health during its completion of the DOH Aboriginal workforce strategy.

Major Achievements 2006-07 – Healthy workforce (continued)

WACHS has identified that there is an urgent need to train Aboriginal Therapy Assistants. In partnership with the Office of Aboriginal Health the Area Health Service initiated a conference of key stakeholders including the Disability Services Commission, National Disability Services WA, and the Office of Aboriginal and Torres Strait Islander Health to develop a proposal to create a pool of funding to facilitate the review of the existing Aboriginal Therapy Assistants program and training modules, and to support regional pilot projects focused on widening the scope of this mainstream program to Aboriginal people.

It is a priority across WACHS to employ additional staff for numerous aboriginal health initiatives especially for remote locations in the Kimberley and Pilbara where additional nurses, local administration and other health support workers have been employed. These workforce initiatives have been accompanied by improvements to clinic and health facilities, and staff housing and accommodation to enhance health services and staff attraction and retention. Capital projects to further support aboriginal health initiatives will continue in 2007-08.

Other workforce achievements during 2006-07 included a position established in Great Southern to provide specific Aboriginal population sexual health and blood borne virus programs, and the Wheatbelt expansion of the Wheatbelt Aboriginal Health Service recruiting Aboriginal health professionals for Northam, Quairading and Moora. These Aboriginal health workers are co-located with general practitioners wherever possible, and negotiations with many general practitioners within the Wheatbelt continuing.

Major Achievements 2006-07 – Healthy hospitals, health services, and infrastructure

The WA Country Health Service provides a range of health care services via its regional network model of service delivery. It is committed to ensuring that services are accessible, innovative and responsive to community needs, and are efficient and of the highest quality.

Safety and quality – Falls Prevention

Falls prevention is an integral part of the Department of Health's safety and quality evidence-based care program that aims to prevent falls and injuries from falls while in hospital or attending health care facilities. The Australian Council of Safety and Quality in Healthcare 'Best Practice and Guidelines Resource Kit' developed for Australian hospitals and residential care facilities for the prevention of falls and harm in older people, has been used by the WA Falls Network to advance this objective.

The Network is actively promoting its distribution and adoption in WA health care facilities and the WACHS has introduced the resource through its Falls Prevention Clinical Practice Improvement Program (CPI). WACHS is represented on the State Falls Action Committee with input to the Falls Model of Care which will be delivered across the three phases of ageing.

During 2006-07, four WACHS regional networks (Midwest, Pilbara, Wheatbelt and Great Southern) established multidisciplinary Clinical Practice Improvement (CPI) teams to plan and implement clinical care process improvements to reduce the risk of falls and harm from falls for inpatients and permanent care residents, specifically falls risk assessments and evidence based prevention interventions. The remaining three regions plan to commence implementation during 2007-2008. CPI teams are collaborating with Aged Care and National Action Plan Coordinators to align falls CPI strategies with the Council of Australian Governments (COAG) National Action Plan/Long Stay Older Patient Initiative.

Some specific area health initiatives and measures to support the falls prevention program goals include gap analysis and benchmarking in the WACHS-Wheatbelt, adult assessments and interventions by occupational therapists and physiotherapists in WACHS-Great Southern and numerous site specific programs at Regional Resource Centres and other service units.

Hospital in the Home

During 2006-07 the Hospital in the Home program has been introduced at a number of sites in WACHS including Albany, Bunbury and Geraldton. This program is to be expanded across the Area Health Service during 2007-08 and will establish consistent reporting mechanisms for home-based care services.

Mental health

Expansion of the Acute Psychiatric Unit in Bunbury (South West) from 15 beds to 33 beds progressed during 2006-07. Capital works are scheduled for completion in late 2007.

Residential care

The Albany Residential Care Line pilot service is currently being evaluated prior to implementation across the Wheatbelt and the South West. This will provide residential aged care services with telephone advice and support that will assist them to better manage sick elderly patients and decrease unnecessary presentations to hospitals and emergency services.

Major Achievements 2006-07 – Healthy hospitals, health services, and infrastructure (continued)

Outpatient data collection

A number of WACHS sites are participating in a new process for collecting information about outpatient services provided from WA public hospitals. The collection will draw on information from metropolitan and country hospitals and will enable data for 23 different clinical services to be collected in a nationally consistent way. This will inform service planning and enable comparisons with services provided in other sites and States.

Patient First

The 'Patient First' initiative aims to empower patients to become active participants in their health care, increasing the patient's understanding of their condition and help them to make informed decisions about their care. Consumer resources have been developed on such topics as informed consent, patient's rights, managing medications, and preventing falls.

'Patient First' is being implemented across all WACHS sites and the District Health Advisory Councils (DHACs) are a key platform underpinning the Area Health Service's strategies for the successful implementation of Patient First. Area management teams are working with their respective DHACs to develop appropriate information and communication plans to inform the community and engage and gain the support of health care professionals. Community communication strategies have included information packages to accompany inpatient correspondence, PO Box distributions and posters in health facilities. Local audits have been conducted to monitor the implementation of the Patient First program.

Accreditation

The Australian Council on Healthcare Standards (ACHS) is an independent authority on the measurement and implementation of quality improvement systems for Australian health care facilities. The ACHS provides a quality improvement framework, namely, the Evaluation and Quality Improvement Program (EQuIP), to assist health care organisations continuously measure their performance and strive for excellence. Over a four year cycle the organisations alternate, annually, between self-assessments and external audits. At all phases of the cycle, the ACHS program provides health services with recommendations for improvement.

During 2006-07, the ACHS conducted a number of on-site audits in some of the regions and reviewed self-assessments submitted by others. The Great Southern, the Southern Goldfields, the Eastern Wheatbelt and the Geraldton Health Service all achieved full accreditation status during their on-site audits in 2006-07. All other regions successfully submitted self-assessments for audit. The Kimberley, the Pilbara and parts of the Mid-West are all due for full organisation wide audits in late 2007, and the South West in 2008.

Capital and infrastructure projects

Numerous capital projects were active during 2006-07 including

- the official opening of Karlarra House, a 56 bed high and low care residential facility saw the completion of Stage 1 of the Hedland Health Campus Redevelopment Project and Stage 2 planning and design process commenced;
- construction of new acute wards was completed at Derby Hospital, with staff and patients transitioning to the new facilities in March 2007;
- construction of the new Kununurra dental clinic was completed in May 2007;
- construction has commenced on the new Denmark health facility scheduled for completion by June 2008;
- the redevelopment of Morawa Health Centre has commenced;
- the refurbishment and upgrade of the Mt Magnet Nursing Post commenced;

- the consultation and planning phases for Stages 1 and 2 of the Carnarvon hospital redevelopment commenced;
- business cases for the redevelopment of the Albany Regional Resource Centre and the Busselton Hospital commenced in 2006-07 with construction scheduled to commence in June 2009 for Albany and September 2008 for Busselton;
- project planning for a new Community Mental Health Clinic and a new 10-chair dental health clinic at the Bunbury Regional Resource Centre was finished in 2006-07 and construction is scheduled for completion in September 2007; and
- expansion of the Bunbury Regional Resource Centre In-patient Psychiatric Unit providing a full spectrum of locally based in-patient mental health services.

In addition to capital projects for health care facilities, WACHS has also progressed a number of projects to improve or increase staff accommodation including

- the purchase and upgrading of a housing complex in Meekatharra;
- the acquisition of new properties in the Pilbara by either purchase or lease; and
- the purchase of five additional one bedroom units and four houses in Esperance and pursuing lease arrangement for two units in Ravensthorpe.

The official opening of the $1.95 million Computed Tomography (CT) Scanner at Broome Regional Resource Centre was held in August 2006. Clinical linkages have been established with Fremantle Hospital to provide a CT advisory service to the radiographers at Broome. The deployment to country areas of enhanced information technology based clinical systems also commenced in 2006-07 including computed radiography at the Geraldton Regional Resource Centre and pathology systems at Northam Hospital.

The 2006-07 clinical equipment program delivered enhanced medical and surgical capacity to country areas with bariatric beds and trolleys for overweight patients at a number of WACHS hospitals, new anaesthetic gas monitoring machines in theatres at a number of sites, and the replacement and upgrading of foetal monitors.

Inpatient rehabilitation – Geraldton

With the completion of the new Geraldton Regional Resource Centre in 2006, a dedicated inpatient rehabilitation unit was established. This unit will create a functional area that better meets the need of patients returning from Perth or needing further rehabilitation as an inpatient, but not requiring the acute level of care provided on the general ward. A day hospital facility, catering for a maximum of 12 clients has also been established, providing a coordinated rehabilitation service for eligible community clients to maintain and improve their functioning.

Aged care

WACHS commenced the establishment of Aged Care Coordination Units in each of its regions in 2006-07. The primary role of these units is to build an effective aged care network to better coordinate the planning and delivery of aged care services. The units will also provide support to service delivery staff to enable the delivery of "best practice" care for the aged in their homes and in the community setting including minimising unnecessary hospitalisations.

Major Achievements 2006-07 – Healthy hospitals, health services, and infrastructure (continued)

Nursing workload

Over the past two years WACHS has further developed the 'Nursing Hours per Patient Day' initiative to assess nursing workload for various in-patient areas in rural locations. All in-patient and emergency service activity is captured electronically and compared to nursing staffing levels for designated operational periods. This data is then mapped against nursing activity categories providing nursing hours and FTE for each occupancy at ward level or operational unit. This project will provide the Area Health Service with valuable information on the nursing hours per patient day in each nursing category that will be used to inform health service management in workforce and service delivery planning.

Major Achievements 2006-07 – Healthy communities

Initiatives to improve the health of people living in rural communities focus on activities that influence the health of individuals as well as the whole population. Goals include improving lifestyles, the prevention of ill health, and the implementation of long-term, integrated health promotion programs. Initiatives implemented by WACHS follow extensive collaboration with government and non-government agencies, general practitioners and community groups.

Chronic disease

Four year funding of $5.5M to address chronic disease has been allocated to Halls Creek, Norseman and the Western Desert communities (Jigalong, Punmu, Parnngurr and Kunawarritji). Health programs to support program outcomes are being finalised and service delivery will commence in 2007.

Obesity prevention

Obesity prevention has been identified as a key strategic direction in the *Western Australian Health Promotion Strategic Framework 2007-2011*. A range of health promotion programs and campaigns, with the capacity to impact on childhood obesity, have been delivered specifically to remote Aboriginal communities in 2006-07. These include the 'Growing Healthy Children' project (promoting healthy breakfasts in remote and Aboriginal communities) and the 'Kimberley Active' Indigenous whole-of-community physical activity program.

Australian Better Health Initiative

Under the Australian Better Health Initiative a number of projects have commenced across WACHS. Funding has been provided to support the implementation of healthier school canteens, to establish dedicated school health promotion coordinators and implement a four-year project for health self-management delivering self-management and improved lifestyle activities in targeted remote communities.

WoundsWest

During 2006-07 WACHS health care services have been active in the WoundsWest project, a three-year initiative established to provide coordinated prevention and management of wounds in the community and acute sector, with specific focus on improving access to expertise in wound care. This project includes the use of surveillance, digital imaging, education and interventions to ensure wound care in WA achieves best practice. The first year, 2006-07, focused on infrastructure development, testing, refinement and wound monitoring.

Smoke Free WA

WACHS is working to be Smoke Free by January 1, 2008. A number of sites have adopted non-smoking policies for their facilities where employees, visitors, volunteers and contractors are not able to smoke in any health service buildings, grounds and other facilities (including cars), nor within designated patient smoking areas or while representing WACHS in any official capacity. Implementation has included a staged approached over a period of time. Planning processes have ensured that the policy implementation supports staff with smoking cessation strategies while at work.

Kimberley word tool

The 'Kimberley Word Tool' has been developed and implemented to assist health professionals communicate with indigenous clients where English is a second language. The tool provides both visual and language prompts for 37 common health messages.

Canning Stock Route Challenge

The Canning Stock Route Challenge is a school based physical activity and nutrition challenge developed by the Pilbara Population Health Unit in 1996. It has since been implemented across WACHS and in 2006-07 was successful in receiving three-year Healthway funding of $200,000 to revise and update the program.

Major Achievements 2006-07 – Healthy communities (continued)

Mental Health

Under the Mental Health Strategy 2004-2007 expanded community supported accommodation services for people with severe mental illness living in Western Australia is a priority initiative. In WACHS the development of Community Supported Residential Units (CRSU) has continued. These units will provide daily rehabilitation and clinical support to residents and help minimise the risk of hospitalisation for people with severe and persistent mental illness. Fifteen CRSUs in Bunbury are scheduled for completion by mid 2008, 10 units in Busselton by December 2007 and eight in Albany. Management of these units will be placed with local non-government organisations under a tender and contracting process.

The WA Country Health Service has been active in implementing the "Mentally Healthy Western Australia" health promotion program across WACHS sites. The program conducted numerous community briefings, workshops and community events branded with the ABC Mentally Healthy logo (Act, Belong, Commit). WACHS pilot sites were Esperance, Geraldton Albany, Northam/York, Karratha and Kalgoorlie.

WACHS – Midwest mental health staff coordinate training for the "Gatekeeper Program" for community groups providing participants with a range of skills and knowledge that improves their ability and levels of confidence to work with suicidal people.

During 2006-07 the WACHS – Midwest has also continued to provide the internationally accredited "Mental Health First Aid" program to raise community mental health and wellness awareness and skills across communities. The program targets local partnerships and collaborations where potential trainers from local community members, sporting groups, work groups or any other group expressing interest with the training. Support is provided by the Central West Mental Health Service. This program received a "Healthy Communities Award" at the November 2006 "Delivering a Healthy Community" conference in Perth.

WACHS – South West has continued its "Understanding and Building Resilience in the South West" project in 2006-07 in collaboration with the Injury Control Council WA and South West non government agencies. This project aims to increase resilience in South West communities to reduce rates of suicide and depression.

During 2006-07 the number of mental health patients transferred to Perth from the South West has decreased significantly. This was due to a range of strategies that has increased service access including additional psychiatrists and other trained staff, the introduction of case management processes, implementation of psycho-social risk screening at all hospitals, and the introduction of emergency department mental health liaison nurses at the Bunbury Regional Resource Centre. A new community mental health clinic is being built on the South West Health Campus. During 2006-07, significant progress has been made on the capital works for the new clinic which is scheduled for completion in late 2007.

WACHS - Great Southern has developed a pilot Mental Health Service Directory for the Upper Great Southern with contact details of service providers with a brief summary of the services available, including Police, general practice counsellors and mental health services for consumers. The Directory is available on the WACHS internet site.

The Dementia Action Group in Albany has developed a 'Clinical Pathway for improving the care of people with dementia within the acute care setting'. The tool is being piloted in the Albany Regional Resource Centre, and will be considered for implementation across the Area Health Service.

Major Achievements 2006-07 – Healthy communities (continued)

All Rural Community Support Service (RCSS) clinicians completed the Mental Health first aid training, with representatives from local non–government providers, to build the awareness and mental illness management capacity in rural communities. The trainers are required to provide a minimum of three workshops in the region to complete their training. These trainers are then eligible to complete the Youth Mental Health First Aid training.

Gascoyne Primary Health

During the year Gascoyne Primary Health won a national award under the Australian Crime and Violence Prevention Award program for their School Holiday (Children and Youth festival) program. This program is a partnership of health, Police, shire, local aboriginal community, Departments of Sport and Recreation, Corrective Services and Community Development and provides a range of safe fun activities for children during the holiday period that are safe and fun. The program has had an impact in reducing levels of antisocial behaviour and juvenile crime.

'Stay on your Feet'

The WA Country Health Service maintained a high prominence in 2006-07 activities for the "Stay On Your Feet" (SOYF) Week program across all regions. Activities and promotions included large newspaper features in local papers such as the Albany Extra, local radio interviews and community based promotions. WACHS health promotion and community health staff also participated in organising special events such as the Albany Anzac Walks led by Digger Cleak from the Returned Service League and the heritage walk led by historian and librarian Malcolm Trail.

Patient Assisted Travel Scheme

The Patient Assisted Travel Scheme (PATS) operated by WACHS is a vital program to ensure country patients have access to appropriate medical and health care services. The Area Health Service is currently reviewing the coordination and administration of the scheme to streamline and simplify the application process. Flexible reimbursement options have been introduced including the commencement of payment processing at the time of travel approval rather than at travel completion, and the implementation of a fuel card scheme.

Pit Stop: Mens Health Program

WACHS, WA Clincial Networks have worked in partnership with Men's Advisory Committee to update the successful Pit Stop Men's Health Package widely used across WACHS. The package relates body functions to mechanics, likening parts of the body to an engine. The updated package has been widely distributed across the Area Health Service and attracts wide interest from local government and interstate health services.

Cancer Care

WACHS has appointed a Rural Cancer Nurse Coordinator to each of the regions. These roles have completed a process of mapping regional cancer services aiming to improve care coordination and linkage for cancer patients between the metropolitan health services and WACHS. The role will also include strategic activities aimed at improving local cancer care delivery and support.

Aboriginal health

WACHS has focused on supporting the evaluation of the WACHS regional area community consultation mechanism (District Health Advisory Council [DHAC]) for their ability to involve Aboriginal people in planning and decision-making resulting in some WACHS areas identifying opportunities for improved Aboriginal consumer participation.

A specific example is WACHS - Great Southern which has facilitated a comprehensive Aboriginal health community advisory body where two Aboriginal members from each regional town form the Great Southern Aboriginal Health Council. This Council meets quarterly providing direct input into WACHS - Great Southern and the Great Southern

Major Achievements 2006-07 – Healthy communities (continued)

Aboriginal Health Service (GSAHS). The Council is supported by the manager of the GSAHS and provides advice to the Regional Director and the Aboriginal Health Service. Matters of strategy, planning and service delivery are routinely discussed and addressed. The Council has recently agreed to become an agency for service assessment and evaluation utilising the mechanism embedded into the DOH 'Cultural Respect Implementation Framework'.

Major Achievements 2006-07 – Healthy partnerships

The WA Country Health Service continues to create stronger links and partnerships with other government agencies, non-government organisations, consumers, community groups, private providers, health professionals, the Commonwealth Government, and those with an interest in the well being of our health system. The role and function of District Health Advisory Councils has been strengthened to maximise local participation and decision-making.

Audiology services

During 2006-07 Australian Hearing provided otoscopy, tympanometry and audiometry testing and diagnosis through a screening program in Aboriginal communities in the Wheatbelt, Midwest, Great Southern and Goldfields. The target group includes three to five year olds in addition to school-aged children. A dedicated and fully equipped audiology room has also been established in the Warburton clinic to enable testing to be provided in this area.

Regional Colleges of TAFE

The close partnership between WACHS – South West and the South West Regional College of TAFE has seen the development of traineeships for sterilising services and health support workers (Personal Care Assistants), further consideration for Indigenous traineeships and 'Frontline Management' training and other allied health areas.

WACHS — Wheatbelt and CY O'Connor College of TAFE established a Memorandum of Understanding for the provision of Commonwealth funded Existing Worker Traineeships for aged care workers in the Wheatbelt. Also in a collaborative effort with the Community Services Industry Training Advisory Body (ITAB), the New Apprenticeships Centre (NAC), and the Apprenticeship and Traineeship Support Network (ATSN), C.Y. O'Connor College of TAFE and WACHS — Wheatbelt, 130 traineeships were provided in Certificate III in Community Services (Aged Care Work) for existing workers and Certificate IV in Community Services (Aged Care Work) for 25 aged care workers. This collaborative effort has achieved two National and one State training awards.

Satellite Dialysis Unit Busselton

Negotiations were successfully conducted between WACHS - South West and St John of God Hospital Bunbury to establish a dialysis unit in Busselton. The unit is scheduled to be operational by the end of 2007.

Rural Clinical School

Bunbury became a Rural Clinical School site with 10 students choosing Bunbury for their clinical placement. This is an ongoing collaboration between the University of WA, The University of Notre Dame and WACHS - South West to ensure that the students can experience rural medicine to complete their studies.

Regional Homelessness Strategy

WACHS - South West and agencies such as the Department of Housing and Works, South West Community Drug Service Team and local non government agencies have successfully applied for National Homelessness Strategy funding, to pilot a model to assist individuals with multiple and complex needs to access accommodation. An amount of $161,500 over 2 years from the Commonwealth Government has been secured.

Outpatient and allied health services

A partnership arrangement between WACHS – Pilbara, BHP Billiton, the Royal Flying Doctor Service and the Commonwealth Government was established in 2006-07. This partnership will enhance access to outpatient and allied health services across the Pilbara and improve outreach services in Newman, Onslow, Tom Price and Paraburdoo.

Major Achievements 2006-07 – Healthy partnerships (continued)

Exmouth MPS

During 2006-07 the Exmouth community in conjunction with WACHS - Midwest is progressing the process to implement a Multi Purpose Service (MPS) model. This model promotes a collaborative approach to health funding, and service planning and delivery between the Commonwealth and State Governments and the community. It enables more flexibility in determining the mix of health services to be provided to the community at the local health service level.

Regional Aboriginal Medical Services

Effective partnerships have been established with Regional Aboriginal Medical Services for the provision of a range of services to the indigenous population of WACHS. This has seen improvements in services such as renal dialysis in the Kimberley, allied health, and comprehensive midwifery, antenatal, after-birth and postnatal programs in the Midwest.

Mental Health

In 2006-07 Geraldton was selected by the National Institute of Clinical Studies (NICS) for a collaborative project on the Mental Health Emergency Care interface. This project was an investigation into the practices and needs of both consumers and staff, aiming to ensure that best possible services are provided to people presenting to the Geraldton emergency department. The project entails a review of staff knowledge and skills training and includes 'simulated' patient roles. Systems and processes of referral and access for consumers have been addressed to improve the service.

The South West Mental Health Service, Greater Bunbury Division of General Practice, GP Down South Division of General Practice, St John of God Community Drug Service Team, South West Aboriginal Medical Service, Bunbury and Warren Blackwood Education Districts, Jobs South West, Bunbury Pathways Inc, Agencies for South West Accommodation Inc, Mission Australia, Edith Cowan University, Youth Focus Inc, and Investing in Our Youth Inc formed a consortium and obtained seed funds to formulate a model and submission for funding under the 'Headspace' program to provide an accessible, effective and sustainable service for youth with mental health/drug and alcohol issues in the region.

Funding was received for a 'Home Assist Project' from the Commonwealth Government for a pilot project to assist people (specifically young men with mental health and drug/alcohol issues) to obtain and maintain tenancies. This project is a partnership with the Department for Housing and Works, Agencies for South West Accommodation, St John of God Community Drug Service Team, Bunbury Accommodation Service, South West Mental Health Service and Bunbury Pathways Inc.

The Great Southern Mental Health Service, Albany Worklink, GSGP Network, and Kipling Cutler and Associates were recipients of Headspace program funding of $1.5m to work as a consortium to provide an accessible, effective and sustainable service for youth with mental illness and drug and alcohol related issues in the Great Southern. The focus will be on promotion, prevention and early intervention, with treatment being provided by the "Better Outcomes for Mental Health**"** program.

Great Southern General Practice Network

The WACHS - Great Southern has partnered the Great Southern General Practice (GS GP) Network to develop the shared care network to facilitate the effective electronic sharing of patient information in a timely manner. This, in turn, improves both the level of patient care as well as improving patient outcomes.

Major Achievements 2006-07 – Healthy partnerships (continued)

District Health Advisory Councils

The WA Country Health Service has a strong commitment to consultation with the community and there are 24 District Health Advisory Councils (DHACs) in operation across WACHS. DHACs are an important part of the organisation's community and consumer consultation strategy providing two-way communication and advocacy between the Area Health Service and community members, consumers and stakeholders. These communications contribute to safety, access, and quality improvements, community input into service planning, and support the "healthy community" approach to health service development. Seven DHACs were established in the South West in 2006-07.

In some areas Local Health Advisory Groups have been established to provide a robust link between individual communities, their local health facilities and the District Health Advisory Council. Eight Local Health Advisory Groups (LHAG) were established in the Eastern area of the Wheatbelt, strengthening community and consumer links.

Training and support is provided by the Health Consumers Council of WA and seven DHAC's accessed advocacy training in 2007. The Council will continue to provide training opportunities as required. A DHAC Member Resource Kit providing support materials and audit tools, has been provided to all DHAC members. DHAC Chairpersons meet at least annually and last met November 2006 with the Minister for Health and the WACHS Chief Executive Officer attending. The DHAC Chairpersons' forums provide feedback and recommendations about health issues and service priorities.

During 2006-07 three DHAC members were supported to attend the 'Communities In Control National Conference' in Melbourne. Attendance by these members at the conference aimed to build capacity and connections and strengthen community and consumer input into country health service improvement.

Aboriginal Health

Significant progress has been made in elevating Aboriginal health as a policy and service delivery priority in 2006-07 through formalising a partnership with the Office of Aboriginal Health (OAH). WACHS invited OAH to be the lead author of the Aboriginal health component of the current WACHS strategic plan: the "Foundations for Country Health Services". The OAH facilitated Aboriginal community and stakeholder consultations, and WACHS management meetings aimed at enhancing WACHS' responsibilities for the health of Aboriginal people.

The "Foundations" strategy prioritises Aboriginal health and details actions to be undertaken across the Area health Service over the next three years. The strategic plan was matched by an implementation plan approved by the Country Health Management Team in December 2006 that articulates five priority action areas:

- partnerships;
- remote service sustainability strategies;
- implementation of the cultural respect framework;
- Aboriginal participation in planning and decision making; and
- clinical or organisational service developments.

A total of thirty-two projects are to be undertaken over the life of the "Foundations" plan and the implementation of the initiatives is embedded in the 2007-08 WACHS Operational plan. The Operational Plan requires all WACHS regional areas to identify, consult and initiate four to five projects each by the end of the financial year. (each project is to be a significant service or system development project undertaken over a two to four year timeframe).

Major Achievements 2006-07 – Healthy partnerships (continued)

Some "Foundations" Aboriginal health projects were identified in 2006-07 such as a General Practitioner / Aboriginal Health Service Integration Project in the Great Southern, development of aged care Aboriginal reference groups throughout the Kimberley, and planning for a Western Desert/Newman Service Integration project in the Pilbara.

WACHS has participated in regular partnership meetings with the Aboriginal Health Council of WA, the Australian Government's Office of Aboriginal and Torres Strait Islander Health and the Office of Aboriginal Health to ensure coordinated state-wide funding and service delivery provider activity.

Similarly, WACHS is a member of the WA Aboriginal Alcohol and Drug Partnership together with the Drug and Alcohol Office, the WA Network of Alcohol and other Drug Agencies, the Australian Government's Office of Aboriginal and Torres Strait Islander Health and the Office of Aboriginal Health.

Regional areas across WACHS are core members of one of the five State-wide Regional Aboriginal Health Planning Forums. The forums have met throughout 2006-07 to prioritise and coordinate delivery of health services to Aboriginal people.

At the local level, effective partnerships have been established with Aboriginal Medical Services for the provision of a range of services to the indigenous population of WACHS. This has seen improvements in services such as renal dialysis in the Kimberley, allied health, and comprehensive midwifery, antenatal, after-birth and postnatal programs in the Midwest.

The partnership established between the Nindilingarri Cultural Health Service (NCHS) and WACHS – Kimberley has been fundamental to the commencement of construction of the new health facility at Fitzroy Crossing that includes new co-located facilities for the NCHS.

Major Achievements 2006-07 – Healthy resources

A key priority for the WA Country Health Service is a sustainable, equitable and accountable health care service to deliver the best health benefit in a safe and quality assured environment. To achieve this outcome as well as routine administration and management practices, WACHS has undertaken some specific actions to ensure resources available to the Area Health Service support the best health outcome for country people.

Resourcing

Following the release in January 2007 of the WACHS "Foundations" strategic plan, the Area Health Service has implemented initiatives to address the recommendations detailed in the plan and improve the information available for health service planning and administration. These include:

- implementing the aboriginal workforce strategy;
- pursuing partnerships with the private and non-government sectors especially with rural general practitioners;
- strengthening financial planning and management systems;
- streamlining and consolidating service delivery;
- developing comprehensive employment remuneration, attraction and retention options; improving systems to recover costs from alternative sources such as DVA, worker's compensation and private health funds; and
- improving WACHS information and communication systems especially telehealth, digital imaging and e-health technologies.

Information technology and equipment

The deployment of enhanced information technology based clinical systems to country regions continued in 2006-07, including implementation of computed radiography at Geraldton Regional Resource Centre and pathology systems at Northam Regional Hospital.

Medical imaging capacity in the WACHS has also been enhanced with the installation of computerised tomography scanners at Port Hedland, Northam and Albany, the replacement of general X-ray machines at Carnarvon, Northam, Esperance, Merredin, Narrogin, Geraldton, Collie and Bridgetown, ultrasound equipment at Albany and Port Hedland, and the installation of new digital screening combined X-ray at Kalgoorlie.

A clinical equipment program has enhanced medical and surgical capacity in country services, including the installation of bariatric beds and trolleys, 12 new anaesthetic gas monitoring machines in theatres at a number of sites, and the replacement and upgrading of foetal monitors.

Telehealth

In country areas there are currently 155 videoconference sites available to health users. Pathways Home funding is enabling the expansion of the number of videoconference units across the rural and metropolitan sectors for mental health services. Funding is being sought through 'Clever Networks' for further infrastructure and broadband access in line with the DOH objective to reduce communications expenditure.

During 2006-07 WACHS telehealth services for the provision of speciality care to rural and remote communities across the State have been enhanced in the areas of psychiatry, neurology, development paediatrics, and geriatric medicine. Pain management, paediatric burns, gastroenterology and hepatology clinics for Regional Western Australia via telehealth video-conferencing have been successfully established and expanded. A trial of the telehealth wound management program was undertaken by WACHS – Midwest in conjunction with Royal Perth Hospital to assist with the discharge of country patients requiring wound management procedures.

Major Achievements 2006-07 – Healthy resources (continued)

Elective surgery waitlist strategy

During 2006-07 WACHS has addressed its elective surgery waiting lists and has made significant improvements in median waiting times and over-boundary cases for the elective surgery categories.

Improvements have been predominantly achieved by refining the administration process, but in order to ensure sustainable gains in waitlist and broader elective surgery reform, a review and improvement of clinical processes is planned as part of the WACHS' "Foundations" strategic plan in conjunction with the State-wide elective surgery reform program. This will be driven through initiatives such as the Ambulatory Surgery Initiative, a review of theatre management, and increasing day of surgery admissions in WACHS Regional Resource Centres. A particular initiative to increase elective surgery activity in country areas was the development of a theatre and recovery nursing program in the South West which has enhanced theatre nurse skills and enabled more complex cases to be undertaken.

Major Achievements 2006-07 – Healthy leadership

Creating an environment that identifies, nurtures and promotes strong leadership at all levels within rural health care services and in the rural community, is vital to the effectiveness of the health system now and in the future. WACHS focuses on recognising, developing and supporting its leaders to create a superior health care service and ensure that all strategic directions are progressed.

Disaster preparedness

WACHS continued its participation in disaster preparedness planning and during the year the Country Health Disaster Management Plan underwent a capability audit and the Area Health Service provided specific disaster management courses and training to disaster management coordinators.

Other activities included:

- contributing to the Hospital Surge Capacity Plan;
- providing volunteers for the Disaster Medical Assistance Team database;
- stockpiling medical equipment and supplies;
- participating in the development of the Disaster Command and Control structure including the processes for activating a health response to an emergency situation through a central point of contact,
- providing case presentations regarding 'Mental Health Involvement' in disaster responses;
- participating in policy development for the Disaster Medical Assistance Team; and
- participating in the pilot Emergency Management course in July 2006 which has subsequently been incorporated in the 2007 training calendar, and in a National Counter Terrorism Exercise.

Leadership programs

WACHS encourages all staff to demonstrate leadership and facilitates leadership development for senior staff and managers. The Area Health Service also encourages mentoring programs for less experienced staff so they can build their skills and capabilities for higher level supervisory and managerial roles.

During 2006-07 a number of WACHS based staff again participated in the Department of Health's leadership development programs. "Leading 100" and "Building Leadership Development Program" had 23 and 26 employees enrolled respectively.

Specific leadership initiatives in 2006-07 include:

- WACHS - South West and South West College of TAFE developing a Frontline Management training program for all managers and supervisors;
- WACHS – Midwest developing a pilot skills development, supervision and mentoring program for middle / senior managers the Midwest Management Enhancement (MME) Program and facilitating internal learning opportunities, and supporting and encouraging staff to access graduate and post-graduate scholarships;
- WACHS - Wheatbelt Population Health Leadership Development Program assisting a number of population health professionals to gain insight into the qualities and capabilities of effective leaders and develop programs to assist them provide effective leadership.

Clinical governance

The appointment of WACHS Head Office Executive Directors for Medical and Nursing Services and regional Medical Directors and clinical governance teams has provided opportunities to develop strong leadership to improve clinical governance across the Area Health Service. These appointments facilitate enhanced focus on clinical governance issues and initiatives such as staff participation in formal clinical review processes for sentinel events, and the development of policies and practices for clinical incidents review and complaint assessment.

Major Achievements 2006-07 – Healthy leadership (continued)

Aboriginal health leadership

In 2006-07 WACHS employed an Acting Area Director Aboriginal Health as a joint appointment with the Office of Aboriginal Health. The co-funded role seeks to embed Aboriginal health policy and improved service delivery at senior management level within WACHS. Recruitment of a permanent WACHS Area Director Aboriginal Health has begun to consolidate Aboriginal health leadership within WACHS' management structure.

WACHS established an Aboriginal Health Reference Group consisting of a member of each regional executive and leadership within the Office of Aboriginal Health. The reference group assists the WACHS Executive to plan, develop and evaluate effective models of Aboriginal health service delivery across the Area Health Service, and facilitate, coordinate and support Aboriginal health projects emanating from "Foundations for Country Health" strategy.

Mental health

The establishment of the position of Area Director, Mental Health in 2005-06 has allowed the development, planning and implementation of mental health policy, 'best practice' mental health models/services, and quality management and governance across the Area Health Service.

A number of community mental health non-government organisations operating across WACHS participated in training workshops to assist them to implement the DOH's new 'Service Standards for Non-Government Providers of Community Mental Health Services'. These standards cover the service contracting areas such as rights and responsibilities, safety, privacy and confidentiality, consumer and carer participation, organisational governance and management, accessible inclusive service provision and the delivery of services. In addition, a mentoring system was established to assist these organisations to comply with the new standards and identify areas for improvement.

Environmental performance

All WACHS hospitals have conducted at least one energy audit during the year detailing recommendations for energy saving measures that have been implemented in numerous sites. Energy management is also now a defined part of Area Health Service performance agreements and service unit managers are trained in energy conservation. There are further opportunities for WACHS to implement energy saving strategies in the design and construction of new and upgraded health facilities under the WACHS capital program. In addition to energy audits, metropolitan hospitals are currently conducting audits of water usage to identify deficiencies in water management practices and it is proposed to extend this audit to WACHS hospitals.

Priorities for 2007-08

Healthy Workforce

The WACHS will continue to develop and deliver models of health care services that address the expected workforce gaps and skills shortages. The Area Health Service will provide capacity for further education, training and leadership skilling for country staff, develop innovation in workforce planning, work redesign and service delivery, and provide flexible working arrangements and a family friendly work environment. A particular priority will be the continued development of the nurse practitioner role in rural and remote locations.

While WACHS will continue to rely on recruiting overseas trained medical officers the Area Health Service will continue to ensure that adequate orientation to the operational and diverse cultural characteristics of health service delivery in country Western Australia is provided to overseas recruited staff.

Strategies will be implemented to address priority workforce satisfaction issues including work-life balance, improved leadership and management and developing a safer work environment, and develop key organisational competencies to match workforce skills and experience with the needs of the health service and the patient. Developing and improving staff attraction and retention options will remain a workforce priority.

It will not be enough to rely on traditional supply and demand approaches to resolving country workforce issues into the future. We also need to consider closely areas such as education, training and leadership, workforce planning, new and innovative service delivery models and work redesign, flexible working arrangements and staff support if we are to ensure the provision of quality, safe and sustainable services.

Healthy Hospitals, Health Services and Infrastructure

New infrastructure designed to provide a physical environment that supports the delivery of high quality, safe and contemporary health services is necessary for WACHS to meet its role delineation plans and strategic reforms. The Area Health Service will also continue to improve infrastructure maintenance ensuring health facilities meet strategic health care objectives, comply with statutory obligations, achieve efficient cost structure and meet duty of care requirements. WACHS' $627M capital investment program which commenced in 2004, aims to replace outdated and inappropriate infrastructure where necessary under a rigorous planning approach to capital decisions.

Immediate priorities include the development of WACHS Regional Resource Centres, the upgrade or replacement of facilities that have outlived their usefulness and addressing the needs of staff accommodation.

WACHS has implemented operational strategies to achieve the recommended timeframes for elective surgery especially the revised Category 3 admission target of 180 days including flexible theatre allocations, the expansion of day hospital services and trials of more flexible theatre arrangements for general practitioners. The Area Health Service will also introduce initiatives to increase activity in ambulatory surgery, transitional care and 'Hospital in the Home' to meet operational targets and further enhance capacity at Regional Resource Centres to cater for overweight patients, replace transport ventilators, upgrade sterilising equipment and progress a bed replacement program.

The WA Country Health Service will continue the enhancement of telehealth as a technological resource available for clinical care with expanded burns management services in partnership with Princess Margaret Hospital and Royal Perth Hospital as well as a trial for delivering oncology education and clinical services to regional hospitals.

Priorities for 2007-08 (continued)

Investment in country medical imaging will continue with computed radiography and the Picture Archiving and Communication System to be installed in all regional resource centres, the Radiological Information System to be implemented across the Area Health Service and the upgrading of ultrasound equipment at the regional resources centres.

A rural home link 1800 telephone number will be established to enable better coordinated discharge planning for country patients who are leaving metropolitan hospitals.

WACHS in partnership with the Royal Flying Doctor Service (RFDS), will develop a 5 year plan for inter-hospital transport services to provide an effective and an efficient aero-medical service to meet the demand for inter-hospital transport, and address operational costs.

Healthy Partnerships

Two particular priorities for WACHS for developing healthy partnerships are to strengthen its relationships with rural doctors (including general practitioners, salaried medical officers and visiting and resident specialists), involving them in hospital and health service planning and decision making, and to work with workforce partner agencies to develop attraction, retention and recruitment strategies for the rural medical workforce, ensuring they are prepared for rural and remote practice.

Healthy Communities

In January 2007 WACHS received an allocation of 60 transition care (residential care) packages from the Commonwealth Government. Twenty packages will be established in Geraldton, Bunbury and Albany.

The transition care program is a jointly funded initiative of the Commonwealth and State Governments that provides time-limited, goal-oriented therapeutic care in a non-hospital environment for frail older people at the conclusion of their hospital stay. The aim of transition care is to improve or maintain the older person's level of independence whilst assisting the person and their family arrange longer term care.

Coordination and effectiveness of aged care services in country areas will be improved through the employment of aged care coordinators in each region, enhancement of discharge planning and better support for patients in the community. This will be supported by establishing access to the Residential Care Line in the Wheatbelt and the South West. This project has been piloted in Albany and has proven successful in providing residential aged care services with telephone advice and support that assists them to better manage elderly patients and decrease unnecessary presentations to hospitals and emergency departments.

The chronic disease pilot programs for heart disease and diabetes self-management in the South West will be evaluated in 2007-08. These programs aim to enable people with these chronic diseases to live independently and self manage their illness at home, and reduce the need for in-patient admissions.

Healthy Leadership

During 2007-08 WACHS will continue to progress its leadership programs and initiatives especially supporting employees in the "Leading 100" and "Vital Leadership" programs offered across WA Health where over 70 country staff have participated in leadership development. Mentoring programs for less experienced staff are also provided so they can build their skills and capabilities for senior supervisory and management roles.

WACHS will progress corporate and clinical governance programs with improvements to its corporate and financial systems, work with the HCN, streamlining and integrating information systems, enhancing WACHS' occupational safety and health capacity, and the ongoing development and coordination of health and medical disciplines via the Area – wide leadership and professional support structure established within the organisation.

Operations

Advertising

The following table lists expenditure on advertising, market research, polling, direct mail and media advertising made by the WA Country Health Service and published in accordance with the requirements of Section 175ZE of the Electoral Act 1907. The total expenditure for Advertising for the WACHS in 2006-07 was $969,369.

Table 19: Advertising

Summary of Advertising	Amount ($)
Advertising Agencies	**869,445**
Market Research Organisations	**22,175**
Polling	**Nil**
Direct Mail Organisations	**Nil**
Media Advertising Organisations	**77,749**

Expenditure Category	Recipient / Organisation	Amount ($)	Total ($)
Advertising Agencies			
	Marketforce	740,461	
	Market Creations	8,740	
	Northern Paper Distributors	197	
	Quantum Recruitment	24,145	
	Seele Limited	495	
	Wavelength	92,858	
	Westcare Industries	2,549	**869,445**
Market Research Organisations			
	Mills Wilson	22,175	**22,175**
Polling Organisations			
			Nil
Direct Mail Organisations			
			Nil
Media Advertising Organisations			
	Advertiser Print	206	
	Albany Advertiser	5,884	
	Albany Chamber of Commerce and Industry	1,185	
	Apex Gascoyne Business	242	
	Avon Valley Advocate	2	
	Bower Bird Information Services	99	
	Chittering Times	616	
	Cottman Australia Pty Ltd	216	
	Crime Alert	484	
	Cunderdin and Meckering Bandicoot Express	34	
	Dalwallinu Telecentre Network	578	
	Denmark Bulletin and Media Services	115	
	Elite Publishing	700	
	Fast Track Media	3,436	
	Fence Post	135	
	Geraldton Newspaper	2,546	

Advertising (continued)

Media Advertising Organisations (continued)			
	Golden West Network	4,468	
	Great Southern Herald	2,640	
	Jerramungup Telecentre Inc	66	
	Lake Grace Telecentre	272	
	Local Business Support and Community Service	268	
	Lions Club Lake Grace	48	
	Media Decisions WA	7,683	
	Messages on Hold	189	
	Midwest Times	3,624	
	North West Telegraph	362	
	Northern Guardian	14,171	
	Pingelly Times	35	
	Plantagenet News	47	
	Radiowest Broadcasters Pty Ltd	599	
	RadioWest Network	2,555	
	Royal Australian College of Surgeons	220	
	Royal Australian and New Zealand Obstetrics and Gynaecology College House	990	
	Rural Press Regional Media	1,635	
	Seabreeze Communications	1,699	
	Seek Limited	165	
	Sensis Pty Ltd	140	
	Shire of Chittering	165	
	Southern Cross Telecentre	22	
	South West Printing & Publishing	1,988	
	Synergy Graphics	49	
	Telstra Corporation Ltd	105	
	The Cancer Council Western Australia	10,826	
	The Communicator	250	
	The Nursing Post	358	
	The Toodyay Herald	30	
	The West Australian	649	
	The Williams	8	
	Town of Narrogin	794	
	WA Police Legacy (Inc)	330	
	Weekender	2,032	
	Wheatbelt Chamber of Commerce	133	
	Wongan Hills Telecentre	84	
	Workplace Safety and Industrial News	429	
	Wyalie Weekly	5	
	Yamatji Times	170	
	York Telecentre	105	
	303 Advertising Pty Ltd	860	**77,749**

Corruption prevention

Government agencies are required to specifically consider the risk of corruption and misconduct by staff, and to report on risk reduction strategies in place within the agency. Within WA Health, the existence of an effective accountability mechanism is fundamental to good corporate governance. This year the Corporate Governance Directorate carried out a total of 121 investigations of alleged misconduct.

Strategies introduced in 2006-07 to assist in preventing corruption include:

- A Fraud and Corruption Control Plan was established to set an appropriate strategic framework that defines management and staff responsibilities and to ensure the implementation of robust practices for the effective detection, investigation and prevention of fraud and corruption of any description associated with WA Health.
- Approval was given for the establishment of a Fraud and Corruption Control Committee to consider system-wide initiatives, monitor and review fraud and corruption risk assessments, and monitor fraud prevention development. The committee has representatives from all areas of WA Health.
- The Corporate Governance Directorate commenced an education awareness program, with a number of presentations already having been made to the Department of Health, North Metropolitan Area Health Service, Child and Adolescent Health Service and WA Country Health Service. These will continue next year and include the South Metropolitan Area Health Service. Presentations were developed in consultation with appropriate external oversight agencies (e.g. The Corruption and Crime Commission [CCC] and the Office of Public Sector Standards Commissioner).

WA Country Health Service

Achieving best practice in the management of risk and preventing corruption where such circumstances can adversely affect the delivery of health care services and the welfare of clients, the public and staff is a priority for the WA Country Health Service. WACHS actively promotes employee responsibility for identifying, minimising and preventing risk and corruption.

WACHS has implemented processes to prevent corruption and comply with the relevant Treasury Instructions on Risk Management and Security, and the directions provided by the Government on "Fraud Prevention in the Western Australian Public Sector", the Financial Management Act, authority delegation schedules, the accounting standards, and for compliance with ACHS service accreditation requirements. Cases of alleged corruption have been investigated internally or referred for external assessment.

Training programs and briefing sessions offered by both the CCC and the Department's Corporate Governance Unit assist WACHS' workforce to comply with the corruption prevention procedures and the Codes of Conduct and Ethics. The duty to act ethically and to comply with all relevant codes governing employee behaviour including the Department's policy on the acceptable use of computers and the Internet, is encompassed in the position duty statements which employees must acknowledge during induction and staff development programs. WACHS maintains thorough records of alleged misconduct to identify particular risk areas and develop preventative strategies, and participates in internal corruption prevention audits.

Disability access and inclusion plan

The *Disabilities Services Act 1993,* amended in 2004, ensures that people with disabilities have the same opportunities as other West Australians, and the WA Country Health Service is committed to providing all people with access to facilities and services.

The Act requires public authorities to develop and implement a Disability Access and Inclusion Plan (DAIP) and undertake a continuous process of review to ensure the organisation meets the outcomes outlined in the Act.

The Area Health Service established the WACHS Disability Access and Inclusion Planning Committee in February 2006 comprising of regional and corporate office representatives to oversee the 2006-2009 WACHS wide DAIP. This DAIP is complimented by plans developed and implemented at the regional level.

Outcome 1: People with disability have the same opportunities as other people to access the services of, and events organised by, the relevant public authority.

- The WA Country Health Service continually reviews and amends its Area wide and regional DAIPs to ensure currency and that all implemented policies address disability and access issues.
- WACHS supports the contribution of people with disabilities to health service consumer forums, and ensures health service events are accessible to people with disabilities. The Disability Service Commission Accessible Events checklist has been incorporated into WACHS event organising guidelines and all WACHS sites provide opportunities for staff and others to submit service initiatives or highlight issues relating to service access for people with a disability.
- Appropriate patient transport services are made available to people with disabilities to attend appointments at health facilities.

Outcome 2: People with disabilities have the same opportunities as other people to access the buildings and other facilities of the relevant public authority.

- The WACHS conducts a continuous auditing process of services and facilities to ensure appropriate access for those with a disability and compliance with applicable Australian Standards and Guidelines.
- Planning for new facilities addresses access issues for people with a disability.
- Resources are allocated annually to upgrade facilities for items such as directional signage, handrails and railings, modifications to toilets and bathrooms, provision of hoists and lifts in vehicles where appropriate, access ramps and automatic doors, and ensuring parking capacity for people with a disability.

Outcome 3: People with disabilities receive information from the relevant public authority in a format that will enable them to access the information as readily as other people are able to access it.

- The WACHS provides information in appropriate formats suitable for people with disabilities in accordance with Department of Health access policies and guidelines.
- Information is provided verbally, in Braille and in electronic formats for sight, hearing and reading impaired people, and many information brochures are produced in large fonts with pictures and diagrams.
- The WACHS maintains networks with representative organisations to obtain expert advice and information regarding appropriate communication and information strategies to assist people with a disability.

Disability access and inclusion plan (continued)

Outcome 4: People with disabilities receive the same level and quality of service from the staff of the relevant public authority as other people receive from that authority.

- Training and staff development is provided to all staff to ensure they understand the needs of people with disabilities and are aware of current issues affecting access to services.
- The Area Health Service reviews levels of staff awareness in regard to disability service issues, and uses this information to structure training programs. Audits are conducted to ensure that training addresses disability access issues, and the introduction of the 'Patient First' program aims to ensure service provision is consistent across all clients.
- Selection criteria for staff positions require applicants to demonstrate awareness of current disability issues.

Outcome 5: People with disabilities have the same opportunities as other people to make complaints to the relevant public authority.

- WACHS has implemented appropriate grievance and complaint mechanisms that provide people with disabilities opportunities to raise issues and make formal complaints regarding access to health services or specific circumstances relating to the services they have received.
- Where appropriate, mechanisms are available to use advocates, make confidential complaints or make verbal representation when a written complaint is not possible.

Outcome 6: People with disabilities have the same opportunities as other people to participate in any public consultation by the relevant public authority.

- The WACHS' Disability Access Committees include community representatives who have a disability, and who can provide input on their behalf.
- Wherever possible, District Health Advisory Councils include members with disabilities to promote the interests and concerns of people with disabilities in service and facility planning.
- Specific interest groups also provide a mechanism for people with disabilities to pursue issues with the Area Health Service, and community consultative groups and networks ensure people with disabilities contribute to the decision-making process.

Employee profile

Agencies are required to report a summary of the number of employees by category, in comparison with the preceding financial year. The table below shows the average number of full-time equivalent staff employed by WACHS year-to-date June 2007 by category.

Table 20: Total FTE by Category

Category	Definition	2005-06	2006-07
Administration and clerical	Includes all clerical-based occupations – ward and clerical support staff, finance managers and officers.	1,064	1,049
Agency	Includes contract staff in occupational categories: administration and clerical, medical support, hotel and site services, medical.	11	21
Agency nursing	Includes nurses engaged on a "contract for service" basis.	68	80
Hotel services	Includes catering, cleaning, stores/supply laundry and transport occupations.	1,215	1,234
Medical	Includes salary and sessional based medical occupations.	178	180
Medical support	Includes all Allied Health and scientific/technical related occupations.	549	554
Nursing	Includes all nursing occupations. Does not include agency nurses.	2,308	2,310
Site services	Includes engineering, garden and security-based occupations.	179	178
Other categories	Includes Aboriginal and ethnic health worker related occupations.	91	75
Total		**5,663**	**5,681**

Equity and diversity

The State Government is committed to developing an equitable and diverse public sector workforce which is representative of the Western Australian community at all levels of employment, and enables employees to combine work and family responsibilities. In 2006 the Government revised its "Equity and Diversity Plan for the Public Sector Workforce" with the release of a Plan for the period 2006-09. This plan reinforces the link between employment equity and diversity, better planning and improved service delivery.

The Department of Health has also released a complimentary WA Health Plan 2007-09 providing a strategic framework for equity and diversity outcomes specific to the public health sector. The Health Plan aligns with WA Health's Strategic and Operational plans and provides targets for workforce participation and distribution objectives.

Please see Appendix 1 of the Department of Health 2006-07 Annual Report for the Equity and Diversity - Workforce Participation and Workforce Distribution achievements in 2006-07.

WA Country Health Service

The WA Country Health Service provides a variety of services and in order to be responsive to the diverse needs of the community has adopted goals and objectives to address these needs, at the same time complying with Government policy as described in the "Plan", and in the Department's Equity and Diversity Plan 2007-09. WACHS also ensures its operations are in accordance with the legislative requirements of the *Equal Opportunity Act 1984.*

Equity and diversity (continued)

Equal Employment Opportunity

The Area Health Service has adopted workplace practices to prevent discrimination in relation to gender, marital status, pregnancy, family status, race, age, or religion or political conviction, and promotes equal opportunity and diversity in the workplace recognising the contribution that indigenous Australians, people with disabilities, people from culturally diverse backgrounds, youth and women make to the service delivery operations of the Area Health Service. Procedures have been adopted to address events of discrimination or harassment, and policy and practice manuals are readily available to all staff. WACHS regions have appointed Equal Opportunity Contact Officers with other nominated staff for regional sites where appropriate.

Recruitment and selection training and induction and orientation programs provide information on equal opportunity and discrimination legislation including the Codes of Conduct and Ethics, the WACHS organisational culture, and the processes for complaints and redress. Resources are available either in hardcopy or electronic formats. WACHS job description forms (JDF) are reviewed to ensure selection criteria remain current to Equal Employment Opportunity (EEO) requirements and position application and orientation packages contain information pertaining to employee obligations under EEO. During 2006-07 JDFs were updated to reflect the Aboriginal Workforce and Cultural Respect Framework.

Equal employment and staffing profiles as well as complaint and issue data is collected from across the Area Health Service to inform management on the diversity of the WACHS workforce and any pertinent issues that may arise.

Family friendly initiatives and work-life balance

The WA Health Work Life Balance Policy came into effect in November 2006, promoting flexible and responsive work practices. In support of the Policy, three initiatives were launched:

- Training for Managers in Creating Flexible Workplaces for WA Health
- 101 Strategies for Achieving Work Life Balance
- WA Health Child Care Program

WACHS remains committed to creating appropriate Work Life Balance (WLB) for its employees. Consistent with the Department's approach, information on flexible work arrangements currently available was distributed to all employees and further information provided to managers on essential management actions for creating WLB. WLB was identified as a key workforce issue in the employee survey in 2006 and forms part of the WACHS' operational plan for 2007-08.

Industrial relations

The Department of Health Industrial Relations Service provides advisory, representation and consultancy services on significant human resource management and industrial relations issues effecting Area Health Services. A key activity for 2006-07 included the conduct of Industrial Agreement negotiations for all categories of health employees.

During the reporting period, replacement Industrial Agreements were also settled for engineering and building trades employees, health professional, administrative, technical and clerical staff, and as at the end of June negotiations for doctors, nurses and support workers employment agreements were ongoing.

WA Country Health Service

The WACHS ensures its industrial relations policies and practices comply with all relevant State and Commonwealth industrial relations legislation, awards, and industrial and certified employment agreements. The Area Health Service has adopted proactive cooperation and consultation processes with its employees and any relevant representative industrial body.

The WACHS experienced no significant industrial disputation during 2006-07.

Internal audit controls

Department of Health

The Corporate Governance Directorate (Internal Audit) has the role of accountability adviser and independent appraiser, reporting directly to the Director General for Health. Audits undertaken were generally planned audits, however on occasion, management initiated audits or Corporate Governance Directorate initiated audits were also carried out. Audits were of a compliance, performance or information system nature. The audits were conducted to assist senior management in achieving sound managerial control. External consultants were utilised to complete some audits.

WA Health has an overarching Audit Committee that considers matters of strategic importance and system-wide issues. This committee is informed by a number of sub-committees, which consider operational issues as they relate to specific areas. Sub-committees have been established for the North Metropolitan Area Health Service (including the Child and Adolescent Health Service), the South Metropolitan Area Health Service, the WA Country Health Service, the Department of Health and Health Corporate Network.

Fifty audits were completed during 2006-07, including clinical governance, control review, Annual Report preparation and PATS processing for the WA Country Health Service.

Please see the Department of Health 2006-07 Annual Report for the full list of audits.

WA Country Health Service

The WACHS has adopted sound procedures and internal controls designed to provide reasonable assurance in regard to achieving the Area Health Service's objectives, in particular those related to:

- effectiveness and efficiency of operations;
- reliability of financial and operations reporting;
- compliance with applicable legal requirements and community expectations;
- stewardship of public resources; and
- minimisation of exposure to adverse events.

To enhance corporate governance within the Area Health Service, the WACHS Audit Committee has recognised the need for formal processes to be implemented to ensure that administrative functions performed by all departments are being properly controlled. To this end the WACHS Operational Plan includes a performance measure that states 100% of all 'Extreme' and 'High' risk rated Internal Audit Committee recommendations are implemented within the agreed timeframe.

Major capital works

Please refer to the 2006-07 Department of Health Annual Report for financial details of major capital works in the WA Country Health Service.

Capital works projects completed in the WACHS during 2006-07	Capital works projects in progress in the WACHS during 2006-07
Albany Regional Resource Centre – refurbishment / expansion of rehabilitation day centre.	Denmark Multi Purpose Centre
Port Hedland Residential Aged Care Facility	Broome Regional Resource Centre - Stage 1.
Moora Multi Purpose Centre	Fitzroy Crossing Multi Purpose Centre
Harvey Hospital – procedure room refurbishment	Kununurra Ward Expansion, Dental Clinic and Support Services
Margaret River Hospital Upgrade	Morawa and Perenjori Multi Purpose Centre
Derby Acute Inpatient Ward and Ambulatory Care Centre	Carnarvon Redevelopment Stage 1
	Port Hedland Regional Resource Centre Stage 2
	South West Health Campus Bunbury – Inpatient mental health expansion, new mental health clinic, new dental clinic.
	Busselton hospital redevelopment
	Kalgoorlie Regional Resource Centre redevelopment

Pricing policy

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

Health Finance sets a schedule of fees each year to cover patients from whom fees apply.

These fees are incorporated into the *Hospital (Service Charges) Regulations 1984* and the *Hospital (Service Charges for Compensable Patients) Determination 2002*.

Dental Health Services utilises fees based on the Australian Government Department of Veterans' Affairs Schedule of fees, with patients charged:

- 50% of the treatment fee if holder of a Health Care Card or Pensioner Concession Card
- 25% of the treatment fee if holder of a pension or an allowance issued by Centrelink or the Department of Veterans' Affairs.

Recordkeeping

Department of Health

During 2006-07 the State Records Commission approved the Department's Retention and Disposal Authority following clearance of a revised Recordkeeping Plan.

The Department of Health and the Area Health Services have developed additional policies to support appropriate recordkeeping practices including the long-term management of electronic records and the management of non-patient records.

WA Country Health Service

WACHS has implemented recordkeeping policies and plans in accordance with Statutory requirements and the Department's Recordkeeping Plan, and Retention and Disposal Authority. Throughout the year, WACHS operational units monitor record handling practice and procedures to ensure compliance with the endorsed statutory requirements and the policies and plans, and to promote standardisation across the Area Health Service.

New WACHS employees are informed of their obligations under the *State Records Act 2000,* and advised regarding the Public Sector recordkeeping policies and procedures, and the Department of Health's Retention and Disposal Authorities and Recordkeeping Plan during their orientation and induction programs. Information regarding the Department's records management and statutory obligations is also maintained via the WA Health intranet.

Training programs are provided to existing staff to ensure records management practices meet current statutory and 'Plan' requirements. The WACHS conducts regular audits of recordkeeping procedures to identify issues and improve practices.

Specific records management activities during 2006-07 have included:

- the ongoing introduction of TOPAS numbering
- audits of the National Inpatient Medical Chart and patient medical records;
- the WACHS Health Information Managers' Network continues to meet regularly to review all facets of records management especially data collection, and records storage and archiving policies and practices;
- A number of sites have undertaken projects to improve the physical and operational aspects of local records management and storage.

Recruitment

Recruitment practice

All WACHS recruitment and selection processes are undertaken in accordance with the criteria set down in the "Public Sector Standards in Human Resource Management".

A WACHS-wide policy for the recruitment, selection and appointment of staff is applied consistently across the Area Health Service and is updated annually to ensure government and departmental guidelines are followed. Policies are available at all WACHS sites and are accessible via the WACHS Intranet site.

Positions are offered for permanent and contract appointment, and where appropriate, via temporary placement on expressions of interest.

Training to ensure potential selection panel convenors and members have the necessary selection skills and an understanding of Public Sector Standards, is provided regularly and selection panels must have at least one member who has attended the appropriate training. Appointments are based on the proper assessment of merit and equity. There is full disclosure of the provisions and entitlements applicable to legislation, awards and employment agreements.

The Health Corporate Network coordinates the recruitment process on behalf of the WACHS. Vacancies are advertised in both print and electronic media especially specific sites such as 'SEEK', 'Nursing Jobs' and 'NursingNetUK'. Recruitment campaigns have been conducted in local and national newspapers and radio, internationally especially for medical officers and nursing staff, at career expos, via promotions in educational institution handbooks, and through the participation in graduate programs. The WA Country Health Service also continued its participation in 2006 in the annual Royal College of Nursing Australia Nursing Expo.

Recruitment initiatives

The recruitment of clinical staff, particularly general nurses, medical officers, mental health clinicians and clinical nurses, registered midwives, and allied health professionals continued to be the focus of WACHS recruitment initiatives in 2006-07.

Specifically, WACHS was successful in recruiting additional psychiatric, general and specialist medical officers for numerous locations across the Area Health Service.

WACHS continues to enhance its attraction and retention packages especially in the area of accommodation to improve the success of their recruitment drives where a number of accommodation acquisitions were undertaken during the year, and has used effectively the regional rotation and migration programs such as the 'Kimberley Rotation' and the expansion of the 'Ocean to Outback' programs as well as temporary overseas sponsorship programs to augment staff recruitment.

Staff development

The quality, skill and adaptability of the WACHS workforce is pivotal to the delivery of quality health services and the achievement of the organisation's strategic objectives. WACHS is committed to maintaining an environment that encourages staff to seek opportunities for personal and professional growth and development.

The "Workforce Learning and Development Policy and Guidelines" adopted by WACHS and the implementation of the WACHS Regional Learning and Development Network supports the professional advancement and personal development of staff throughout the organisation, and enhances the promotion and utilisation of their existing skills and knowledge. Regional sites have implemented complimentary workforce programs to address local workforce issues, for example, the "Wheatbelt Workforce Development Program" with its "Workforce Development Reference Group", and the "Learning Opportunities and Outcomes Program" (LOOP) in the South West.

Employees are able to access training and development to meet service competency requirements, career development objectives, and strategic and operational goals. Compliance with employment awards and conditions, public sector standards, legislative and corporate governance requirements is also assessed. Training is addressed in line with equity principles and quality standards, and preference is given to local training providers. Self directed and on-line learning options are also supported.

The provision of quality staff training and development opportunities is reflected in staff satisfaction, peer networking and communication, and the achievement of health care objectives. WACHS provides a number of mechanisms to assist staff in career and personal development including study leave, financial support for approved development programs, supported placement in approved courses, graduate and undergraduate training programs, and peer support and mentoring programs.

WACHS continues to develop telehealth video conferencing for staff development and training programs and has a number of staff participating in the "*Leading 100*" program. WACHS extensively uses its Intranet site to provide access to on-line training resources and advice.

Local information packages for new employees are provided where appropriate. For example, in the Kimberley employees receive an induction booklet on generic North West employment conditions, local services and facilities, remote area travel, and tropical weather conditions.

2006-07 workforce learning programs

WACHS provides mandatory staff induction or orientation programs which feature topics such as fire and emergency procedures, occupational safety and health, infection control (if appropriate), risk management, Public Sector Standards and Codes of Ethics and Conduct, manual handling, workplace behaviour and bullying, and information technology familiarisation and Telehealth.

Established training opportunities also continued in 2006-07 and included:

- first aid and emergency medical training
- performance management
- team building, leadership and management
- aged care
- clinical learning and development in:
  - paediatrics
  - mental health
  - burn emergency care and management
  - advanced life support
  - post-natal depression
  - triage practice
  - transfusion management
  - remote area nursing
  - diabetes management.

Substantive equality

Please see the Department of Health Annual Report 2006-07.

Sustainability

Please see the Department of Health Annual Report 2006-07.

Workers' compensation and rehabilitation

The following table provides information on the number of worker's compensation claims made during 2006-07 within the WA Country Health Service.

Table 21: Workers' Compensation and Rehabilitation

WACHS	Medical	Nursing Services	Admin and Clerical	Medical Support	Hotel Services	Maintenance	Other
Goldfields	0	6	1	0	9	0	2
Great Southern	0	15	3	6	11	2	2
Kimberley	0	10	1	0	6	4	1
Midwest	0	14	5	0	12	4	9
South West	1	48	2	7	23	3	10
Pilbara	3	13	2	0	14	3	1
Wheatbelt	0	15	6	2	25	9	4
Area Office	0	0	1	0	0	0	0
Total	**4**	**121**	**21**	**15**	**100**	**25**	**29**

Note - Categories include the following:

- Administration and Clerical – health project officers, ward clerks, receptionists and clerical staff
- Medical Support – physiotherapists, speech pathologists, medical imaging technologists, pharmacists, occupational therapists, dieticians and social workers
- Hotel Services – cleaners, caterers and patient service assistants
- Medical – salaried officers
- Other – includes site services, OSH and technical support staff.

Occupational Safety and Health Initiatives

The WA Country Health Service has adopted a Safety Management System based on the 'WorkSafe Plan' and "WA Occupational Safety and Health Act 1984". This system allows all aspects of Occupational Safety and Health (OS&H) to be integrated in the day-to-day practices of all managers and employees within the organisation. During 2006-07 WACHS continued developing its OS&H policies and strategies, quality assurance and risk monitoring, and reporting programs. WACHS ensures there is a consistent approach to OS&H and employee rehabilitation across the Area Health Service.

The main elements of the WACHS Safety Management System are:

- Management commitment recognising managers and supervisors responsibilities in managing the Occupational Safety and Health duty of care provisions of the Act;
- Planning for safety and health allowing for the OS&H requirements and responsibilities to be integrated on an area and regional level;
- Hazard Management for WACHS to adopt standard practises and procedures to reporting, assessing;

Workers' compensation and rehabilitation (continued)

- controlling and evaluating the hazards in the workplace;
- Consultation and cooperation building on the structures for employees and management to discuss issues in relation to OS&H through elected representatives and the safety committee; and
- Safety and health training providing compulsory training according to risk assessment for all staff, specifically safety representative and managers and supervisors.

The WACHS OS&H Program Manager and the appointed regional OS&H coordinators form the WACHS OS&H Reference Group providing regular performance data on OS&H and injury management, to both Regional and Area executives. Regional OS&H coordinators are also responsible for informing management on workplace occupational safety and health matters, and for OS&H audits. Coordinators provide advice on specific training initiatives for WACHS staff including facilitating off-road driving and general vehicle maintenance courses applicable to conditions in remote areas providing instructions to prepare for cyclones, developing guidelines for hazard inspections and fire / evacuation drills, and initiating ergonomic assessments when necessary.

Occupational Injury Prevention and Rehabilitation

The WACHS Workers Compensation and Injury Management system provides timely and effective intervention for WACHS employees that have injured themselves at work or those employees who have injuries that may affect their ability to undertake their duties. WACHS' regional worker's compensation staff ensure that injured employees receive their entitlements and can access 'best practice' injury management interventions and rehabilitation programs including structured 'return to work' programs providing light or restricted duties for those employees with injuries. These programs are developed in conjunction with the employee, their doctor and medical providers, their work supervisor and the OS&H coordinator.

The WACHS uses a combination of internal and external rehabilitation program providers and all staff involved in rehabilitation programs participate in injury management training and are provided with appropriate instruction to undertake their responsibilities. The WACHS also has implemented OS&H databases and hazard registers providing incident information and the capacity for pro-active hazard reporting and investigation. "Root Cause Analysis" methodology for investigating clinical incidents has been adopted to ensure comprehensive investigation of occupational injuries.

Financial Statements Certification Statement

WA Country Health Service

Certification of financial statements
For the year ended 30 June 2007

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 present fairly the financial transactions for the financial year ending 30 June 2007 and the financial position as at 30 June 2007.

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

J.W. Leaf

John Leaf
Chief Finance Officer
WA Country Health Service

Date: 13 September 2007

Dr Neale Fong
Accountable Authority
WA Country Health Service

Date: 13 September 2007

Financial Statements Audit Opinion

AUDITOR **GENERAL**

INDEPENDENT AUDIT OPINION

To the Parliament of Western Australia

WA COUNTRY HEALTH SERVICE
FINANCIAL STATEMENTS AND KEY PERFORMANCE INDICATORS
FOR THE YEAR ENDED 30 JUNE 2007

I have audited the accounts, financial statements, controls and key performance indicators of the WA Country Health Service.

The financial statements comprise the Balance Sheet as at 30 June 2007, and the Income Statement, Statement of Changes in Equity and Cash Flow Statement of WA Country Health Service for the year then ended, a summary of significant accounting policies and other explanatory Notes.

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

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

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

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

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

WA Country Health Service
Financial Statements and Key Performance Indicators for the year ended 30 June 2007

Audit Opinion
In my opinion,

(i) the financial statements are based on proper accounts and present fairly the financial position of the WA Country Health Service at 30 June 2007 and its financial performance and cash flows for the year ended on that date. They are in accordance with Australian Accounting Standards (including the Australian Accounting Interpretations) and the Treasurer's Instructions;

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

(iii) the key performance indicators of the Health Service are relevant and appropriate to help users assess the Health Service's performance and fairly represent the indicated performance for the year ended 30 June 2007.

COLIN MURPHY
AUDITOR GENERAL
25 September 2007

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Financial Statements

WA Country Health Service

Income Statement

For the year ended 30 June 2007

	Note	2007 $000
COST OF SERVICES		
Expenses		
Employee benefits expense	8	418,275
Fees for visiting medical practitioners		44,087
Patient support costs	9	95,445
Finance costs	10	1,757
Depreciation and amortisation expense	11	29,791
Asset impairment losses		374
Capital user charge	12	52,625
Loss on disposal of non-current assets	13	307
Other expenses	14	80,074
Total cost of services		722,735
INCOME		
Revenue		
Patient charges	15	25,111
Commonwealth grants and contributions	16a	15,396
Other grants and contributions	16b	7,434
Donations revenue	17	1,072
Interest revenue		129
Other revenues	18	15,276
Total revenue		64,418
Total income other than income from State Government		64,418
NET COST OF SERVICES		658,317
INCOME FROM STATE GOVERNMENT		
Service appropriations	19	660,595
Assets assumed / (transferred)	20	20
Liabilities assumed by the Treasurer	21	854
Total income from State Government		661,469
SURPLUS/(DEFICIT) FOR THE PERIOD		3,152

The Income Statement should be read in conjunction with the notes to the financial statements.

WA Country Health Service

Balance Sheet
As at 30 June 2007

	Note	2007 $000
ASSETS		
Current Assets		
Cash and cash equivalents	22	17,885
Restricted cash and cash equivalents	23	442
Receivables	24	13,343
Amounts receivable for services	25	8,386
Inventories	26	3,581
Other current assets	27	844
Total Current Assets		44,481
Non-Current Assets		
Amounts receivable for services	25	87,945
Property, plant and equipment	28	793,233
Intangible assets	30	103
Other financial assets	31	6
Total Non-Current Assets		881,287
Total Assets		**925,768**
LIABILITIES		
Current Liabilities		
Payables	32	31,361
Borrowings	33	1,547
Provisions	34	60,711
Other current liabilities	35	9,664
Total Current Liabilities		103,283
Non-Current Liabilities		
Borrowings	33	26,537
Provisions	34	11,773
Total Non-Current Liabilities		38,310
Total Liabilities		**141,593**
NET ASSETS		**784,175**
EQUITY		
Contributed equity	36	781,023
Accumulated surplus/(deficiency)	37	3,152
TOTAL EQUITY		**784,175**

The Balance Sheet should be read in conjunction with the notes to the financial statements.

WA Country Health Service

Statement of Changes in Equity

For the year ended 30 June 2007

	Note	2007 $000
Balance of equity at start of period		-
CONTRIBUTED EQUITY	36	
Balance at start of period		-
Capital contribution		58,904
Other contributions by owners		722,119
Balance at end of period		**781,023**
ACCUMULATED SURPLUS	37	
Balance at start of period		-
Surplus/(deficit) for the period		3,152
Balance at end of period		**3,152**
Balance of equity at end of period		**784,175**
Total income and expense for the period (a)		3,152

(a) The aggregate net amount attributable to each category of equity is: surplus $3,152,203.

The Statement of Changes in Equity should be read in conjunction with the notes to the financial statements.

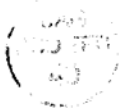
WA Country Health Service

Cash Flow Statement

For the year ended 30 June 2007

	Note	2007 $000 Inflows (Outflows)
CASH FLOWS FROM STATE GOVERNMENT		
Service appropriations		573,832
Capital contributions		50,417
Net cash provided by State Government	38(c)	624,249
Utilised as follows:		
CASH FLOWS FROM OPERATING ACTIVITIES		
Payments		
Supplies and services		(215,255)
Employee benefits		(413,561)
Finance costs		(12)
GST payments on purchases		(23,460)
Receipts		
Receipts from customers		23,897
Commonwealth grants and contributions		15,396
Other grants and subsidies		6,391
Donations		895
Interest received		129
GST receipts on sales		2,520
GST refunds from taxation authority		18,389
Other receipts		14,065
Net cash (used in) / provided by operating activities	38(b)	(570,606)
CASH FLOWS FROM INVESTING ACTIVITIES		
Payments for purchase of non-current physical assets		(54,160)
Proceeds from sale of non-current physical assets	13	45
Net cash (used in) / provided by investing activities		(54,115)
Net increase / (decrease) in cash and cash equivalents		(473)
Cash and cash equivalents at the beginning of period		18,800
CASH AND CASH EQUIVALENTS AT THE END OF PERIOD	38(a)	18,327

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



WA Country Health Service

Notes to the Financial Statements
For the year ended 30 June 2007

Note 1 Australian equivalents to International Financial Reporting Standards

General

The WA Country Health Service's financial statements for the year ended 30 June 2007 have been prepared in accordance with Australian equivalents to International Financial Reporting Standards (AIFRS), which comprise a Framework for the Preparation and Presentation of Financial Statements (the Framework) and Australian Accounting Standards (including the Australian Accounting Interpretations).

In preparing these financial statements the WA Country Health Service has adopted, where relevant to its operations, new and revised Standards and Interpretations from their operative dates as issued by the Australian Accounting Standards Board (AASB) and formerly the Urgent Issues Group (UIG).

Early adoption of standards

The WA Country Health Service cannot early adopt an Australian Accounting Standard or Australian Accounting Interpretation unless specifically permitted by Treasurer's Instruction 1101 'Application of Australian Accounting Standards and Other Pronouncements'. No Standards and Interpretations that have been issued or amended but are not yet effective have been early adopted by the WA Country Health Service for the annual reporting period ended 30 June 2007.

Note 2 Summary of significant accounting policies

(a) General Statement

The financial statements constitute a general purpose financial report which has been prepared in accordance with the Australian Accounting Standards, the Framework, Statements of Accounting Concepts and other authoritative pronouncements of the Australian Accounting Standards Board as applied by the Treasurer's instructions. Several of these are modified by the Treasurer's instructions to vary application, disclosure, format and wording.

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

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

(b) Basis of Preparation

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

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

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

The judgements that have been made in the process of applying the WA Country Health Service's accounting policies that have the most significant effect on the amounts recognised in the financial statements are disclosed at note 3 'Judgements made by management in applying accounting policies'.

The key assumptions made concerning the future, and other key sources of estimation uncertainty at the balance sheet date that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are disclosed at note 4 'Key sources of estimation uncertainty'.

(c) Contributed Equity

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

Transfer of net assets to/from other agencies are designated as contributions by owners where the transfers are non-discretionary and non-reciprocal. (See note 36 'Contributed Equity')

Notes to the Financial Statements
For the year ended 30 June 2007

(d) Income

Revenue recognition

Revenue is measured at the fair value of consideration received or receivable. Revenue is recognised as follows:

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

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

Interest
Revenue is recognised as the interest accrues. The effective interest method, which is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset to the net carrying amount of the financial asset, is used where applicable.

Service Appropriations
Service Appropriations are recognised as revenues at nominal value in the period in which the WA Country Health Service gains control of the appropriated funds. The WA Country Health Service gains control of appropriated funds at the time those funds are deposited to the bank account or credited to the holding account held at Treasury. (See note 19 'Service Appropriations')

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

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

Where contributions recognised as revenues during the reporting period were obtained on the condition that they be expended in a particular manner or used over a particular period, and those conditions were undischarged as at the balance sheet date, the nature of, and amounts pertaining to, those undischarged conditions are disclosed in the notes.

Gains

Gains may be realised or unrealised and are usually recognised on a net basis. These include gains arising on the disposal of non-current assets and some revaluations of non-current assets.

(e) Property, Plant and Equipment

Capitalisation/Expensing of assets
Items of property, plant and equipment costing $1,000 or more are recognised as assets and the cost of utilising assets is expensed (depreciated) over their useful lives. Items of property, plant and equipment costing less than $1,000 are immediately expensed direct to the Income Statement (other than where they form part of a group of similar items which are significant in total).

Initial recognition and measurement
All items of property, plant and equipment are initially recognised at cost.

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

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

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

Where market-based evidence is not available, the fair value of land and buildings is determined on the basis of existing use. This normally applies where buildings are specialised or where land use is restricted. Fair value for existing use assets is determined by reference to the cost of replacing the remaining future economic benefits embodied in the asset, ie. the depreciated replacement cost.

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

Notes to the Financial Statements
For the year ended 30 June 2007

Independent valuations of land and buildings are provided annually by the Western Australian Land Information Authority (Valuation Services) and recognised with sufficient regularity to ensure that the carrying amount does not differ materially from the asset's fair value at the balance sheet date.

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

Valuation of land and buildings
The revaluations of land and buildings have been undertaken on the following bases:

Land (clinical site)	Market value for existing use
Land (non-clinical site)	Current market buying values
Buildings (clinical)	Market value for existing use
Buildings (non-clinical)	Current market buying values

Refer to note 28 'Property, plant and equipment' for further information on revaluations.

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

Land is not depreciated. Depreciation on other assets are calculated using the reducing balance method, using rates which are reviewed annually. Expected useful lives for each class of depreciable asset are:

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

Works of art controlled by the WA Country Health Service are classified as property, plant and equipment, which are anticipated to have very long and indefinite useful lives. Their service potential has not, in any material sense, been consumed during the reporting period and so no depreciation has been recognised.

(f) Intangible Assets

Capitalisation/Expensing of assets
Acquisitions of intangible assets costing $1,000 or more and internally generated intangible assets costing $1,000 or more are capitalised. The cost of utilising the assets is expensed (amortised) over their useful life. Costs incurred below these thresholds are immediately expensed directly to the Income Statement.

All acquired and internally developed intangible assets are initially recognised at cost. For assets acquired at no cost or for nominal cost, the cost is their fair value at the date of acquisition.

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

Amortisation for intangible assets with finite useful lives is calculated for the period of the expected benefit (estimated useful life) on the reducing balance basis using rates which are reviewed annually. All intangible assets controlled by the WA Country Health Service have a finite useful life and zero residual value. The expected useful lives for each class of intangible asset are:

Computer Software	5 years

Software that is an integral part of the related hardware is treated as property, plant and equipment. Software that is not an integral part of the related hardware is treated as an intangible asset.

(g) Impairment of Assets

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

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

Notes to the Financial Statements
For the year ended 30 June 2007

Intangible assets with an indefinite useful life and intangible assets not yet available for use are tested for impairment at each balance sheet date irrespective of whether there is any indication of impairment.

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

Refer note 29 'Impairment of assets' for the outcome of impairment reviews and testing.

Refer also to note 2(o) 'Receivables' and note 24 'Receivables' for impairment of receivables.

(h) Non-current Assets Classified as Held for Sale

Non-current assets held for sale are recognised at the lower of carrying amount and fair value less costs to sell and are presented separately from other assets in the Balance Sheet. Assets classified as held for sale are not depreciated or amortised.

(i) Leases

Leases of property, plant and equipment, where the WA Country Health Service has substantially all of the risks and rewards of ownership, are classified as finance leases.

Finance lease rights and obligations are initially recognised, at the commencement of the lease term, as assets and liabilities equal in amount to the fair value of the leased item or, if lower, the present value of the minimum lease payments, determined at the inception of the lease. The assets are disclosed as leased assets, and are depreciated over the period during which the WA Country Health Service is expected to benefit from their use. Minimum lease payments are apportioned between the finance charge and the reduction of the outstanding lease liability, according to the interest rate implicit in the lease.

Leases in which the lessor retains significantly all of the risks and rewards of ownership are classified as operating leases. Operating lease payments are expensed on a straight line basis over the lease term as this represents the pattern of benefits derived from the leased items.

(j) Financial Instruments

The WA Country Health Service has two categories of financial instruments:
- Loans and receivables (cash and cash equivalents, receivables); and
- Non trading financial liabilities (finance leases, payables).

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

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

(k) Cash and Cash Equivalents

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

(l) Accrued Salaries

Accrued salaries (refer note 35) represent the amount due to employees but unpaid at the end of the financial year, as the pay date for the last pay period for that financial year does not coincide with the end of the financial year. Accrued salaries are settled within a fortnight of the financial year end. The WA Country Health Service considers the carrying amount of accrued salaries to be equivalent to its net fair value.

(m) Amounts Receivable for Services (Holding Account)

The WA Country Health Service receives funding on an accrual basis that recognises the full annual cash and non-cash cost of services. The appropriations are paid partly in cash and partly as an asset (Holding Account receivable) that is accessible on the emergence of the cash funding requirement to cover items such as leave entitlements and asset replacement.

See also note 19 'Service appropriations' and note 25 'Amounts receivable for services'.

Notes to the Financial Statements
For the year ended 30 June 2007

(n) Inventories

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

Inventories not held for resale are valued at cost unless they are no longer required in which case they are valued at net realisable value. (See Note 26 ' Inventories')

(o) Receivables

Receivables are recognised and carried at original invoice amount less an allowance for any uncollectible amounts (i.e. impairment). The collectability of receivables is reviewed on an ongoing basis and any receivables identified as uncollectible are written-off. The allowance for uncollectible amounts (doubtful debts) is raised when there is objective evidence that the WA Country Health Service will not be able to collect the debts.

The carrying amount is equivalent to fair value as it is due for settlement within 30 days from the date of recognition. (See note 2(j) 'Financial instruments' and note 24 'Receivables')

Change to accounting procedure for GST
Rights to collect amounts receivable from the Australian Taxation Office and responsibilities to make payment for GST were assigned on the 1 January 2006 to the Minister for Health in his Capacity as the Deemed Board of the Metropolitan Public Hospitals. This change in accounting procedure was a result of application of the grouping provisions of "A New Tax System (Goods and Service Tax) Act 1999" whereby the Minister for Health in his Capacity as the Deemed Board of the Metropolitan Public Hospitals became the representative member for Health entities as part of governments' shared services initiative.

(p) Payables

Payables are recognised at the amounts payable when the 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 they are generally settled within 30 days. See note 2(j) 'Financial instruments and note 32 'Payables'.

(q) Borrowings

All loans are initially recognised at cost being the fair value of the net proceeds received. Subsequent measurement is at amortised cost using the effective interest rate method. (See note 2(j) 'Financial instruments' and note 33 'Borrowings')

(r) Borrowing Costs

Borrowing costs are recognised as an expense in the period in which they are incurred.

(s) Provisions

Provisions are liabilities of uncertain timing or amount and are recognised where there is a present legal or constructive obligation as a result of a past event and when the outflow of resources embodying economic benefits is probable and a reliable estimate can be made of the amount of the obligation. Provisions are reviewed at each balance sheet date. See note 34 'Provisions'.

Provisions - Employee Benefits

Annual Leave and Long Service Leave
The liability for annual and long service leave expected to be settled within 12 months after the end of the balance sheet date is recognised and measured at the undiscounted amounts expected to be paid when the liabilities are settled. Annual and long service leave expected to be settled more than 12 months after the end of the balance sheet date is measured at the present value of amounts expected to be paid when the liabilities are settled. Leave liabilities are in respect of services provided by employees up to the balance sheet date.

When assessing expected future payments consideration is given to expected future wage and salary levels including non-salary components such as employer superannuation contributions. In addition, the long service leave liability also considers the experience of employee departures and periods of service.

The expected future payments are discounted using market yields at the balance sheet date on national government bonds with terms to maturity that match, as closely as possible, the estimated future cash outflows.

All annual leave and unconditional long service leave provisions are classified as current liabilities as the WA Country Health Service does not have an unconditional right to defer settlement of the liability for at least 12 months after the balance sheet date.

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

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

Superannuation
The Government Employees Superannuation Board (GESB) administers the following superannuation schemes.

Employees may contribute to the Pension Scheme, a defined benefit pension scheme now closed to new members or the Gold State Superannuation Scheme (GSS), a defined benefit lump sum scheme also closed to new members.

The WA Country Health Service has no liabilities under the Pension or the GSS Schemes. The liabilities for the unfunded Pension Scheme and the unfunded GSS Scheme transfer benefits due to members who transferred from the Pension Scheme, are assumed by the Treasurer. All other GSS Scheme obligations are funded by concurrent contributions made by the WA Country Health Service to the GESB. The concurrently funded part of the GSS Scheme is a defined contribution scheme as these contributions extinguish all liabilities in respect of the concurrently funded GSS Scheme obligations.

Employees commencing employment prior to 16 April 2007 who are not members of either the Pension or the GSS Schemes became non-contributory members of the West State Superannuation Scheme (WSS). Employees commencing employment on or after 16 April 2007 became members of the GESB Super Scheme (GESBS). Both of these schemes are accumulation schemes. The WA Country Health Service makes concurrent contributions to GESB on behalf of employees in compliance with the Commonwealth Government's Superannuation Guarantee (Administration) Act 1992. These contributions extinguish the liability for superannuation charges in respect of the WSS and GESBS Schemes.

The GESB makes all benefit payments in respect of the Pension and GSS Schemes, and is recouped by the Treasurer for the employer's share .

(See also note 2 (t) 'Superannuation expense')

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

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

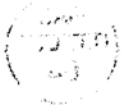
Gratuities
The WA Country Health Service is obliged to pay the medical practitioners and nurses for gratuities under Medical Practitioners (WA Country Health Service – North West) AMA Industrial Agreement and the Nurses (WA Government Health Services) Agreement 2001. These groups of employees are entitled to a gratuity payment for each completed year of continuous service in specified regions in Western Australia.

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

Provisions - Other

Employment on-costs

Employment on-costs, including workers' compensation insurance, are not employee benefits and are recognised separately as liabilities and expenses when the employment to which they relate has occurred. Employment oncosts are included as part of 'Other expenses' and are not included as part of the WA Country Health Service's 'Employee benefits expense'. Any related liability is included in 'Employment on-costs provision'. (See note 14 'Other expenses' and note 34 'Provisions'.)



Notes to the Financial Statements
For the year ended 30 June 2007

(t) Superannuation Expense

The following elements are included in calculating the superannuation expense in the Income Statement:

(a) Defined benefit plans - Change in the unfunded employer's liability (i.e. current service cost and, actuarial gains and losses) assumed by the Treasurer in respect of current employees who are members of the Pension Scheme and current employees who accrued a benefit on transfer from that Scheme to the Gold State Superannuation Scheme (GSS); and

(b) Defined contribution plans - Employer contributions paid to the GSS, the West State Superannuation Scheme (WSS), and the GESB Super Scheme (GESBS).

Defined benefit plans - in order to reflect the true cost of services, the movements (i.e. current service cost and, actuarial gains and losses) in the liabilities in respect of the Pension Scheme and the GSS transfer benefits are recognised as expenses. As these liabilities are assumed by the Treasurer (refer note 2(s), a revenue titled 'Liabilities assumed by the Treasurer' equivalent to the expense is recognised under Income from State Government in the Income Statement. (See note 21 'Liabilities assumed by the Treasurer')

The superannuation expense does not include payment of pensions to retirees, as this does not constitute part of the cost of services provided in the current year.

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

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

Resources received free of charge or for nominal cost that can be reliably measured are recognised as income and as assets or expenses as appropriate, at fair value.

(v) Comparative Figures

The WA Country Health Service commenced operations on the 1st July 2006. As this is the first year of operations, no comparative information is provided.

Government Gazette No 44 dated 27th June 2006 notified that the boards of WA Country Health and South West Health Board were to be reorganised on the 1st July 2006 by amalgamating them to form a new board assigned the name "WA Country Health Service". Under the directives of the Hospital and Health Services (Directions for Reorganisationof Hospital Boards) Instrument 2006, any assets, liabilities, obligations under control of the former boards are to be transfered to the new WA Country Health Service.

(w) Special Purpose Accounts

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

Details of Trust Accounts are reported as a note to the financial statements (refer to Note 7).

Note 3 Judgements made by management in applying accounting policies

Judgements are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances.

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

Buildings

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

Operating lease commitments

The Health Service has entered into a number of commercial leases and has determined that the lessors retain all the significant risks and rewards of ownership of these properties. Accordingly, the leases have been classified as operating leases.

Notes to the Financial Statements
For the year ended 30 June 2007

Note 4 Key sources of estimation uncertainty

The key estimates and assumptions made concerning the future, and other key sources of estimation uncertainty at the balance sheet date that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year include:

Buildings

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

Employee benefits provision

In estimating the non-current long service leave liabilities, employees are assumed to leave the WA Country Health Service each year on account of resignation or retirement at 10.6%. This assumption was based on an analysis of the turnover rates exhibited by employees over the past five years. Employees with leave benefits to which they are fully entitled are assumed to take all available leave uniformly over the following five years or to age 65 if earlier.

Note 5 Disclosure of changes in accounting policy and estimates

Initial application of an Australian Accounting Standard

The WA Country Health Service has applied the following Australian Accounting Standards and Australian Accounting Interpretations effective for annual reporting periods beginning on or after 1 July 2006:

1) AASB 2005-9 'Amendments to Australian Accounting Standards [AASB 4, AASB 1023, AASB 139 & AASB 132]' (Financial guarantee contracts). The amendment deals with the treatment of financial guarantee contracts, credit insurance contracts, letters of credit or credit derivative default contracts as either an "insurance contract" under AASB 4 'Insurance Contracts' or as a "financial guarantee contract" under AASB 139 'Financial Instruments: Recognition and Measurement'. The WA Country Health Service does not currently undertake these types of transactions, resulting in no financial impact in applying the Standard.

2) UIG Interpretation 4 'Determining whether an Arrangement Contains a Lease' as issued in June 2005. This Interpretation deals with arrangements that comprise a transaction or a series of linked transactions that may not involve a legal form of a lease but by their nature are deemed to be leases for the purposes of applying AASB 117 'Leases'. At balance sheet date, the WA Country Health Service has not entered into any arrangements as specified in the Interpretation, resulting in no impact in applying the Interpretation.

3) UIG Interpretation 9 'Reassessment of Embedded Derivatives'. This Interpretation requires an embedded derivative that has been combined with a non-derivative to be separated from the host contract and accounted for as a derivative in certain circumstances. At balance sheet date, the WA Country Health Service has not entered into any contracts as specified in the Interpretation, resulting in no impact in applying the Interpretation.

The following Australian Accounting Standards and Interpretations are not applicable to the WA Country Health Service as they have no impact or do not apply to not-for-profit entities:

AASB Standards and Interpretation	
AASB 2005-1	'Amendments to Australian Accounting Standard' (AASB 139 – Cash flow hedge accounting of forecast intragroup transactions)
AASB 2005-5	'Amendments to Australian Accounting Standards [AASB 1 & AASB 139]'
AASB 2006-1	'Amendments to Australian Accounting Standards [AASB 121]'
AASB 2006-3	'Amendments to Australian Accounting Standards [AASB 1045]'
AASB 2006-4	'Amendments to Australian Accounting Standards [AASB 134]'
AASB 2007-2	'Amendments to Australian Accounting Standards arising from AASB Interpretation 12 [AASB 1, AASB 117, AASB 118, AASB 120, AASB 121, AASB 127, AASB 131 & AASB 139]' – paragraph 9
UIG 5	'Rights to Interests arising from Decommissioning, Restoration and Environmental Rehabilitation Funds'
UIG 6	'Liabilities arising from Participating in a Specific Market – Waste Electrical and Electronic Equipment'
UIG 7	'Applying the Restatement Approach under AASB 129 Financial Reporting in Hyperinflationary Economies'
UIG 8	'Scope of AASB 2'

Notes to the Financial Statements
For the year ended 30 June 2007

Note 5 Disclosure of changes in accounting policy and estimates (continued)

Future impact of Australian Accounting Standards not yet operative

The WA Country Health Service cannot early adopt an Australian Accounting Standard or Australian Accounting Interpretation unless specifically permitted by TI 1101 'Application of Australian Accounting Standards and Other Pronouncements'. Consequently, the WA Country Health Service has not applied the following Australian Accounting Standards and Australian Accounting Interpretations that have been issued but are not yet effective. These will be applied from their application date:

1) AASB 7 'Financial Instruments: Disclosures' (including consequential amendments in AASB 2005-10 'Amendments to Australian Accounting Standards [AASB 132, AASB 101, AASB 114, AASB 117, AASB 133, AASB 139, AASB 1, AASB 4, AASB 1023 & AASB 1038]'). This Standard requires new disclosures in relation to financial instruments. The Standard is considered to result in increased disclosures, both quantitative and qualitative of the WA Country Health Service's exposure to risks, enhanced disclosure regarding components of the WA Country Health Service's financial position and performance, and possible changes to the way of presenting certain items in the financial statements. The WA Country Health Service does not expect any financial impact when the Standard is first applied. The Standard is required to be applied to annual reporting periods beginning on or after 1 January 2007.

2) AASB 2005-10 'Amendments to Australian Accounting Standards (AASB 132, AASB 101, AASB 114, AASB 117, AASB 133, AASB 139, AASB 1, AASB 4, AASB 1023, & AASB 1038)'. The amendments are as a result of the issue of AASB 7 'Financial Instruments: Disclosures', which amends the financial instrument disclosure requirements in these standards. The WA Country Health Service does not expect any financial impact when the Standard is first applied. The Standard is required to be applied to annual reporting periods beginning on or after 1 January 2007.

3) AASB 101 'Presentation of Financial Statements'. This Standard was revised and issued in October 2006 so that AASB 101 has the same requirements as IAS 1 'Presentation of Financial Statements' (as issued by the IASB) in respect of for-profit entities. The WA Country Health Service is a not-for-profit entity and consequently does not expect any financial impact when the Standard is first applied. The Standard is required to be applied to annual reporting periods beginning on or after 1 January 2007.

4) AASB 2007-4 'Amendments to Australian Accounting Standards arising from ED 151 and Other Amendments (AASB 1, 2, 3, 4, 5, 6, 7, 102, 107, 108, 110, 112, 114, 116, 117, 118, 119, 120, 121, 127, 128, 129, 130, 131, 132, 133, 134, 136, 137, 138, 139, 141, 1023 & 1038)'. This Standard introduces policy options and modifies disclosures. These amendments arise as a result of the AASB decision that, in principle, all options that currently exist under IFRSs should be included in the Australian equivalents to IFRSs and additional Australian disclosures should be eliminated, other than those now considered particularly relevant in the Australian reporting environment. The Department of Treasury and Finance has indicated that it will mandate to remove the policy options added by this amending Standard. This will result in no impact as a consequence of application of the Standard. The Standard is required to be applied to annual reporting periods beginning on or after 1 July 2007.

5) AASB 2007-5 'Amendment to Australian Accounting Standard – Inventories Held for Distribution by Not-for-Profit Entities (AASB 102)'. This amendment changes AASB 102 'Inventories' so that inventories held for distribution by not-for-profit entities are measured at cost, adjusted when applicable for any loss of service potential. The WA Country Health Service does not have any inventories held for distribution so does not expect any financial impact when the Standard is first applied. The Standard is required to be applied to annual reporting periods beginning on or after 1 July 2007.

6) AASB Interpretation 4 'Determining whether an Arrangement Contains a Lease [revised]'. This Interpretation was revised and issued in February 2007 to specify that if a public-to-private service concession arrangement meets the scope requirements of AASB Interpretation 12 'Service Concession Arrangements' as issued in February 2007, it would not be within the scope of Interpretation 4. At balance sheet date, the WA Country Heath Service has not entered into any arrangements as specified in the Interpretation or within the scope of Interpretation 12, resulting in no impact when the Interpretation is first applied. The Interpretation is required to be applied to annual reporting periods beginning on or after 1 January 2008.

7) AASB Interpretation 12 'Service Concession Arrangements'. This Interpretation was issued in February 2007 and gives guidance on the accounting by operators (usually a private sector entity) for public-to-private service concession arrangements. It does not address the accounting by grantors (usually a public sector entity). It is currently unclear as to the application of the Interpretation to the WA Country Health Service if and when public-to-private service concession arrangements are entered into in the future. At balance sheet date, the WA Country Health Service has not entered into any public-to-private service concession arrangements resulting in no impact when the Interpretation is first applied. The Interpretation is required to be applied to annual reporting periods beginning on or after 1 January 2008.

8) AASB Interpretation 129 'Service Concession Arrangements: Disclosures [revised]'. This Interpretation was revised and issued in February 2007 to be consistent with the requirements in AASB Interpretation 12 'Service Concession Arrangements' as issued in February 2007. Specific disclosures about service concession

arrangements entered into are required in the notes accompanying the financial statements, whether as a grantor or an operator. At balance sheet date, the WA Country Health Service has not entered into any public-to-private service concession arrangements resulting in no impact when the Interpretation is first applied. The Interpretation is required to be applied to annual reporting periods beginning on or after 1 January 2008.

The following Australian Accounting Standards and Interpretations are not applicable to the WA Country Health Service as they have no impact or do not apply to not-for-profit entities:

AASB Standards and Interpretation	
AASB 8	'Operating Segments'
AASB 1049	'Financial Reporting of General Government Sectors by Governments'
AASB 2007-1	'Amendments to Australian Accounting Standards arising from AASB Interpretation 11
AASB 2007-2	'Amendments to Australian Accounting Standards arising from AASB Interpretation 12 [AASB 1, AASB 117, AASB 118, AASB 120, AASB 121, AASB 127, AASB 131 & AASB 139]' – paragraphs 1 to 8
AASB 2007-3	'Amendments to Australian Accounting Standards arising from AASB 8 [AASB 5, AASB 6, AASB 102, AASB 107, AASB 119, AASB 127, AASB 134, AASB 136, AASB 1023 & AASB 1038]'
AASB 2007-6	Amendments to Australian Accounting Standards arising from AASB 123 [AASB 1, AASB 101, AASB 107, AASB 111, AASB 116 & AASB 138 and Interpretations 1 & 12]'.
AASB 2007-7	Amendments to Australian Accounting Standards [AASB 1, AASB 2, AASB 4, AASB 5, AASB 107 & AASB 128]'.
Interpretation 10	'Interim Financial Reporting and Impairment'
Interpretation 11	'AASB 2 – Group and Treasury Share Transactions'

Note 6 Services of the WA Country Health Service

Information about the Health Service's services and, the expenses and revenues which are reliably attributable to those services are set out in Note 50. The ten key services of the Health Service are:

Admitted Patient Services
Admitted patient services are provided for the care of inpatients in public hospitals and public patients treated in private facilities under contract to the Department of Health. Care involves an admission to hospital and can be for periods of one or more days. Care includes medical and surgical treatment, renal dialysis, specialist older persons mental health inpatient care, oncology services and obstetric care.

Specialised Mental Health Services
Authorised mental health units are hospitals or hospital wards devoted to the treatment and care of patients with psychiatric, mental or behavioural disorders; that are by law able to admit people as involuntary patients for psychiatric treatment.

Palliative Care
Palliative care services provide inpatient and home based multi disciplinary care and support for terminally ill people and their families and carers. Education and advisory services are also available to assist professionals, particularly those in rural areas.

Non-admitted Patient Services
Non-admitted services are provided by medical officers, nurses and allied health staff. Services include outpatient health and medical care as well as similar emergency services as described for metropolitan emergency departments but provided in smaller country hospitals.

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

Prevention and Promotion Services
Prevention and promotion services include cancer prevention and detection, child, community and primary health care, health promotion, genomics, preventive health, Aboriginal health, mental health, health policy and clinical reform, and the management and development of health information.

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

Notes to the Financial Statements
For the year ended 30 June 2007

Note 6 Services of the WA Country Health Service (continued)

Aged Care Assessment Services
Aged care assessment services determine eligibility for, and the level of care required by, the frail aged. It includes assessments for those who require permanent care in an appropriate aged care facility including the Care Awaiting Placement program, and eligibility for Community Aged Care Packages.

Community Mental Health Services
Community mental health care provides a range of community-based services for people with mental health disorders, which may include emergency assessment and treatment, case management, psycho-geriatric assessment and day programs provided in either a clinic or home environment. Service providers include both government and non-government service agencies. Contracted non-government non-clinical support services also support long-term mental health patients living in the community.

Residential Care
Residential care services are provided for people assessed as no longer being able to live at home. Services include non-acute admitted continuing care, nursing home care, nursing home type care provided in public hospitals and hostel care.

Note 7 Administered trust accounts	**2007 $000**
Funds held in these trust accounts are not controlled by the WA Country Health Service and are therefore not recognised in the financial statements.	
a) The Health Service administers a trust account for the purpose of holding patients' private moneys.	
A summary of the transactions for this trust account is as follows:	
Opening Balance	722
Add Receipts	
- Patient Deposits	1,269
- Interest	5
	1,996
Less Payments	
- Patient Withdrawals	(1,306)
- Interest / Charges	(1)
Closing Balance	690
b) The Health Service administers a trust account for salaried medical practitioners under the rights to private practice scheme.	
A summary of the transactions for this trust account is as follows:	
Opening Balance	200
Add Receipts	
- Fees collected on behalf of medical practitioners	212
- Interest	2
	414
Less Payments	
- Payments to medical practitioners	(208)
- Charges	(2)
Closing Balance	204
c) Other trust accounts - not controlled by the Health Service	
Accommodation Bonds Account	147
Staff Development and Diabetes Education Fund	4
	151
Opening Balance	151
Add Receipts	
- Deposits	0
- Interest	1
	152
Less Payments	
- Withdrawals	(148)
- Charges	(0)
Closing Balance	4

Notes to the Financial Statements
For the year ended 30 June 2007

Note 8 Employee benefits expense

	2007 $000
Salaries and wages (a)	343,539
Superannuation - defined contribution plans (b)	31,040
Superannuation - defined benefit plans (c) (d)	854
Annual leave and time off in lieu leave (e)	36,410
Long service leave (e)	6,433
	418,275

(a) Includes the value of the fringe benefit to the employees plus the fringe benefits tax component.

(b) Defined contribution plans include West State and Gold State (contributions paid).

(c) Defined benefit plans include Pension scheme and Gold State (pre-transfer benefit).

(d) An equivalent notional income is also recognised. (See note 21 'Liabilities assumed by the Treasurer')

(e) Includes a superannuation contribution component.

Employment on-costs expense is included at note 14 'Other expenses'. The employment on-costs liability is included at note 34 'Provisions'.

Note 9 Patient support costs

Medical supplies and services	37,360
Domestic charges	5,778
Fuel, light and power	13,761
Food supplies	7,098
Patient transport costs	18,598
Purchase of external services	12,849
	95,445

Note 10 Finance costs

Interest paid	1,757
	1,757

Note 11 Depreciation and amortisation expense

Depreciation	
Buildings	17,956
Leasehold improvements	110
Computer equipment	1,857
Furniture and fittings	261
Motor vehicles	679
Medical equipment	6,913
Other plant and equipment	1,983
	29,759
Amortisation	
Intangible assets	31
Total depreciation and amortisation	29,791

Note 12 Capital user charge

	52,625

The charge was a levy applied by Government for the use of its capital. In 2006-07, the final year in which the charge was levied, the payments equal to the appropriation for 2006-07 less any adjustment relating to 2005-06. The charge was paid by the Department of Health on behalf of the Health Service.

Notes to the Financial Statements
For the year ended 30 June 2007

Note 13 Net gain / (loss) on disposal of non-current assets

	2007 $000
Cost of disposal of non-current assets	
Computer equipment	(66)
Furniture and fittings	(45)
Motor vehicles	(2)
Medical equipment	(120)
Other plant and equipment	(119)
	(352)
Proceeds from disposal of non-current assets:	
Computer equipment	2
Furniture and fittings	7
Motor vehicles	16
Medical equipment	4
Other plant and equipment	16
	45
Net gain/(loss)	(307)

See note 2(h) 'Non-current assets held for sale' and note 28 'Property, plant and equipment'.

Note 14 Other expenses

Communications	4,755
Computer services	989
Employment on-costs (a)	15,606
Insurance	3,884
Legal expenses	661
Motor vehicle expenses	4,620
Operating lease expenses	7,550
Printing and stationery	2,636
Rental of property	4,268
Repairs, maintenance and consumable equipment expense	18,777
Bad and doubtful debts expense	381
Purchase of external services	5,019
Other	10,928
	80,074

(a) Includes workers' compensation insurance and other employment on-costs. The on-costs liability associated with the recognition of annual and long service leave liability is included at note 34 'Provisions'. Superannuation contributions accrued as part of the provision for leave are employee benefits and are not included in employment on-costs.

Note 15 Patient charges

Inpatient charges	19,018
Outpatient charges	6,094
	25,111

WA Country Health Service

Notes to the Financial Statements
For the year ended 30 June 2007

Note 16 Grants and contributions	2007 $000
a) Commonwealth grants and contributions	
Grant for nursing homes	3,656
Grant for National Respite Carers Program	1,451
Grant for RHS	3,615
Grant for Community Aged Care Program	497
Grant for Primary Health Care Access Program	1,404
Grant for Carelink	444
Grant for Dept Veterans Affairs - Home & Domicilliary Care	181
Grant for Aged Care Training Program	515
Grant for Health Training	20
Grant for MSOAP Funding	203
Grant for HIV Treatment	145
Grant for Communicable Diseases from Dept Health & Aging	47
Grant for Aborigional Health	114
Grant for Training Hotel Services Staff - Dept Education & Training	113
OATSIH - Wheatbelt Aborigional Health Service	939
Grant for Primary Health Care Aborigional People - Wheatbelt DHA	774
Customs	191
DOA Pilbara	95
Healthy for Life	434
Mobile Respite Program	89
Grant for Young & Disabled Carers	24
Other grants	444
	15,396
b) Other grants and contributions	
Disability Services Commission - Community Aids and Equipment Program	1,462
Disability Services Commission - Therapy Services	1,896
Grants for MSOAP	635
WACRRM	276
Great Southern GP Network - For Ante Natal Program& Office relocation	219
Healthways Aborigional Traineeship	100
BHP	935
Great Southern Development Commission	754
Grant for Pilbara Development Commission - Wickham Hostel Upgrade	154
Other grants	1,003
	7,434
Note 17 Donations revenue	
General public contributions	505
Hospital Auxiliaries	57
Estate of Alfred Marklove Wilton (deceased)	337
Abbotts Australia - Pumps	173
	1,072
Note 18 Other revenues	
Recoveries	4,473
Use of hospital facilities	2,463
Rent from residential properties	287
Boarders' accommodation	3,270
Sale of Sundry Items	-
Other	4,783
	15,276

Notes to the Financial Statements
For the year ended 30 June 2007

Note 19 Service appropriations

	2007 $000
Appropriation revenue received during the year:	
Service appropriations	660,595

Service appropriations are accrual amounts reflecting the net cost of services delivered. The appropriation revenue comprises a cash component and a receivable (asset). The receivable (holding account) comprises the depreciation expense for the year and any agreed increase in leave liability during the year.

Note 20 Assets assumed / (transferred)

The following assets have been assumed from / (transferred to) other state government agencies during the financial year:

- Plant & Equipment	20
Total assets assumed / (transferred)	20

Where the Treasurer or other entity has assumed a liability, the WA Country Health Service recognises revenues equivalent to the amount of the liability assumed and an expense relating to the nature of the event or events that initially gave rise to the liability. From 1 July 2002 non-discretionary non-reciprocal transfers of net assets (i.e. restructuring of administrative arrangements) have been classified as Contributions by Owners under Treasurer's Instruction 955 and are taken directly to equity. Discretionary non-reciprocal transfer of assets/liabilities between State Government agencies are reported as Assets assumed/ (transferred).

Note 21 Liabilities assumed by the Treasurer

The following liabilities have been assumed by the Treasurer during the financial year:

- Superannuation	854

The assumption of the superannuation liability by the Treasurer is a notional income to match the notional superannuation expense reported in respect of current employees who are members of the Pension Scheme and current employees who have a transfer benefit entitlement under the Gold State Superannuation Scheme (The notional superannuation expense is disclosed at note 8 'Employee benefits expense').

Note 22 Cash and cash equivalents

Cash on hand	172
Cash at bank - general	15,520
Cash at bank - donations	2,129
Other short - term deposits	64
	17,885

Notes to the Financial Statements
For the year ended 30 June 2007

Note 23 Restricted cash and cash equivalents

	2007 $000
Cash assets held for specific purposes	
Cash at bank	442
	442

Restricted cash and cash equivalents are assets, the uses of which are restricted, by specific legal or externally imposed requirements. Externally appointed committees control the uses of these specific purpose donated funds for the Midwest region.

Note 24 Receivables

Current	
Patient fee debtors	3,082
Other receivables	8,358
Less: Allowance for impairment of receivables	(452)
	10,988
GST receivable	2,355
	13,343

See also note 2(o) 'Receivables' and note 49 'Financial Instruments'.

Note 25 Amounts receivable for services

Current	8,386
Non-current	87,945
	96,330
Balance at start of the year	-
Assets transferred in on commencement	75,885
Credit to holding account	32,375
Less holding account drawdown	(11,929)
Balance at end of the year	96,330

This asset represents the non-cash component of service appropriations which is held in a holding account at the Department of Treasury and Finance. It is restricted in that it can only be used for asset replacement or payment of leave liability. See note 2(m) 'Amounts receivable for services'.

Note 26 Inventories

Current	
Supply stores - at cost	1,686
Pharmaceutical stores - at cost	1,291
Engineering stores - at cost	604
	3,581

See note 2(n) 'Inventories'.

Note 27 Other current assets

Prepayments	844
	844

WA Country Health Service

Notes to the Financial Statements
For the year ended 30 June 2007

Note 28 Property, plant and equipment	2007 $000
Land	
At fair value	71,659
	71,659
Buildings	
Clinical:	
At fair value	583,495
Accumulated depreciation	(19,311)
	564,184
Non-Clinical:	
At fair value	66,695
Accumulated depreciation	(420)
	66,275
Total land and buildings	702,118
Leasehold improvements	
At cost	830
Accumulated depreciation	(110)
	720
Computer equipment	
At cost	4,744
Accumulated depreciation	(1,839)
	2,905
Furniture and fittings	
At cost	2,729
Accumulated depreciation	(258)
	2,472
Motor vehicles	
At cost	1,649
Accumulated depreciation	(678)
	971
Medical equipment	
At cost	36,358
Accumulated depreciation	(6,902)
Accumulated impairment losses	(374)
	29,081
Other plant and equipment	
At cost	14,674
Accumulated depreciation	(1,967)
	12,707
Works in progress	
Buildings under construction (at cost)	41,593
Other Work in Progress (at cost)	601
	42,194
Art Works	
At cost	66
	66
Total of property, plant and equipment	793,233

Notes to the Financial Statements
For the year ended 30 June 2007

Note 28 Property, plant and equipment (continued)

Reconciliations

Reconciliations of the carrying amounts of property, plant and equipment at the beginning and end of the current financial year are set out below.

	2007 $000
Land	
Carrying amount at start of year	-
Assets transferred in on commencement	70,172
Additions	941
Transfers from Work in Progress	545
Carrying amount at end of year	71,659
Buildings	
Carrying amount at start of year	-
Assets transferred in on commencement	591,540
Additions	5,004
Transfers from Work in Progress	51,721
Depreciation	(17,956)
Transfer between asset classes	150
Carrying amount at end of year	630,459
Leasehold improvements	
Carrying amount at start of year	-
Assets transferred in on commencement	433
Transfers from work in progress	397
Depreciation	(110)
Carrying amount at end of year	720
Computer equipment	
Carrying amount at start of year	-
Assets transferred in on commencement	3,399
Additions	1,413
Transfers from Work in Progress	10
Disposals	(66)
Depreciation	(1,857)
Transfer between asset classes	4
Carrying amount at end of year	2,905

Notes to the Financial Statements
For the year ended 30 June 2007

Note 28 Property, plant and equipment (continued)	2007 $000
Furniture and fittings	
Carrying amount at start of year	-
Assets transferred in on commencement	2,138
Additions	654
Disposals	(45)
Depreciation	(261)
Transfer between asset classes	(15)
Carrying amount at end of year	2,472
Motor vehicles	
Carrying amount at start of year	-
Assets transferred in on commencement	1,298
Additions	355
Disposals	(2)
Depreciation	(679)
Carrying amount at end of year	971
Medical equipment	
Carrying amount at start of year	-
Assets transferred in on commencement	26,563
Additions	9,683
Transfers from Work in Progress	76
Disposals	(120)
Impairment losses (a)	(374)
Depreciation	(6,913)
Transfer between asset classes	167
Carrying amount at end of year	29,081
Other plant and equipment	
Carrying amount at start of year	-
Assets transferred in on commencement	10,673
Additions	3,675
Transfers from Work in Progress	439
Disposals	(119)
Transfer from/(to) other reporting entities	20
Depreciation	(1,983)
Transfer between asset classes	2
Carrying amount at end of year	12,707
Works in progress	
Carrying amount at start of year	-
Assets transferred in on commencement	44,762
Additions	51,545
Write-down of assets	(617)
Transfers from Work in Progress	(53,188)
Transfer between asset classes	(309)
Carrying amount at end of year	42,194
Art Works	
Carrying amount at start of year	-
Assets transferred in on commencement	66
Carrying amount at end of year	66

Notes to the Financial Statements
For the year ended 30 June 2007

Note 28 Property, plant and equipment (continued)

	2007 $000
Total property, plant and equipment	
Carrying amount at start of year	-
Assets transferred in on commencement	751,045
Additions	73,270
Write-down of assets	(617)
Disposals	(352)
Transfer from/(to) other reporting entities	20
Impairment losses (a)	(374)
Depreciation	(29,759)
Carrying amount at end of year	793,233

(a) Recognised in the Income Statement. Where an asset measured at cost is written-down to recoverable amount, an impairment loss is recognised in the Income Statement. Where an asset measured at fair value is written-down to recoverable amount, the loss is accounted for as a revaluation decrement.

Note 29 Impairment of Assets

The Health Service identified impairments to property, plant and equipment totalling $374,235 during 2006-07.

The WA Country Health Service held no goodwill or intangible assets with an indefinite useful life during the reporting period and at the balance date there were no intangible assets not yet available for use.

All surplus assets at 30 June 2007 have been classified as assets held for sale or written off.

Note 30 Intangible assets

Computer software	
At cost	134
Accumulated amortisation	(31)
	103

Reconciliation

Reconciliation of the carrying amount of intangible assets at the beginning and end of the current financial year is set out below.

Computer software	
Carrying amount at start of year	-
Assets transferred in on commencement	98
Additions	36
Amortisation expense (a)	(31)
Carrying amount at end of year	103

(a) Recognised in Income Statement.

Note 31 Other financial assets

Shares in Mount Barker Cooperative Ltd at cost	6

Note 32 Payables

Current	
Trade creditors	12,428
Accrued expenses	18,714
Accrued interest	219
	31,361

(See also note 2(p) 'Payables' and note 49 'Financial instruments')

Notes to the Financial Statements
For the year ended 30 June 2007

Note 33 Borrowings

	2007 $000
Current	
Western Australian Treasury Corporation loans	551
Department of Treasury and Finance loans	996
	1,547
Non-current	
Western Australian Treasury Corporation loans	9,477
Department of Treasury and Finance loans	17,060
	26,537
Total borrowings	28,084
Western Australian Treasury Corporation (WATC) loans	
Balance at start of year	-
Liabilities transferred in on commencement	10,567
Less repayments this year	(539)
Balance at end of year	10,028

The debt is held in a portfolio of loans managed by the Department of Health. Repayments of the debt are made by the Department of Health on behalf of the WA Country Health Service.

Department of Treasury and Finance loans	
Balance at start of year	-
Liabilities transferred in on commencement	19,006
Less repayments this year	(950)
Balance at end of year	18,056

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

Note 34 Provisions

Current	
Employee benefits provision	
Annual leave (a)	32,521
Time off in lieu leave (a)	10,574
Long service leave (b)	15,805
Deferred salary scheme	711
Gratuities	1,099
	60,711
Non-current	
Employee benefits provision	
Long service leave (b)	11,282
Gratuities	491
	11,773
Total Provisions	72,484

(a) Annual leave liabilities and time off in lieu leave liabilities have been classified as current as there is no unconditional right to defer settlement for at least 12 months after balance sheet date.

Assessments indicate that actual settlement of the liabilities will occur as follows:

Within 12 months of balance sheet date	28,655
More than 12 months after balance sheet date	14,440
	43,095

(b) Long service leave liabilities have been classified as current where there is no unconditional right to defer settlement for at least 12 months after balance sheet date. Assessments indicate that actual settlement of the liabilities will occur as follows:

Within 12 months of balance sheet date	6,482
More than 12 months after balance sheet date	20,605
	27,087

Notes to the Financial Statements
For the year ended 30 June 2007

Note 35 Other liabilities

	2007 $000
Current	
Accrued salaries	9,179
Income received in advance	545
Refundable deposits	(114)
Other	54
	9,664

Note 36 Contributed equity

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

Balance at start of the year	-
Contributions by owners	
Capital contributions (a)	58,904
Transfer of net assets from other agencies (a)	722,119
Total contributions by owners	781,023
Balance at end of year	781,023

(a) Capital Contributions (appropriations) and non-discretionary (non-reciprocal) transfers of net assets from other State government agencies have been designated as contributions by owners in Treasurer's Instruction 955 'Contribution by Owners Made to Wholly Owned Public Sector Entities' and are credited directly to equity.

Note 37 Accumulated surplus/(deficiency)

Balance at start of year	-
Result for the period	3,152
Balance at end of year	3,152

Notes to the Financial Statements
For the year ended 30 June 2007

Note 38 Notes to the Cash Flow Statement	2007 $000
a) Reconciliation of cash	
Cash assets at the end of the financial year as shown in the Cash Flow Statement is reconciled to the related items in the Balance Sheet as follows:	
Cash and cash equivalents (see note 22)	17,885
Restricted cash and cash equivalents (see note 23)	442
	18,327
b) Reconciliation of net cash flows to net cost of services used in operating activities	
Net cash used in operating activities (Cash Flow Statement)	(570,606)
Increase/(decrease) in assets:	
GST receivable	1,238
Other current receivables	2,333
Inventories	(411)
Prepayments	142
Decrease/(increase) in liabilities:	
Doubtful debts provision	(23)
Payables	(3,432)
Accrued salaries	916
Current provisions	(4,659)
Non-current provisions	1,195
Income received in advance	1,043
Other liabilities	59
Non-cash items:	
Depreciation and amortisation expense (note 11)	(29,791)
Net gain / (loss) from disposal of non-current assets (note 13)	(307)
Interest paid by Department of Health	(1,776)
Capital user charge paid by Department of Health (note 12)	(52,625)
Asset Impairment Losses	(374)
Superannuation liabilities assumed by the Treasurer (note 21)	(854)
Write down of assets (note 28)	(617)
Adjustment for other non-cash items	232
Net cost of services (Income Statement)	(658,317)
c) Notional cash flows	
Service appropriations as per Income Statement	660,595
Capital appropriations credited directly to Contributed Equity (Refer Note 36)	58,904
Holding account drawdowns credited to Amounts Receivable for Services (Refer Note 25)	11,929
	731,429
Less notional cash flows:	
Items paid directly by the Department of Health for the Health Service and are therefore not included in the Cash Flow Statement:	
Interest paid to WA Treasury Corporation	(651)
Repayment of interest-bearing liabilities to WA Treasury Corporation	(539)
Interest paid to Department of Treasury & Finance	(1,125)
Repayment of interest-bearing liabilities to Department of Treasury & Finance	(950)
Capital user charge	(52,625)
Accrual appropriations	(32,375)
Capital works expenditure	(18,928)
Other non cash adjustments to service appropriations	12
	(107,180)
Cash Flows from State Government as per Cash Flow Statement	624,249

At the reporting date, the Health Service had fully drawn on all financing facilities, details of which are disclosed in the financial statements.

Notes to the Financial Statements
For the year ended 30 June 2007

		2007 $000
Note 39	**Revenue, public and other property written off or presented as gifts**	
a)	Revenue and debts written off under the authority of the Accountable Authority.	324
b)	Public and other property written off under the authority of the Accountable Authority.	106
c)	Revenue and debts written off under the authority of the Minister.	-
d)	Public and other property written off under the authority of the Minister.	146
e)	Gifts of public property provided by the WA Country Health Service.	-

Note 40 Losses of public monies and other property

Losses of public moneys and public or other property through theft or default	4
Less amount recovered	-
Net losses	4

Note 41 Remuneration of members of the Accountable Authority and senior officers

Remuneration of members of the Accountable Authority
The Director General of Health is the Accountable Authority for WA Country Health Service. The remuneration of the Director General of Health has been disclosed in the notes of the Department of Health.

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

	2007
$70,001 - $80,000	1
$110,001 - $120,000	1
$120,001 - $130,000	2
$130,001 - $140,000	2
$140,001 - $150,000	2
$150,001 - $160,000	3
$160,001 - $170,000	1
$170,001 - $180,000	3
$300,001 - $310,000	1
Total	16

	$000
The total remuneration of senior officers is:	2,449

The total remuneration includes the superannuation expense incurred by the WA Country Health Service in respect of senior officers other than senior officers reported as members of the Accountable Authority.

Number of senior officers presently employed who are members of the Pension Scheme: -

Note 42 Remuneration of auditor

Remuneration to the Auditor General for the financial year is as follows:	
Auditing the accounts, financial statements and performance indicators	570

Notes to the Financial Statements
For the year ended 30 June 2007

Note 43 Commitments	2007 $000
a) Capital expenditure commitments	
Capital expenditure commitments, being contracted capital expenditure additional to the amounts reported in the financial statements, are payable as follows:	
Within 1 year	58,008
Later than 1 year, and not later than 5 years	20,156
Later than 5 years	-
	78,164
The capital commitments include amounts for:	
- Buildings	77,776
The capital expenditure commitments are all inclusive of GST.	
b) Operating lease commitments:	
Commitments in relation to non-cancellable leases contracted for at the balance date but not recognised in the financial statements, are payable as follows:	
Within 1 year	4,095
Later than 1 year, and not later than 5 years	6,637
Later than 5 years	66
	10,798
Representing:	
Cancellable operating leases	-
Non-cancellable operating leases	10,798
	10,798
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.	
c) Other expenditure commitments:	
Other expenditure commitments contracted for at the balance date but not recognised as liabilities, are payable as follows:	
Within 1 year	338
Later than 1 year, and not later than 5 years	-
Later than 5 years	-
	338
The other expenditure commitments are all inclusive of GST.	

Notes to the Financial Statements
For the year ended 30 June 2007

	2007 $000
Note 44 Contingent liabilities and contingent assets	

Contingent Liabilities

In addition to the liabilities incorporated in the financial statements, the WA Country Health Service has the following contingent liabilities:

Litigation in progress

Pending litigation that are not recoverable from Riskcover insurance and may affect the financial position of the WA Country Health Service	1,100
Number of claims	3

Contaminated Sites

Under the Contaminated Sites Act 2003, the WA Country Health Service is required to report known and suspected contaminated sites to the Department of Environment and Conservation (DEC). In accordance with the Act, DEC classifies these sites on the basis of the risk to human health, the environment and environmental values. Where sites are classified as contaminated – remediation required or possibly contaminated – investigation required, the WA Country Health Service may have a liability in respect of investigation or remediation expenses.

During the year the WA Country Health Service identified 15 suspected contaminated sites and has reported these sites to DEC. These have yet to be classified. The WA Country Health Service is unable to assess the likely outcome of the classification process, and accordingly, it is not practicable to estimate the potential financial effect or to identify the uncertainties relating to the amount or timing of any outflows. Whilst there is no possibility of reimbursement of any future expenses that may be incurred in the remediation of these sites, the WA Country Health Service may apply for funding from the Contaminated Sites Management Account to undertake further investigative work or to meet remediation costs that may be required.

Note 45 Events occurring after balance sheet date

There were no events occurring after the balance sheet date which had significant financial effects on these financial statements.

Note 46 Related bodies

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

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

Note 47 Affiliated bodies

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

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

WA Country Health Service

Notes to the Financial Statements

For the year ended 30 June 2007

Note 48 Explanatory Statement

Significant variations between estimates and actual results for 2007

Significant variations between the estimates and actual results for income and expenses are detailed below. Significant variations are considered to be those greater than 10% of the budget estimates.

	Note	2007 Actual $000	2007 Estimates $000	Variance $000
Operating expenses				
Employee benefits expense	(a)	418,275	402,326	15,949
Other goods and services	(b)	304,459	271,930	32,529
Total expenses		722,734	674,256	48,478
Less: Revenues	(c)	(64,418)	(40,681)	(23,737)
Net cost of services		658,316	633,575	24,741

(a) Employee benefits expense

Employee expenses varied due to:.

(i) Additional appropriation funding made available to the WA Country Health Service during the financial year for services that were not included in the initial allocation and to meet the additional back pay costs associated with an award increase and reclassifications for allied health professionals. 12,874

(ii) Additional services funded from new and increased grants from the Commonwealth, other State Government agencies and private organisations. 4,953

(b) Other goods and services

Other Goods and Services expenses varied due to:.

(i) Capital User Charge exceeding initial estimates, primarily as a consequence of the revaluation of land and buildings. 8,949

(ii) Additional appropriation funding made available to the WA Country Health Service during the financial year for services that were not included in the initial allocation. 8,997

(iii) Additional services funded from new and increased grants from the Commonwealth, other State Government agencies and private organisations. 3,145

(iv) Additional expenditure recognised in relation to Riskcover charges which had been netted against performance adjustment refunds and returns on fund investments in the initial budget. 3,101

(v) Additional expenditures associated with new radiology contract arrangements. 2,041

(vi) Additional expenditures associated with various other new and increased own sourced revenues. 4,429

(c) Revenues from ordinary activities

Revenues varied due to:.

(i) Funding associated with a number of Commonwealth Programs previously paid by the Commonwealth to the Department of Health and now paid directly to the WA Country Health Service. (6,932)

(ii) New and increased grants received from the Commonwealth, other State Government agencies and private sector organisations. (8,098)

(iii) Revenues recognised in relation to Riskcover performance adjustments and returns on fund investments which had been netted against expenditure in the initial budget. (3,101)

(iv) Additional patient revenue resulting from targeted private patient initiatives and changes to radiology cantracting arrangements. (4,274)

(v) Additional revenues received in relation to interest, donations, rent and boarders. (1,341)

WA Country Health Service

Notes to the Financial Statements
For the year ended 30 June 2007

Note 49 Financial instruments

a) **Financial risk management objectives and policies**

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

Credit risk

The WA Country Health Service trades only with recognised, creditworthy third parties. The 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 the WA Country Health Service's exposure to bad debts is minimal. There are no significant concentration of credit risk.

Liquidity risk

The WA Country Health Service has appropriate procedures to manage cash flows including drawdowns of appropriations by monitoring forecast cash flows to ensure that sufficient funds are available to meet its commitments.

Cash flow interest rate risk

The WA Country Health Service's exposure to market risk for changes in interest rates relate primarily to the long-term debt obligations, cash and cash equivalents and restricted cash. The WA Country Health Service's borrowings are all obtained through the Western Australian Treasury Corporation (WATC) and the Department of Treasury and Finance (DTF). The borrowings are at fixed rates with varying maturities. The risk is managed by WATC and DTF through portfolio diversification and variation in maturity dates. Cash and cash equivalents and restricted cash are held in interest bearing bank accounts.

b) **Financial instrument disclosures**

Interest rate risk exposure

The following table details the WA Country Health Service's exposure to interest rate risk as at the balance sheet date:

	Weighted average effective Interest rate	Variable interest rate	Fixed interest rate maturities Within 1 year	1-2 years	2-3 years	3-4 years	4-5 years	More than 5 years	Non-interest bearing	Total
As at 30 June 2007	%	$000	$000	$000	$000	$000	$000	$000	$000	$000
Financial Assets										
Cash and cash equivalents	0.4%	17,821	33	31					-	17,885
Restricted cash and cash equivalents	5.8%	442							-	442
Restricted other financial assets		6								6
Receivables									13,343	13,343
		18,269	33	31	-	-	-	-	13,343	31,676
Financial Liabilities										
Payables									31,361	31,361
Borrowings										
- W A Treasury Corporation loans	6.0%		551	564	576	589	603	7,145		10,028
- Department of Treasury & Finance loans	6.1%		996	1,045	1,090	1,137	1,193	12,595		18,056
		-	1,547	1,609	1,666	1,726	1,795	19,740	31,361	59,445
Net financial assets / (liabilities)		18,269	(1,514)	(1,578)	(1,666)	(1,726)	(1,795)	(19,740)	(18,018)	(27,770)

WA Country Health Service

Notes to the Financial Statements

For the year ended 30 June 2007

Note 50 Schedule of Income and Expenses by Services

	Admitted Patient Services 2007 $000	Specialised Mental Health 2007 $000	Palliative Care 2007 $000	Non-Admitted Patient 2007 $000	Patient Transport 2007 $000	Prevention & Promotion 2007 $000	Home & Community Care 2007 $000	Aged Care Assess-ment 2007 $000	Community Mental Health 2007 $000	Residential Care 2007 $000	Total 2007 $000
COST OF SERVICES											
Expenses											
Employee benefits expense	196,318	5,007	995	85,160	9,697	44,714	9,629	2,242	19,121	45,392	418,275
Fees for visiting medical practitioners	29,230	28	21	12,910	83	230	68	107	477	933	44,087
Patient support costs	44,798	1,142	227	19,432	2,213	10,203	2,197	512	4,363	10,358	95,445
Finance costs	824	21	4	359	41	188	40	9	80	191	1,757
Depreciation and amortisation expense	13,982	357	71	6,065	690	3,185	686	160	1,362	3,233	29,791
Asset impairment losses	175	4	1	76	9	40	9	2	17	41	374
Capital user charge	24,700	630	125	10,714	1,220	5,626	1,212	282	2,406	5,710	52,625
Loss on disposal of non-current assets	144	4	1	62	7	33	7	2	14	33	307
Other expenses	37,584	958	190	16,303	1,856	8,560	1,843	429	3,661	8,690	80,074
Total cost of services	347,755	8,151	1,635	151,081	15,816	72,779	15,691	3,745	31,501	74,581	722,735
INCOME											
Revenue											
Patient charges	12,886	96	-	7,612	(0)	209	34	0	0	4,274	25,111
Commonwealth grants and contributions	783	2	0	627	83	7,708	5,172	12	959	50	15,396
Other grants and contributions	1,245	1	38	1,583	7	2,102	21	10	121	2,306	7,434
Donations revenue	481	4	1	226	9	142	55	5	19	130	1,072
Interest revenue	58	0	0	27	1	17	6	2	2	16	129
Other revenues	6,849	56	21	3,225	124	2,021	781	77	271	1,851	15,276
Total income other than income from State Government	22,302	159	60	13,300	224	12,199	6,069	106	1,372	8,627	64,418
NET COST OF SERVICES	**325,453**	**7,992**	**1,575**	**137,781**	**15,592**	**60,580**	**9,622**	**3,639**	**30,129**	**65,954**	**658,317**
INCOME FROM STATE GOVERNMENT											
Service appropriations	326,579	8,020	1,580	138,256	15,646	60,790	9,656	3,651	30,233	66,182	660,595
Assets assumed / (transferred)	11	0	0	4	0	2	0	0	1	2	20
Liabilities assumed by the Treasurer	422	10	2	179	20	79	12	5	39	86	854
Total income from State Government	327,012	8,030	1,582	138,441	15,666	60,871	9,668	3,656	30,273	66,270	661,469
SURPLUS/(DEFICIT) FOR THE PERIOD	**1,559**	**38**	**7**	**660**	**74**	**291**	**46**	**17**	**144**	**316**	**3,152**

Appendices

Appendix 1: Abbreviations

ABS	Australian Bureau of Statistics
ACAT	Aged Care Assessment Team
ACHS	Australian Council on HealthCare Standards
AMI	Acute Myocardial Infarction
ATSI	Aboriginal and Torres Strait Islander
ATSN	Apprenticeship and Traineeship Support Network
CALD	Culturally and Linguistically Diverse
CCC	Corruption and Crime Commission
COAG	Council of Australian Governments
CPI	Consumer Price Index
CPR	Cardiac Pulmonary Resuscitation
CRSU	Community Supported Residential Units
DAIP	Disability Access and Inclusion Plan
DHAC	District Health Advisory Council
DOH	Department of Health
DPC	Department of Premier and Cabinet
DSC	Disability Services Commission
DVA	Department of Veterans' Affairs
ED	Emergency Department
EEO	Equal Employment Opportunity
EQUIP	Evaluation and Quality Improvement Program
FNOF	Fractured Neck of Femur
FOI	Freedom of Information
FTE	Full Time Equivalent
GP	General Practitioner
GSAHS	Great Southern Aboriginal Health Service
GSGP	Great Southern General Practice
HACC	Home and Community Care
HCN	Health Corporate Network
HMDS	Hospital Morbidity Data System
HRIT	Health Reform Implementation Taskforce
ICAM	Information Collection and Management Directorate
ITAB	Industry Training Advisory Body
LHAG	Local Health Advisory Group
LOOP	Learning Opportunities and Outcomes Program
MME	Midwest Management Enhancement
MOU	Memorandum of Understanding
MPS	Multi-Purpose Service
NAC	New Apprenticeships Centre
NCHS	Nindilingarri Cultural Health Service
NGO	Non Government Organisation

NICS	National Institute of Clinical Studies
OAG	Office of the Auditor General
OAH	Office of Aboriginal Health
OATSIH	Office of Aboriginal and Torres Strait Islander Health
OMH	Office of Mental Health
OPSSC	Office of the Public Sector Standards Commissioner
OSH	Occupational Safety and Health
PATS	Patient Assisted Travel Scheme
RCSS	Rural Community Support Service
RFDS	Royal Flying Doctor Service
SOYF	Stay on Your Feet
SQUIRE	Safety and Quality Investment in Reform
TI	Treasury Instruction
UWA	University of WA
VMP	Visiting Medical Practitioner
WACHS	WA Country Health Service
WLB	Work Life Balance

Delivering a Healthy WA

Healthy Workforce · Healthy Hospitals · Healthy Partnerships · Healthy Communities · Healthy Resources · Healthy Leadership

Produced by the
Analysis and Performance Reporting Directorate

Government of Western Australia
Department of Health