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

Annual Report

2021–2022

Acknowledgement

The WA Country Health Service acknowledges the Aboriginal people of the many traditional lands and language groups of Western Australia. We acknowledge the wisdom of Aboriginal Elders past and present and pay respect to Aboriginal communities of today.

Within Western Australia, the term Aboriginal is used in preference to Aboriginal and Torres Strait Islander, in recognition that Aboriginal people are the original inhabitants of Western Australia. Aboriginal and Torres Strait Islander may be referred to in the national context and Indigenous may be referred to in the international context. No disrespect is intended to our Torres Strait Islander colleagues and community.

Aboriginal people should be aware that this publication may contain images or names of deceased persons in photographs or printed material.

Featured artwork

WA Country Health Service would like to acknowledge Leeann Kelly/Pedersen and her artwork, which is featured throughout this report.

Leeann is a proud Wajarri/ Nhanda nyarlu, from the Midwest of Western Australia and works for the WA Country Health Service (WACHS). Leeann is a recognised artist in the Midwest community.

We sincerely thank Leeann for allowing us to feature her artwork in the WACHS Annual Report 2021-22.

About this report

This Annual Report describes the performance and operation of the WA Country Health Service during 2021–22. The report has been prepared according to parliamentary reporting and legislative requirements and is arranged as follows:

- **Overview**
  An introduction to the WA Country Health Service, legislative environment, services overview, executive summary, strategic plan and key highlights from 2021-22.
- **Governance**
  Information about our structure, Board and Executive members.
- **Agency performance**
  Summarises our performance against agreed financial and service delivery outcomes. This section includes financial statements and key performance indicators along with clinical performance information.
- **Significant issues**
  Key issues and focus areas for the WA Country Health Service in 2021-22.
- **Disclosure and compliance**
  Auditor opinion, financial statements, certification of key performance indicators, governance disclosures, government policy requirements and other legal requirements.
- **Appendices**
  Additional information and data to supplement the report.

You will notice our teams physically distancing during the COVID pandemic at times throughout this report. Some of the images featured were taken prior to these measures being put in place or at a time when they were not required.

Cover page photo: Zulieka Nuggett and baby girl Khaydence Smith, born 30 June 2022 in Derby Hospital.

Statement of compliance

FOR YEAR ENDED 30 JUNE 2022

Hon Amber-Jade Sanderson MLA
Minister for Health

In accordance with Section 63 of the *Financial Management Act 2006,* we hereby submit for your information and presentation to Parliament, the Annual Report of the WA Country Health Service for the reporting period ended 30 June 2022.

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

Dr Neale Fong
Board Chair
WA Country Health Service
16 September 2022

Mr Alan Ferris
Board Member
WA Country Health Service
16 September 2022

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Overview

Foreword

Board Chair, Dr Neale Fong

On behalf of the WA Country Health Service Board, I am pleased to present the WA Country Health Service 2021-22 Annual Report.

Unprecedented is a word that has been used a great deal in the last two years, however, 2021-22 was again a year in which we faced unprecedented challenges in the ongoing COVID pandemic response.

L-R: Kelly Howlett, Sheldon Paice, Lisa Biglin, Karen Horsley, Daniel Heredia, Paul Fitzpatrick, Dr Neale Fong, Meredith Waters, James Thomas and Subin Daniel.

Many WA Country Health Service (WACHS) staff have had their own experience of COVID, either personally or among teams, colleagues, friends and family. Despite these personal challenges, our staff have worked tirelessly to maintain our critical services in innovative ways throughout the year. The Board thanks our entire team for continuing to embody WACHS' values and deliver on our commitment to the best possible care for our communities.

The Board reduced its regional engagement program to three meetings in 2021–22 to allow local teams to focus on service delivery, travelling to the Wheatbelt in August, the Midwest in November and to the Kimberley at the end of June. During these visits Board members were able to see many examples of our staff delivering high quality care. The Board commends all staff for their ongoing commitment and looks forward to safely resuming its regional engagement program in 2022-23.

I would like to recognise and commend our staff for their commitment and going above and beyond to ensure that we were able to maintain services throughout 2021-22. WACHS continues to implement strategies to support teams to respond to increased activity, including working with partner agencies to build capacity and deliver patient services differently across WA. I thank our service partners and key stakeholders for their continued collaboration, which helps us to deliver on our mission to provide and advance high-quality care for country WA communities.

In 2021, Mrs Meredith Waters' term on the Board concluded, and I would like to acknowledge her significant contribution as an inaugural Board member and wish her the very best for the future. I also thank my fellow Board members: Ms Wendy Newman, our Deputy Chair; Mr Alan Ferris; Mr Paul Fitzpatrick; Dr Daniel Heredia; Ms Kelly Howlett; Dr Kim Isaacs; Dr Diane Mohen and Mrs Mary Anne Stephens for their ongoing commitment to engagement with our staff, communities and stakeholders.

The Board and I also thank the WACHS leadership team, led by Chief Executive Mr Jeffrey Moffet. The Executive's effective governance, leadership and capacity for innovation have ensured our health services have been maintained in rural and remote areas throughout this year.

Our health care facilities and the people who work within them are cornerstones of country communities. I again acknowledge our staff for their amazing efforts and resourcefulness during 2021-22. Their dedication to providing high quality health care for country WA communities is truly commendable. The Board is extremely proud of the WACHS team who live the values of community, compassion, quality, integrity, equity and curiosity every day.

Dr Neale Fong
Board Chair

Foreword

Chief Executive, Jeffrey Moffet

As the financial year draws to a close, we have the opportunity to again reflect on the remarkable efforts of our people who have maintained our services in the most challenging of times.

The COVID pandemic has again tested us, as individuals, family members, employees, employers and community members. To our staff we say thank you for your unwavering professionalism, compassion and commitment to your community.

In this year's report we want to acknowledge the efforts of our staff who continue to meet the needs of our communities in these challenging times and the vital work they do in serving the people of Western Australia. We acknowledge the significant impact that the COVID pandemic has had on our staff and their families and the way all have come together to support each other has been inspiring.

Our staff have continued to strive for excellence in achieving positive outcomes for our patients and communities.
I want to congratulate our staff on their resilience, ability to adapt to new working environments and embracing new technology.

This year has seen us further innovate to bring care closer to home through our Operations Hub, virtual care initiatives and our Acute Patient Transport Coordination Centre, which you will read more about throughout this report.

In closing, I again thank our teams for their dedication, solidarity, and the way they continue to step up and meet the needs of their communities.

Jeffrey Moffet
Chief Executive

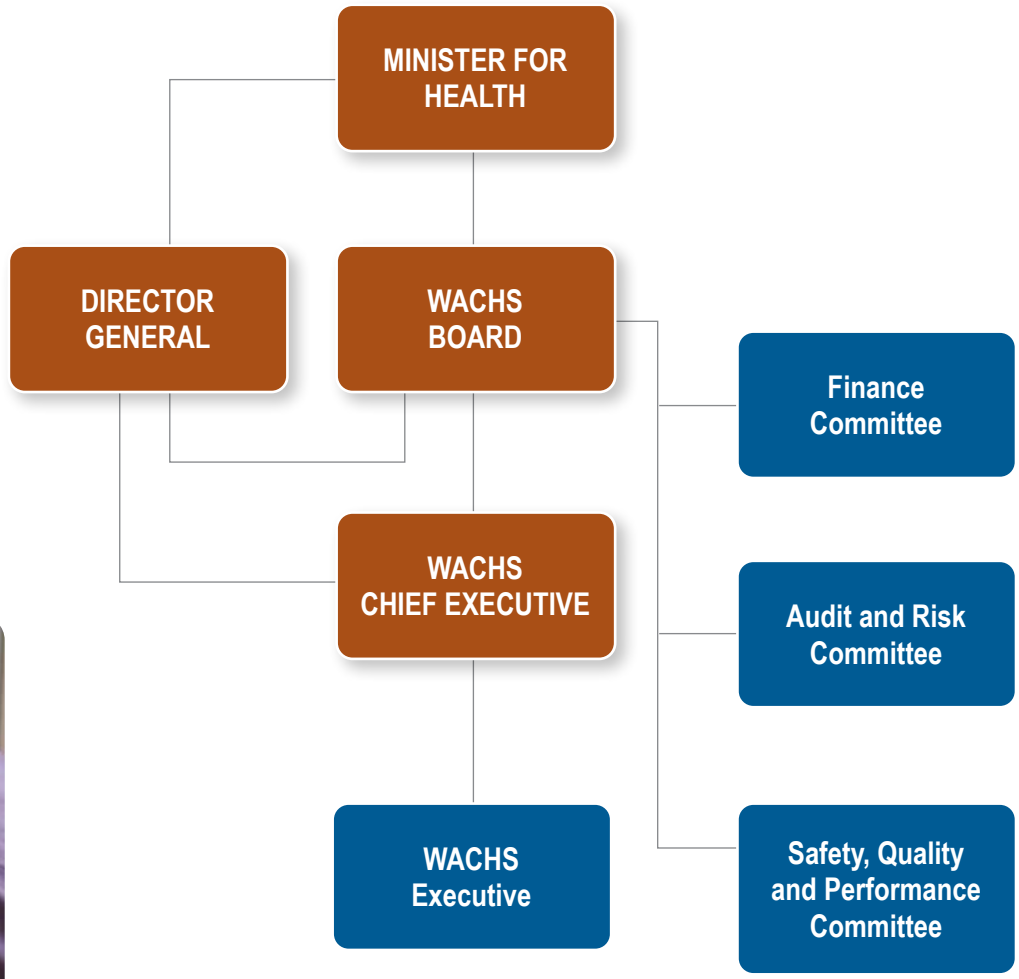
Our place in the wider health system

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

Each health service provider is governed by a Board appointed by the Minister for Health. Board members bring a wealth of experience in a range of fields such as healthcare, finance and law.

Health service providers are responsible and accountable for the delivery of safe, high quality, efficient and effective health services to their local areas and communities. They are the WA Country Health Service, Health Support Services, Child and Adolescent Health Service, East Metropolitan Health Service, North Metropolitan Health Service, South Metropolitan Health Service and PathWest. While we are the State Government healthcare provider for people residing in Country WA, we work in partnership with the Department of Health and other health service providers to ensure country patients receive coordinated care when needed.

Figure 1: Organisational structure



Minister

The WA Country Health Service is responsible to the Minister for Health, the Honourable Amber-Jade Sanderson MLA.

Accountable authority

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

The Board Chair, Dr Neale Fong is the reporting officer for the WA Country Health Service in 2021-22.

Enabling legislation

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

Executive summary

WA Country Health Service at a glance

It's our privilege to be able to provide exceptional, patient centred healthcare to people living in country WA.

From nursing posts and outreach services, to child health clinics and bustling regional hospitals, the WA Country Health Service (WACHS) plays an important role in the lives of people in country communities.

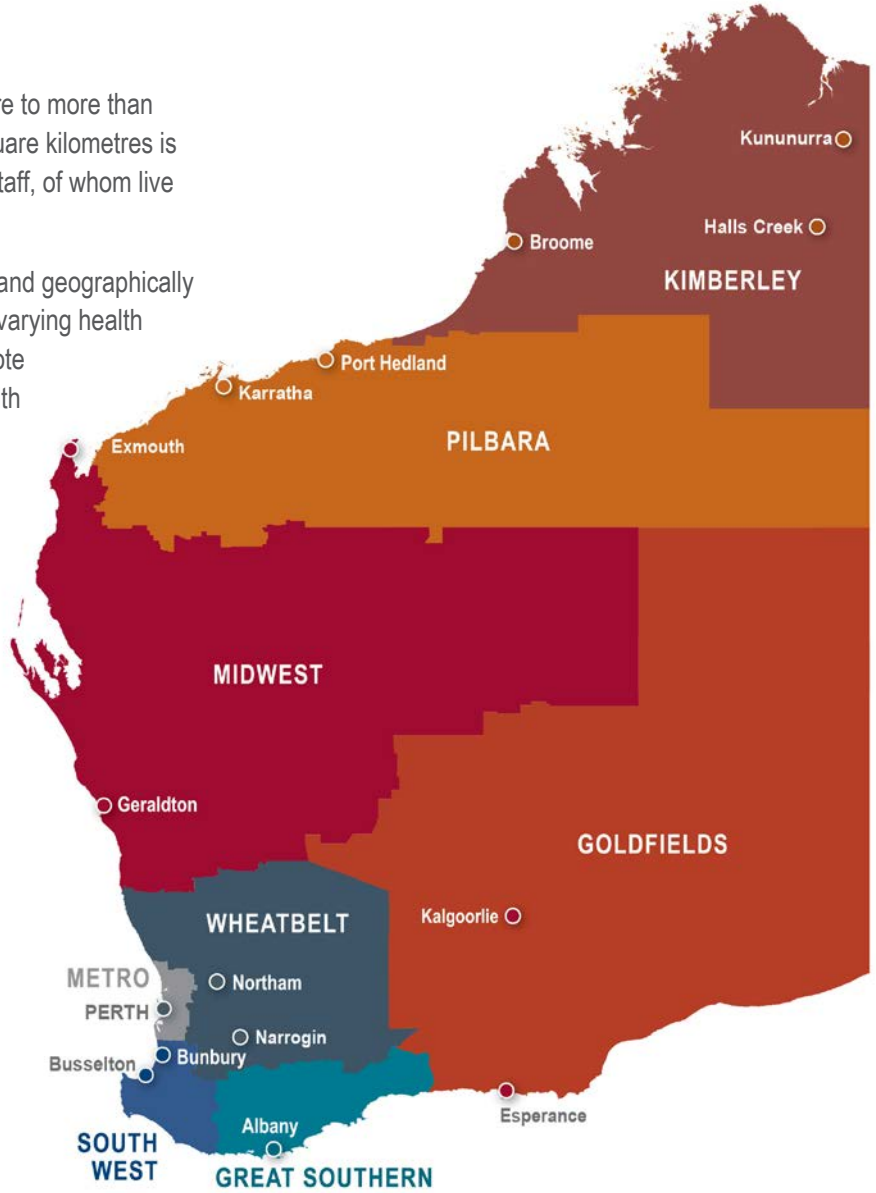
Across the State we have 6 large regional hospitals, 15 medium sized district hospitals and 48 small hospitals. In addition, there are 31 health centres and nursing posts, 4 dedicated mental health inpatient units, 24 dedicated mental health services which also provide outreach services to more remote locations, and more than 170 other facilities where population health teams are based.

We are often the largest employer in the towns in which we operate and we take seriously our responsibility within the communities we serve. WACHS employs nearly 10,000 people working across more than 100 facilities, in some of the most remote and sparsely populated towns.

We know that providing the best possible health care can impact people's day-to-day health and have a positive impact on the economic and social sustainability of our country communities.

Delivering the best possible healthcare to more than 530,000 people across 2.5 million square kilometres is only made possible by our amazing staff, of whom live and work in country communities.

The population we service is diverse and geographically dispersed and as a result has widely varying health needs. People living in rural and remote areas experience poorer general health than those in metropolitan areas, and Aboriginal health and life expectancy is significantly lower than that of non-Aboriginal people.



Employing nearly **10,000 staff** working across more than 200 facilities

Delivering healthcare to more than **530,000 people**

Executive summary

WA Country Health Service at a glance

In 2021-22 our regional emergency department teams attended to almost 444,000 presentations.

Our expert surgical teams conducted 5493 lifesaving and life-enhancing surgeries, with 23,626 patients seen who were on the Elective Surgery Waiting List.

There were 727,177 outpatient appointments attended and we helped to deliver more than 4500 babies in our WACHS Hospitals.

The Patient Assisted Travel Scheme subsided the cost of accommodation and/or travel for 35,612 country Western Australians to support access to specialist medical care.

Our 24 community mental health teams supported around 16,300 people, across all ages, with mental healthcare.

WHAT WE PROVIDE

Our services span across an area of more than 2.5 million square kilometres, from Kalumburu in the Kimberley to Albany in the Great Southern providing:

- EMERGENCY AND HOSPITAL SERVICES
- POPULATION AND PUBLIC HEALTHCARE
- ABORIGINAL HEALTH SERVICES
- MENTAL HEALTH SERVICES
- DRUG AND ALCOHOL SERVICES
- CHILD, COMMUNITY AND SCHOOL HEALTHCARE
- VIRTUAL CARE
- RESIDENTIAL AND COMMUNITY AGED CARE SERVICES

Attended to almost **444,000** emergency department presentations

Conducted **5493** lifesaving and life-enhancing surgeries

23,626 patients seen who were on the Elective Surgery Waiting List

727,177 outpatient appointments attended

Helped to deliver over **4500 babies** in WACHS hospitals

Helped **35,612 people** access PATS

Supported almost **16,300 people** with mental healthcare

Executive summary

WA Country Health Service at a glance

In 2021-22 we either commenced, progressed, funded or completed construction on 13 major facilities including large regional hospitals, small emergency departments, cancer treatment accommodation, aged care facilities and community health centres.

The new emergency department and outpatient centre at the Newman Health Service became operational.

We officially opened the brand-new Derby Community Health Service and the Gnullingoo Mia residential aged care and palliative care facility, located beside the Carnarvon Hospital.

The Bunbury Regional Hospital redevelopment, is currently underway and will be the biggest ever transformation of a WA regional hospital once complete.

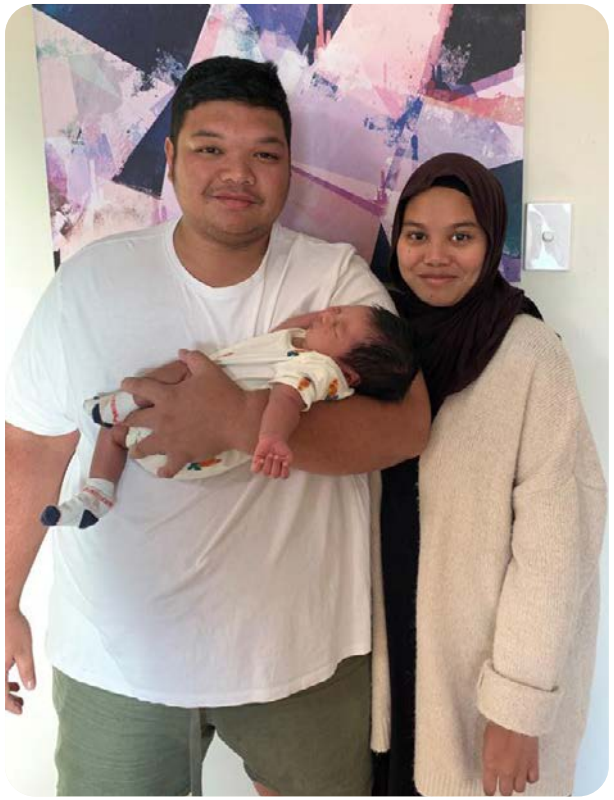
Executive summary

WA Country Health Service at a glance

Our staff have managed a once-in-a-generation pandemic while proudly safeguarding business continuity to ensure the best possible care for all our patients.

Since the first emergency telehealth consult ten years ago, Western Australia has been a leader in the advancement of digital healthcare solutions for rural and remote communities. We now have 86 emergency telehealth-enabled regional sites, along with 59 sites where local staff can provide continuity of high-quality care for inpatients with the support of telehealth, seven days a week.

While our 'business as usual' has started to look a little different as we learn to live with COVID, we couldn't be prouder of the extraordinary response from our teams that has kept regional communities safe. Our commitment to providing the best possible healthcare can be seen in the significant achievements we are proud to acknowledge throughout this report.



Executive summary

Working in partnership

Health service provision across Western Australia requires a range of service providers working in partnership throughout the patient journey to deliver high quality, safe and integrated healthcare.

In regional and remote Western Australia providing integrated care for patients is even more complex. Collaborating with our partners helps us provide a sustainable health system that enables all country Western Australians to have access to safe and high-quality healthcare.

The WA Country Health Service (WACHS) shares responsibility for delivering care with a range of other State agencies including, but not limited to: metropolitan health service providers; the Mental Health Commission; WA Police; the Department of Corrective Services; and the Department of Communities' Disability Service and Child Protection and Family Support divisions. We also work closely with general practitioners; the WA Primary Health Alliance; Aboriginal Community Controlled Health Services; local government; and other care and service providers in regional and remote communities across the State.

Curtin University is a key partner for WACHS, supporting sustainable and high-quality health systems in regional, rural and remote Western Australia through the WACHS-Curtin University Research and Innovation Alliance (the Alliance).

L-R: Jeffrey Moffet, Shelley Kneebone, Alan Ferris, Jo Moore, Wendy Newman, Dr Kim Issacs, Nick Mildenhall outside the Derby Aboriginal Health Service.

Launched in November 2021, the Alliance supports innovative projects that capitalise on the strengths of the university and health service to create positive change within the regional and remote healthcare ecosystem. The Alliance is led by key researchers and academics, allowing WACHS to drive its own research agenda supported by Curtin University's expertise and strong track record. It is also focused on novel and sustainable workforce development and capability-building initiatives, with research and innovation projects supporting WACHS to attract and retain our workforce and integrate training into our broader credentials.

A key area in which WACHS collaborates with partners is in the provision of services for children living in rural and remote Western Australia. WACHS works with Aboriginal Community Controlled Health Services (ACCHS) providing support to rural and remote communities across the State. This includes services to deliver child and school health services for children aged 0-5 years, providing screening and assessment, early intervention, health promotion and education services. Child and school health nurses in ACCHS also provide vaccinations under the WA Immunisation Schedule for vaccine preventable diseases.

Executive summary

Working in partnership

We know that travelling long distances can be a difficult experience for our patients and the time it takes our clinicians to organise a patient transfer can take them away from the care they need to be delivering to that patient. WACHS is committed to making patient transport a seamless and supported experience for all patients.

Since February 2021, we have collaborated with our transport partners Royal Flying Doctor Service (RFDS) and St John Ambulance (SJA) to design an integrated and coordinated inter-hospital patient transfer service.

In January 2021, we each collocated our key staff within the WACHS Command Centre, and through use of real time information we are now finding better and more efficient ways of coordinating patient movements. Currently operating 12 hours a day, the WACHS Command Centre has coordinated the transfer of over 4000 patients.

WACHS continues its partnership with RFDS to provide country patients who are living, working or travelling in regional Western Australia with access to vital health services if they need them.

On 10 May 2022 the first WACHS patient was transferred in the new RFDS helicopter from Harvey Health Service to Fiona Stanley Hospital.

This new patient transfer service supports time critical patient transfers from a 250km radius of Jandakot airport. Supported by a robust evaluation plan and ongoing partnerships with metropolitan health service partners, the RFDS helicopter has provided time critical transfers for approximately 18 patients so far.

WACHS also has a pivotal partnership with SJA in supporting a sustainable country ambulance service.

Through recent investments from the State Government WACHS has worked collaboratively with SJA to introduce 27 new paramedics across the State. This investment has increased the number of community paramedics in country WA, and added a number of paid paramedics to sub-centres previously operated solely by volunteers to support the safe transfer of country patients by road.

Strategic plan

To read more about our Strategic Plan and the priorities and actions that will help us get there – click here

The WA Country Health Service Strategic Plan 2019-2024 outlines the strategic direction of the organisation for five years, set against a fifteen-year horizon.

While our core focus is always improving the quality of care we deliver to country communities in the present, we are also planning for the future, where we aim to realise the transformative potential of new and emerging technologies in healthcare.

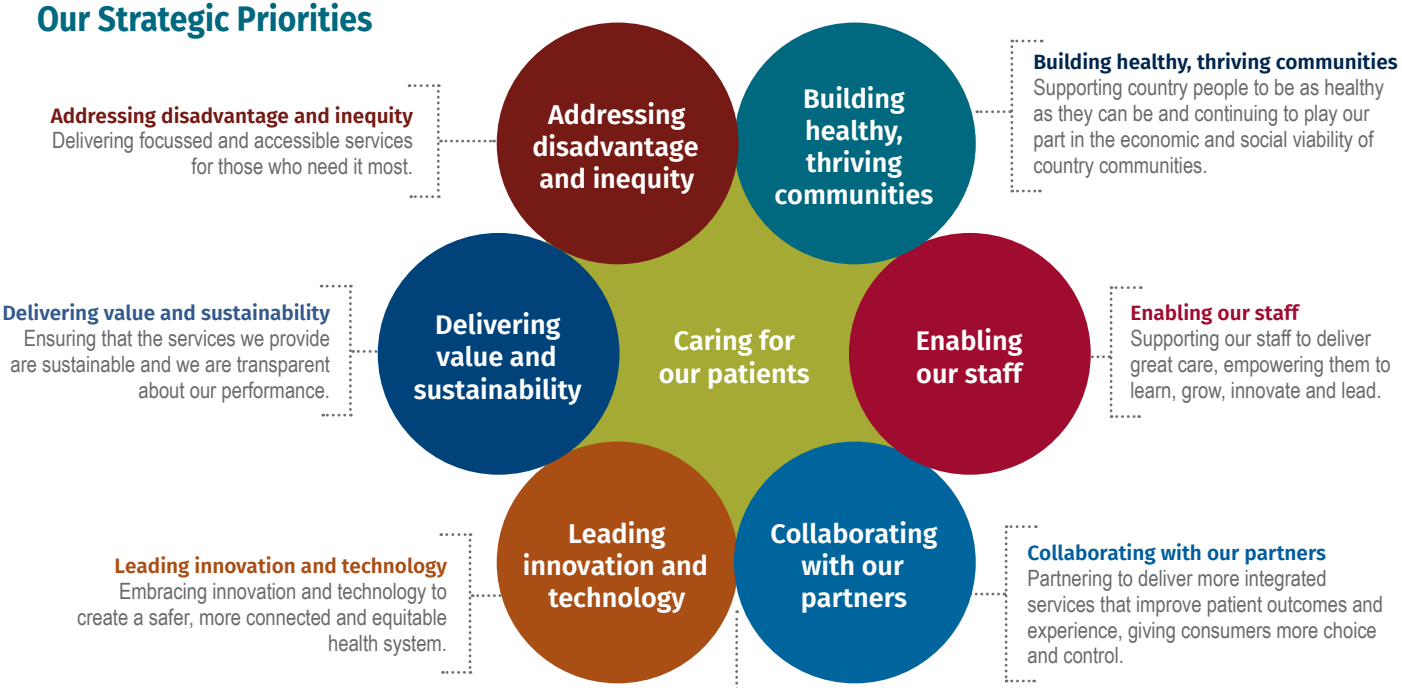
Our Mission

To deliver and advance high quality care for country WA communities.

Our Vision

To be a global leader in rural and remote healthcare.

Our Strategic Priorities



Addressing disadvantage and inequity
Delivering focussed and accessible services for those who need it most.

Building healthy, thriving communities
Supporting country people to be as healthy as they can be and continuing to play our part in the economic and social viability of country communities.

Delivering value and sustainability
Ensuring that the services we provide are sustainable and we are transparent about our performance.

Enabling our staff
Supporting our staff to deliver great care, empowering them to learn, grow, innovate and lead.

Leading innovation and technology
Embracing innovation and technology to create a safer, more connected and equitable health system.

Collaborating with our partners
Partnering to deliver more integrated services that improve patient outcomes and experience, giving consumers more choice and control.

Caring for our patients
Providing safe, patient-centred care, ensuring the needs of our patients are at the core of everything we do.

Our Values

Community

We live and work in country communities. We are invested in the health, wellness and viability of country communities and the vibrancy, diversity and future of country WA.

Compassion

We are inclusive, respectful, and considerate. We care deeply about the people in our care and country communities.

Quality

We provide safe, high-quality care, constantly striving to innovate, improve and achieve trust in our care.

Integrity

We bring honesty, collaboration and professionalism to everything that we do.

Equity

We are passionate about fairness in healthcare for all Western Australians, especially the most vulnerable and disadvantaged people and communities.

Curiosity

We continually enquire and seek to understand, using the best evidence, insight and research to improve care.

Investing in our services and small community hospitals

The WA Country Health Service continues to lead the development of infrastructure and services that enhance healthcare available to country communities, including through our small community hospitals and services.

This support has been achieved through significant State investment in both infrastructure and virtual care services.

Over the past decade, the WA Country Health Service (WACHS) has overseen the completion of close to 100 separate building projects which have included a number of new health campuses, primary health facilities, remote clinics and extensions and refurbishments to existing health campuses, totalling over $1.2 billion dollars.

A new Busselton Health Campus opened in 2015. Other WACHS Health Campus redevelopments occurred at Onslow, Karratha, Geraldton, Harvey, Esperance, Warren, Pingelly, Broome and Collie.

In 2016 construction of new small hospitals or nursing posts were completed in Gnowangerup, Kojonup, Tambellup and Wagin.

Developed by WACHS, the half a billion dollar Southern Inland Health Initiative (SIHI) was introduced as part of the 2011-12 State Government Budget. Funding for SIHI included more than $250 million to reform emergency, acute care and primary health services in southern inland parts of country WA, expand the telehealth network and the range of services delivered by telehealth, as well as $300 million for capital works upgrades.

Investing in our services and small community hospitals

The State Government has committed $6 million over four years for the Improving Ear, Eye and Oral Health of Children Living in Rural and Remote Aboriginal Communities. Funded through the Royalties for Regions Program, this initiative continued with Aboriginal Health Workers to screen for ear, eye and oral conditions.

As part of the Australian Government's $45.8 million Bringing Renal Dialysis and Support Services Closer to Home, a total of 72 renal hostel beds are now available at Derby, Kununurra, Fitzroy Crossing, Kalgoorlie and Carnarvon. An additional 17 dialysis chairs are located at Kalgoorlie, Fitzroy Crossing, Esperance and Roebourne.

A cancer diagnosis can be a difficult experience, and we are continuing to make enhancements to the chemotherapy services in our communities.

In 2016 we opened the Midwest Cancer Centre, which has six chemotherapy chairs, one chemotherapy bed and expanded treatment facilities. The Chemotherapy Cancer Centre at the Albany Health Campus has six chemotherapy chairs. Geraldton Hospital has a unit including four chemotherapy chairs and one chemotherapy bed. The Kalgoorlie Chemotherapy Cancer Centre has four chemotherapy chairs and one chemotherapy bed.

Investing in our services and small community hospitals

In 2018-19 an additional $1.4 million was invested to expand our existing mental health capacity for mental health services in the Goldfields. This has funded four additional mental health staff including doctors, nurses and allied health professionals.

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

Since its inception in 2012 over 115,000 people have accessed our Emergency Telehealth Services.

Our focus has been on providing care closer to home, and the substantial investment in technology, infrastructure and services in country health over the past decade. We have been able to keep hospitals and health services operational and continue to support country communities. More regional and remote towns now have modern health services and facilities, and new technology is constantly being rolled out to maintain services closer to where country people live.

In this section we bring you some stories that illustrate how we are delivering on our strategic priorities by continuing to invest in our community hospitals and services.

Investing in our services and small community hospitals

Technology supporting care closer to home and staff wellbeing

Across the WA Country Health Service, telehealth technology delivers a range of services including specialist emergency support to staff in country hospitals treating acute emergency patients, including mental health concerns; inpatient consults through virtual ward rounds; outpatient consults with specialists, as well as training and education for health staff and consumers.

WACHS COMMAND CENTRE

Caring for our patients

The WACHS Command Centre is now well established as an invaluable 24/7 resource for country clinicians in hospitals across the State, delivering a digitally-enabled, flexible and dedicated specialist clinical workforce to country hospitals and nursing posts in real-time.

During the pandemic, Command Centre services have proved their worth in providing back-up clinical support to our hard working front-line staff, helping to maintain service continuity across more than 80 WACHS sites while keeping patients in their communities wherever possible.

EMERGENCY TELEHEALTH SERVICE MEDICAL SUPPORT KEEPS EMERGENCY DEPARTMENTS OPERATIONAL

Leading innovation and technology

Service continuity support via the Emergency Telehealth Service (ETS) is an on-going process. The ETS supports sites in the absence of a local doctor as well as providing triage support when there is no on-site triage experienced nurse. During COVID, helping clinicians in remote sites treating patients when other staff are furloughed has never been more important.

For example, the ETS was called upon to provide vital senior medical support to a large regional site. As soon as the call for help came in, an emergency huddle with key stakeholders was instigated to identify how the ETS could best support the medical workforce at the site. In response, ETS increased its senior emergency department (ED) medical practitioner cover, enabling provision of a dedicated senior ED medical practitioner for the local team who assisted with decision making to ensure patient safety was maintained and the site team was receiving the appropriate level of collegiate support. Through this support, the ED staff were able to continue providing a critical service to the local community.

EMERGENCY TELEHEALTH SERVICE NURSING SUPPORT

Building healthy, thriving communities

In response to the pandemic, ETS nurses have been rapidly deployed to regions to provide senior ED experience to sites with critical workforce shortages.

This rapid deployment of staff has enabled sites to continue to provide a health service to the community as well as assisting local staff with fatigue management.

On a daily basis, the ETS nursing workforce provides triage support in the absence of local experienced triage nurses. When required, the ETS nurses can provide intensive support via virtual care to help manage fatigue and support our junior nurses working in the regions.

The ETS nursing team recently supported a Clinical Nurse Manager in a small Wheatbelt hospital by providing nursing support overnight, ensuring the hospital could continue servicing the community.

Investing in our services and small community hospitals

Technology supporting care closer to home and staff wellbeing

BACKUP SUPPORT FOR NEWLY QUALIFIED NURSES

Enabling our staff

The expansion of the WA Health Graduate Nurse Program in 2021 has resulted in a number of newly qualified graduate nurses (NQGN) being posted to WACHS sites. The increase in NQGN positions has not only provided nursing and midwifery graduates with more job opportunities in a supported environment, it has also significantly boosted the nursing workforce in country WA and helped maintain service continuity.

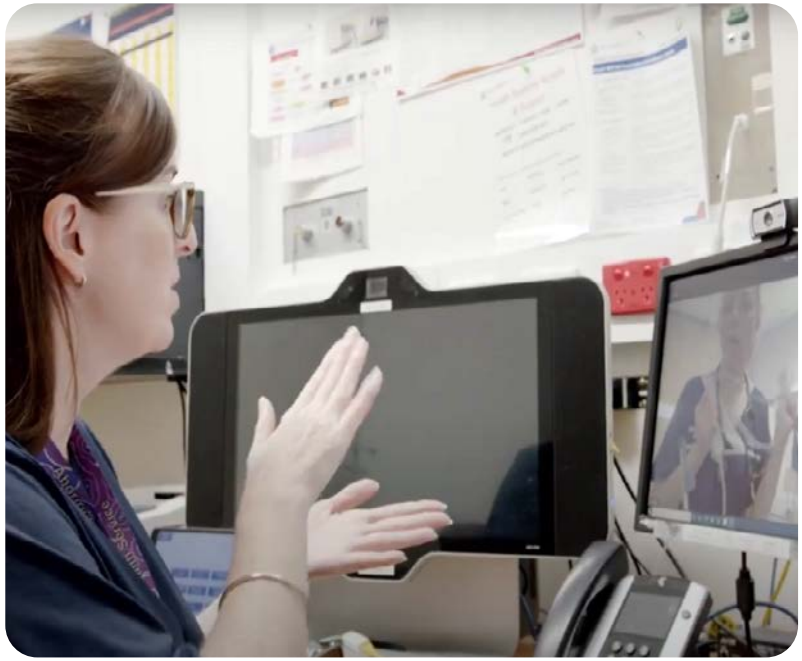
WACHS has welcomed these graduates with open arms and understands that going to a regional site as a graduate is much easier when there is support available. That's where the Command Centre's BACKUP service has proven to be invaluable for many of these NQGNs.

BACKUP's clinical nurse workforce provides peer support and education via world-leading videoconferencing technology to nurses working remotely, when their usual on-site support is not readily available.

This has been vital during the pandemic where agency or metro-based nurses are deployed to a new site and may not be completely familiar with that hospital's ED or theatre environment, as well as supporting increasing numbers of NQGNs.

The 24/7 support line is available to help newly-qualified and transitional nurses with any issues they are experiencing, whether they are clinical or personal, including on demand support in real time, mentoring and expert advice, ongoing skills development and simulations, reflection and debrief.

The BACKUP team has also been able to deploy staff to support critical workforce shortages and essential education and state-wide training programs to ensure continuity of safe, quality care.



MENTAL HEALTH EMERGENCY TELEHEALTH SERVICE SUPPORTS LOCAL TEAMS

Caring for our patients

The Mental Health Emergency Telehealth Service (MHETS) is a 24/7 specialist mental health virtual service staffed by experienced nurses, doctors and psychiatrists. Recently, MHETS has adapted service delivery to provide services to patients in emergency departments and mental health services across WACHS sites.

The MHETS team has provided increased in-reach to EDs where mental health staff shortages were being experienced as well as increasing the scope of service delivery to ensure timely care to patients when community mental health teams experienced unexpected staff furloughing and increased demand.

Through collaboration, partnerships and commitment of staff we were able to quickly and safely adjust service delivery to meet the needs of patients in country communities.

Investing in our services and small community hospitals

Technology supporting care closer to home and staff wellbeing

MIDWIFERY AND OBSTETRICS EMERGENCY TELEHEALTH SERVICE

Leading innovation and technology

Despite a national shortage of midwives and GP obstetricians in country communities, WACHS continues to offer birthing services in 18 sites across WA. In addition, WACHS has introduced an innovative new service that provides timely specialist advice and support to clinical staff at birthing and non-birthing sites, enabling more expectant mothers to stay closer to home wherever possible.

The Command Centre's Midwifery and Obstetrics Emergency Telehealth Service (MOETS) launched in February 2022, providing 24/7 support to midwives, obstetrics teams and non-birthing sites across WACHS. MOETS senior midwives and obstetricians are available to support clinicians on the ground with decision-making on the management of a woman's labour and assist if maternity and neonate transfers are required.

In the past 12-months, WACHS has installed electronic cardiotocograph (CTG) machines at all regional birthing sites. As a result MOETS clinicians can provide second clinician reviews of CTGs for midwives at the birthing site, meaning less travel for expectant mothers and safer care closer to home.

MOETS has provided invaluable support to our small community hospitals. With the expertise of the local midwives and the back-up of specialist obstetrics support via MOETS, expectant mothers have been able to continue accessing birthing services at their local hospital.

Investing in our services and small community hospitals

Technology supporting care closer to home and staff wellbeing

INPATIENT TELEHEALTH SERVICE – READY TO SUPPORT CONTINUITY OF CARE

Building healthy, thriving communities

The Inpatient Telehealth Service (ITS) allows patient care to continue seamlessly at small hospitals by connecting country patients with rural generalists via an iPad, when the local doctor is away or as has sometimes been the case during the pandemic - furloughed. The ITS has proven to be flexible and nimble in providing solutions that maintain service continuity and provide care closer to home for country residents.

When there was a COVID outbreak at WACHS's Wogerlin House Residential Aged Care Facility in Corrigin, the ITS team quickly came up with a plan that would allow the residents to stay at the facility while receiving appropriate medical care and clinical oversight.

Moving the COVID patients from Wogerlin House to the Corrigin Hospital would have increased the risk of exposure for patients and staff at the hospital. Instead, the ITS went to Wogerlin House.

A nurse from the hospital took the Command Centre's iPad to the aged care facility and supported the ITS doctor to review the residents who had been infected. Treatment was carried out on site, preventing further infection. It was an innovative solution that proved to be very effective and has since been replicated elsewhere.

For our hardworking and dedicated rural doctors, the ITS support means they can recover from illness or take the weekend off to rest and recharge while knowing the nursing staff are supported and their patients will continue to receive the best quality care.

PIVOTING OUTPATIENT APPOINTMENTS TO TELEHEALTH

Caring for our patients

Telehealth has played a key role in maintaining outpatient service continuity for regional and remote communities while keeping patients and staff safe from COVID. In the past 12 months, WACHS has continued to successfully pivot a significant proportion of outpatient appointments to telehealth, ensuring continued access to care keeping patients closer to home and reducing their exposure to the virus.

In February 2022 regional patients attended over 4500 outpatient appointments via telehealth, an increase of 62 per cent from the same time last year.

Of these, WACHS provided 2244 outpatient appointments. 72 per cent of which were provided in a home or community setting, making it even easier for country patients to minimise unnecessary travel and minimise COVID risk.

As COVID cases have increased, our staff have been at the forefront of the challenges faced every step of the way. They have risen to these and have been agile and flexible in their approach. WACHS has also increased resourcing and staff training to support this increased access to outpatient care via telehealth for country patients.

Investing in our services and small community hospitals

Workforce initiatives for sustainable services

In these unique times, our staff across the organisation continue to pull out all stops to ensure service stability and continuity for country communities.

In what has been an extraordinary response, service stability has been maintained thanks to the commitment of the WACHS workforce.

On any given day around 400 nursing staff are deployed to provide support to regional and remote facilities where workforce shortages are encountered for a variety of reasons.

WACHS WORKS WITH STAKEHOLDERS TO BOLSTER REGIONAL WORKFORCE

Enabling our staff

As staff furloughing increased during 2022 due to the COVID pandemic, WACHS has been agile in establishing a number of workforce initiatives and has collaborated with other health service providers and stakeholders to secure short-term staff to bolster the regional and remote workforce. Here are a few of these initiatives:

- WA prioritised support from NurseWest for agency staff to go to country locations to cover placements up to 12 weeks.
- WACHS Collaborate is an initiative between WACHS and metropolitan health service providers where a pool of metropolitan clinical staff has been established for deployment to regional locations across WA, providing much needed relief and assistance to local health teams. Deployments have been for two to six weeks and depending on their availability for release from their metropolitan hospital, are planned or a short notice deployment.
- Management of an interim incentivisation scheme offered to nurses and midwives on a daily basis for priority sites, when workforce shortages are identified for specific time periods.
- Collaboration with nursing agencies to provide nurses from interstate to support country workforce placemenmts for 10-13 weeks.
- Deploying Command Centre nurses and midwives from the ETS and MOETS teams to regional health sites to support short term furloughing.
- Returning clinical staff working in management and administrative positions to clinical roles where appropriately trained and registered to do so.
- Provide professional development for clinicians to enable flexibility across additional areas during high furlough periods.
- Increasing our intake of Newly Qualified (Graduate) Registered Nurses from 196 in 2021 to 267 in 2022.

- Plans to increase the medical internship program from 35 full time equivalent (FTE) to 65 FTE over the next five years and the commencement of 35 rural generalist trainees in 2021.
- Increasing national and international advertising campaigns for experienced nurses.
- Social media recruitment campaigns to entice clinical staff from within WA, eastern states and internationally to consider a career in the country.
- Creation of roles to engage registered nurse students who have not yet completed their qualification, but who wish to work in Assistant in Nursing roles whilst studying and are at the appropriately assessed skill level.

Investing in our services and small community hospitals

Workforce initiatives for sustainable services

COMMUNITY SUPPORT HELPS TO STAFF COVID TESTING CLINICS

Collaborating with our partners

In early 2022, COVID testing clinics were established across regional Western Australia in preparation for the opening of the WA border. These clinics required a workforce of hundreds, and it was clear an alternative workforce would need to be sourced to ensure country communities had access to testing clinics as close to home as possible.

Regional and Central Office teams set about recruiting hundreds of country and metropolitan people to staff the COVID testing clinics. From taxi drivers to retired nurses and medical students, people across the State answered the call to help country WA's effort against COVID.

Comprehensive training in the collection of COVID pathology samples and how to prepare specimens and register requests for processing was developed and made available in the form of online training and assessment modules. These allowed for recruitment and training of specimen collectors locally.

Where there was a cluster of cases in a specific town, WACHS staff worked closely with health partners such as Aboriginal Medical Services to ensure temporary testing clinics were quickly set up. Logistically, this required organising transportable buildings, personal protective equipment, testing kits, rosters and the mobilisation of clinical and non-clinical staff who stepped up when their community needed them.

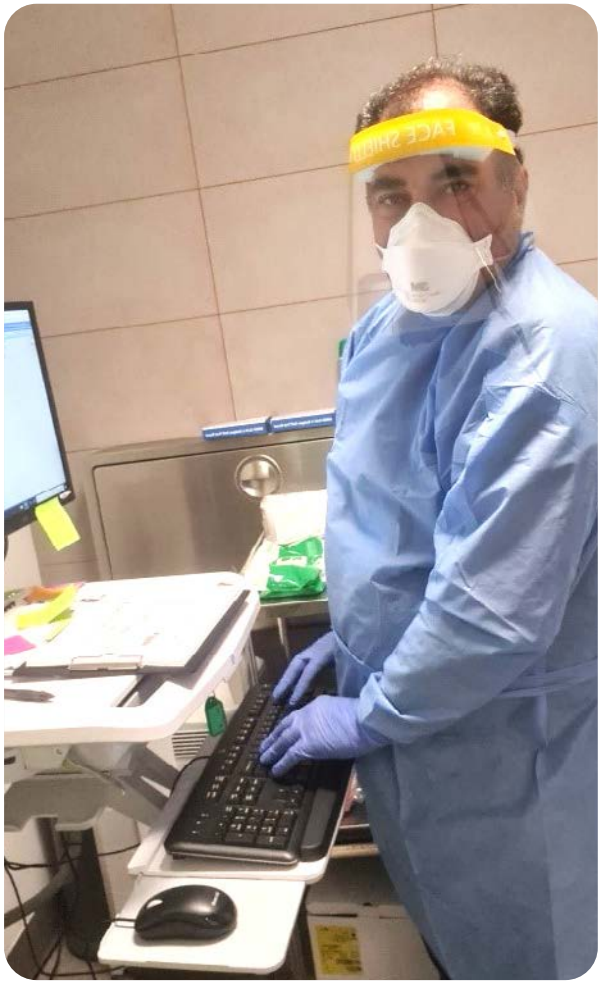
PathWest partnered with WACHS to help upskill our collection workforce as well as deploying some of their own staff to regional clinics when there were surges in testing or WACHS staff shortages due to furlough.

PathWest also deployed the Cobas Liat and GeneXpert instruments and developed associated training packages for their use, enabling WACHS to undertake rapid COVID tests in regional sites.

Feedback from some of the specimen collectors deployed to WACHS sites to support local communities was very positive:

"Great opportunity to work with and meet new people. Experiencing and learning about Aboriginal health and culture was a unique experience. Working in the Kimberley benefitted my personal growth which increased my enjoyment, acceptance and learning on the job."

"It was a fantastic experience - everyone was so kind and welcoming I never felt like an outsider or outcast. People were always willing to help and assist on any matters and were often quick to respond or provide solutions. Furthermore, it was also just a lot of fun as well as interesting learning experiences and a beautiful location to be in."



Perth taxi driver Omid Namdar trained to be a specimen collector and has been deployed to a number of sites across WACHS.

Investing in our services and small community hospitals

Investing in country infrastructure

WACHS is currently undertaking a range of infrastructure projects that will see improvements to staff accommodation and upgrades to health facilities, making working and living conditions better for our staff and health facilities more comfortable for our patients.

UPGRADING INFRASTRUCTURE AND IMPROVING STAFF RETENTION

Enabling our staff

WACHS is committed to providing staff safe and secure workplaces and accommodation in regional towns. We acknowledge availability of accommodation is an important consideration for people seeking work in a country location.

- A three-year $29.1 million stimulus program is well advanced with regional minor works upgrades and refurbishment projects due for completion in 2022-23. The wide-ranging projects include staff accommodation and health facility upgrades.
- WACHS funding commitment of $10.8 million has been allocated to:
  - undertake priority refurbishments to 49 staff accommodation properties.
  - undertake WACHS-wide security risk assessment on all WACHS leased and owned properties. As part of the security risk assessments project, a WACHS-wide staff survey was conducted to gather feedback on dwelling safety and security. One of the outcomes of the survey has been WACHS developing a CCTV ‘opt in’ trial proposal for staff in WACHS accommodation.
- The State Government allocated $5 million in the 2022-23 budget for WACHS to purchase dwellings and establish demountable housing solutions.
- A further $2.5 million was allocated over four years for health facility minor works that in 2021–22 included upgrades at Kununurra, Collie and Carnarvon Hospitals, Hedland and Geraldton Health Campuses.

Graduate nurse Monique Maunton in the refurbished staff accommodation.

Upgraded staff accommodation in Kununurra.

Investing in our services and small community hospitals

Investing in country infrastructure

INVESTMENT TO IMPROVE QUALITY OF LIFE FOR WACHS AGED CARE RESIDENTS

Addressing disadvantage and inequity

WACHS is committed to investing in the health, wellness and viability of country communities.

In mid-2021, there was an opportunity for WACHS to apply for a Commonwealth grant that would significantly improve the day-to-day life of residents in our aged care facilities. The $40 million grant opportunity was in response to the Royal Commission into Aged Care Quality and Safety final report, to support minor capital projects that directly relate to the provision of residential aged care as part of the Multi Purpose Services Program.

WACHS Aged Care and Infrastructure teams worked with staff across our sites, residents of the Multi-purpose sites (MPS) and community members in developing 35 grant applications, with the aim to better support residents experiencing dementia, create more home-like environments and improve quality and safety of services delivered at our aged care facilities.

WACHS was successful in securing $13.92 million in Commonwealth grant funding for 35 MPS across country WA - around 39 per cent of the total funding awarded by the Commonwealth. The total estimated value of the projects across the 35 sites is $22.05 million, with WACHS committing a further $8.13 million.

Carnarvon Hospital.

This significant upgrade project includes capital works and new furnishings to resident rooms, bathrooms, common areas and outdoor areas; incorporating contemporary dementia-friendly environment design principles. It is estimated the works will be completed by mid 2024, with several projects forecast to be completed earlier.

The upgrades support the National Safety and Quality Health Service Standards MPS Aged Care Module actions related to consumer dignity and choice, supports for daily living and providing a home-like service environment.

Investing in our services and small community hospitals

Investing in country infrastructure

WACHS INVESTMENT HELPS OLDER DONGARA RESIDENTS STAY IN THEIR COMMUNITY

Building healthy, thriving communities

A partnership between WACHS, the Department of Primary Industries and Regional Development and the Shire of Irwin has helped older residents of Dongara and surrounding communities to remain connected to family, friends and loved ones for longer, with the construction of six new purpose-built age-friendly homes in the centre of town.

Constructed with a $2.4 million investment from WACHS's $26 million Residential and Dementia Investment Strategy, the homes are designed with simple innovations that can help older people live independently, safely and well in their community.

Officially opened in June 2022, the independent living units ensure residents feel comfortable, supported and most of all – at home.

The six new homes are part of a specially designed age-friendly precinct to encourage residents to meet, talk and foster community spirit, with the reassurance of safe pedestrian access to shops and other essential local amenities.

A total of 46 new homes have been constructed across regional Western Australia as part of the Residential and Dementia Investment Strategy, as well as a community centre that is due to open in Albany later in 2022.

KALGOORLIE RENAL HOSTEL – SUPPORTING TREATMENT CLOSER TO HOME

Caring for our patients

A 19-bed residential facility for people undertaking dialysis at the Kalgoorlie Health Campus has opened, allowing them to stay on country and remain connected to their community, family and friends.

The WACHS-managed and operated Kalgoorlie Renal Hostel, is a much-needed facility, providing modern accommodation in a respectful and culturally appropriate setting and enabling renal patients to stay for the duration of their treatment. The hostel is currently operating at full capacity since the first intake of residents took place on 12 October 2020.

This year, to improve the cultural safety of the environment, a fire pit and cultural yarning circle will be built in the centre of the hostel grounds. This will serve as a place for residents and staff to communicate with each other and will also assist as a place to heal the mind, body and spirit; a particular benefit to those who miss their homelands and extended families.

Without this facility, people requiring long-term accommodation from the many communities around the Goldfields would need to go to Perth for their dialysis treatment.

For people undergoing dialysis treatment or recovering from a kidney transplant, the renal hostel offers a self-care environment that includes healthy meals as well as activities and support through partnerships with external services.

The $7.4 million Kalgoorlie Renal Hostel is part of the Commonwealth Government's $45.8 million Bringing Renal Dialysis and Services Closer to Home program, with operational costs funded by the WA State Government.

Kalgoorlie Renal Hospital.

Investing in our services and small community hospitals

Thinking outside the square to keep important services running

Throughout the pandemic, WA Country Health Service staff have found ways to continue to deliver services to country communities, no matter the obstacles.

BROOME RECOVERY CENTRE STAFF FIND A WAY TO STAY CONNECTED TO THEIR COMMUNITY

Addressing disadvantage and inequity

The WA Country Health Service's Broome Community Recovery Centre provides a place where people with lived expertise, community-based organisations and Kimberley Mental Health and Drug Service (KMHDS) staff collaborate in the design and delivery of events, programs and activities focusing on wellbeing and recovery.

People with mental health and drug and alcohol issues, their carers and families, and interested community members are all welcome to participate. The recovery centre incorporates cultural security, inclusion, connectedness, hope and optimism in all aspects of its operations.

In early 2022 as a result of COVID protocols, the recovery centre had to cease all face-to-face contact with the Broome community. This was a significant disruption as providing a space for meaningful human connection is one of the most important aspects offered. Recovery centre staff were determined to find a way to support people's wellbeing and maintain a connection with the diverse groups of people they had established relationships with over the years, and so the Art for Everyone Program was created.

Amy Wallace, a peer worker at the recovery centre co-facilitated this non face-to-face eight week program with Broome artist, Tamara Burchell. Participants were introduced to a variety of art media through guided exercises. It was offered to people in Broome, Kununurra and Derby including staff, KMHDS clients, community members and recovery centre users. The level of response was very unexpected with registrations coming in daily.

Some of the participants' artwork.

Broome Recovery Centre Peer Worker Amy Wallace with some of the artwork on her computer.

Investing in our services and small community hospitals

Thinking outside the square to keep important services running

The Art for Everyone Program incorporated the following features:

- An inclusive format accommodated participants with all levels of technological resources with both printed and video instructions;
- Distribution of a personal art pack to each participant with good quality art materials and equipment to complete exercises;
- Regular contact with peer worker co-facilitator; and
- a private Facebook group to share work and get feedback from the artist co-facilitator.

The program enabled the recovery centre to continue providing a shared learning space where staff, community members, consumers and carers came together to engage in meaningful activities.

The program broadened the opportunity for more people to experience a dynamic learning environment. There are plans to continue the Art for Everyone Program in a non-face-to-face format once the recovery centre can open its doors again.

Artist Tamara Burchell.

Investing in our services and small community hospitals

Thinking outside the square to keep important services running

GENERAL PRACTITIONER STEPS UP TO ENSURE ONGOING MEDICAL COVERAGE IN REMOTE COMMUNITIES

Collaborating with our partners

For 14 years, WA Country Health Service (WACHS) medical officer Dr Charl Du Plessis has been a reassuring presence in the towns of Leonora and Laverton, ensuring the communities have a regular General Practitioner (GP) and medical coverage at the hospitals.

In 2018, Dr Du Plessis expanded his practice to Meekatharra, sharing the GP and on-call hospital workload with permanent and locum GPs across the three towns depending on need, as well as working at his city practice. It was a busy time with Dr Du Plessis spending a lot of hours travelling.

When COVID struck, the pool of locum GPs quickly dried up, leaving the remote communities short on medical cover. Dr Du Plessis made the decision to put the community first and based himself in Laverton for 12-months, while still helping with shifts at Meekatharra and Leonora hospitals when required.

It has meant time away from his family, long work hours and being on-call 24/7. But Dr Du Plessis says it has been worth it to ensure the communities have reliable medical care.

"I have personal relationships with many people in these communities and they really appreciate what I do," he said.

"It is nice to make a difference, see how people change when they look after their health."

Dr Du Plessis said working with WACHS offers the best of both worlds – allowing him to use his emergency skills as well as seeing his patients in the general practice clinics, located at the Meekatharra Laverton and Leonora hospitals.

Dr Du Plessis is a shining example of how WACHS staff go above and beyond to ensure country communities can continue to access high quality health care.

Dr Charl Du Plessis.

Investing in our services and small community hospitals

Developing our future leaders

WA Country Health Service (WACHS) is committed to building a sustainable workforce.

Enabling our staff

One way WACHS has invested in 'growing our own' is through the WACHS Future Leaders Program. This customised program which commenced in 2018, assists a number of WAHS leaders to develop leadership skills. The program was delivered in conjunction with the Australasian College of Health Service Management and the University of New England.

The Future Leaders Program, which was a WACHS first, included an academic component, face to face professional development and coaching and mentoring support.

In 2021 our inaugural cohort graduated from the program. 12 leaders completed the program over a four-year period and have each obtained a postgraduate qualification at Masters or Graduate Certificate level.

A graduation ceremony was held at Grace Vaughan House, attended by the WACHS Board and Executive, as well as the families and colleagues of our Future Leaders. At the ceremony, graduands were congratulated for their significant investment of time, energy and commitment to completing the program.

L-R Back row: Vernon Dann, Jacinta Herbert, Peter Tredinnick, Jeffrey Moffet – Chief Executive, Trisha Power, Joanne Clark, Basil Paulose. L-R Front row: Yvonne Bagwell, Louise Steedman, Jemimah Solomon, Dr Neale Fong, Michelle Carrington, Alicia Michalanney.

The Future Leaders program allowed us to develop the skills and expertise of our current staff, creating experienced and educated leaders for health care in country WA for the future. The program was evaluated with positive results.

Governance

WA Country Health Service Board

The WA Country Health Service (WACHS) is a State Government statutory authority under the *Health Services Act 2016.* The legislation establishes the WACHS Board as being the responsible and accountable governing body for delivering safe, high-quality, efficient and economical health services to country Western Australian communities.

The WACHS Board is comprised of highly capable and committed professionals with a diverse range of experience across the fields of medicine and healthcare, business, finance and law.

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

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

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

L-R Front Row: Dr Neale Fong (Board Chair), The Honourable Amber-Jade Sanderson MLA, Wendy Newman (Deputy Chair), Jeffrey Moffet (Chief Executive), On Screen: Members of the WACHS Board and Margaret Denton (Chief Operating Officer).

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

WACHS Board regional engagement since 2016

WA Country Health Service Board

BOARD REGIONAL ENGAGEMENT

WACHS has a strong and proud commitment to engagement with our local communities and has given priority to this engagement throughout Western Australia.

Integral to the WACHS Board's decision making and strategy development is the engagement with our regional communities, including those who work with or within our services. The strength and accomplishments of our services are reliant on the ongoing and constructive relationships between our staff and their communities.

Since its inception in 2016, the WACHS Board has ensured it spends time working with our Executive and management teams. The Board endeavours to hold meetings at least five times each year in regional Western Australia. These important regional engagement visits are complemented by opportunities for direct engagement with local staff, consumers, carers and many of our partners and stakeholders.

Engagement builds upon and strengthens our relationships with our staff, communities and stakeholders.

It also allows for meaningful conversations for a shared and better understanding of issues, challenges, successes, feedback and ideas within each community; local priorities and partnerships that could help improve health outcomes; WACHS strategic directions and priorities, and employee and community experiences.

L-R Front Row: Jeffrey Moffet, Meredith Waters, Dr Neale Fong, Dr Kim Issacs, Kelly Howlett. L-R Back Row: Alan Ferris, Paul Fitzpatrick, Wendy Newman, Dr Diane Mohen in front of the Meekatharra Hospital.

WA Country Health Service Board

Due to COVID restrictions, the Board's regional engagement was limited to three visits in 2021-22, however the Board looks forward to safely resuming its customary regional engagement program in 2022-23.

Board meetings were held in the following country towns:

- **Northam (27 August 2021)**
- **Geraldton (26 November 2021)**
- **Broome (1 July 2022)**

The Board would like to acknowledge the Regional Directors and their dedicated teams for their involvement in regional Board meetings and engagement activities.

L-R: William Harding, Jeffrey Moffet, Wendy Newman, Keven Renshaw during demonstration with a airway mannequin.

L-R: Jo Forbes, Leanne Sice, Kelly Howlett, Paul Fitzpatrick, Dr Neale Fong and Vanessa Parker at the Morawa and Perenjori Health Service.

WA Country Health Service Board

FULL BOARD MEETING

Table 1: Board member's Full Board Meeting attendance for 2021-22

Name	Number of meetings	Number of meetings attended
Dr Neale Fong (Chair)	9	9
Wendy Newman	9	9
Alan Ferris	9	9
Paul Fitzpatrick	9	9
Dr Daniel Heredia	9	9
Kelly Howlett	9	9
Dr Kim Isaacs	9	9
Dr Diane Mohen	9	9
Mary Anne Stephens	9	9
Meredith Waters*	2	2

Note: *Ceased as a WACHS Board Member as at 30 September 2021.

FINANCE COMMITTEE

Table 2: Board member attendance at Finance Committee for 2021-22

Name	Number of meetings	Number of meetings attended
Alan Ferris (Chair)	5	5
Wendy Newman	5	5
Mary Anne Stephens	5	5

AUDIT AND RISK COMMITTEE

Table 3: Board member attendance at Audit and Risk Committee for 2021-22

Name	Number of meetings	Number of meetings attended
Mary Anne Stephens (Chair)	7	6
Meredith Waters*	2	2
Kelly Howlett	7	7
Paul Fitzpatrick	7	7
Dr Diane Mohen**	5	5

Note:
*Ceased as a WACHS Board Member as at 30 September 2021.
**Committee member from 13 October 2021.

SAFETY AND QUALITY COMMITTEE

Table 4: Board member attendance at Safety and Quality Committee for 2021-22

Name	Number of meetings	Number of meetings attended
Dr Daniel Heredia (Chair)	10	10
Dr Kim Isaacs	10	10
Meredith Waters*	3	2
Dr Diane Mohen	10	10

Note: *Ceased as a WACHS Board Member as at 30 September 2021.

WA Country Health Service Board

DR NEALE FONG (CHAIR)

Dr Neale Fong is a registered medical practitioner with over 35 years' experience in a wide range of leadership roles in the private and public hospital systems.

He is currently Chief Executive Officer and Executive Director of Bethesda Health Care, a Director of several health companies, President of the Australasian College of Health Service Management, and Chair of the International Hospital Federation Global Healthcare Management Special Interest Group. Dr Fong has been the Director General of the WA Department of Health, CEO of St John of God Hospital Subiaco and Director of the Curtin Health Innovation Research Institute at Curtin University. He was Project Lead to the Australian Health Ministers Council in developing Australia's first Health Leadership Development Capability Framework.

Dr Fong was the Chairman and Commissioner of the WA Football Commission for 12 years and was Chaplain to the West Coast Eagles Football Club for 22 years.

He has Bachelor degree in Medicine and Surgery, a Masters of Theological Studies and a Masters of Business Administration.

Dr Fong was awarded the Gold Medal of Australasian College of Health Service Management in 2019, named a finalist in the 2010 WA Citizen of the Year Awards and awarded a Centenary Medal in 2011 for services to healthcare by the Australian Government.

MS WENDY NEWMAN (DEPUTY CHAIR)

Wendy Newman has extensive experience in individual, organisational and regional development. In addition to her role as Deputy Chair of the WA Country Health Service Board, Wendy is Deputy Chair of Regional Early Education and Development (REED) Inc. and on the Board of Regional Development Australia – Wheatbelt.

Wendy has extensive experience as an executive and non-executive director working at all levels of government and across industry sectors to develop strategy, drive reform and deliver initiatives that result in improved economic and social outcomes for regional communities.

Such initiatives include driving collaboration across local government boundaries and key government agencies on priority development issues, assisting in the development and delivery of sustainable childcare services and developing and delivering innovative models for aged care in regional settings.

Wendy has a Masters of Commerce (Management), a Bachelor of Education and is a graduate of the Australian Institute of Company Directors.

WA Country Health Service Board

MR ALAN FERRIS

Alan Ferris is the Director of Corporate Services at the City of Melville, a position he has held since 2019. Prior to this Alan has had his own consulting business and led the consulting team at BDO, a large accounting firm. He has significant experience in government and not-for-profit sectors. He has worked in the Senior Executive Service of the State Government in positions including General Manager of the Perth Theatre Trust and Director General of the Department of Culture and the Arts. He also held the position of Chief Financial Officer in Culture and the Arts for seven years.

Alan is the Chair of the Palmerston Association Incorporated, a not-for-profit provider of drug and alcohol counselling services. Besides working at the City of Melville, Alan's previous experience in Local Government was as Mayor of the Town of East Fremantle for six years and a Councillor for eight years.

Alan holds a Bachelor of Commerce (Accounting and Information Systems), is a Certified Practising Accountant and a Fellow of Leadership WA.

Outside of the finance industry, Alan enjoys all sports, especially soccer and golf, and spending time with his wife and two daughters.

Alan chairs the WA Country Health Service Board Finance Committee.

MR PAUL FITZPATRICK

Paul Fitzpatrick was a partner of Clayton Utz between 1 July 1985 and 30 September 2019 and practised in the areas of commercial litigation, competition law, national competition policy, international and domestic arbitration and sports law.

Paul is a former Partner in Charge of the Perth Office of Clayton Utz, and has conducted a wide range of complex litigation, including contractual disputes and cases relating to the Competition and Consumer Act, the corporations law, professional negligence, and intellectual property.

Paul was named Competition Lawyer of the Year, Perth in 2013 by Best Lawyers Australia, and has been named by Best Lawyers as one of Australia's best lawyers in litigation, competition and alternative dispute resolution.

Paul was a legal advisor to the Western Australian Football Commission and the West Australian Institute of Sport (WAIS), is a former Director of WAIS, current Director of the Wally Foreman Foundation Inc. and the Deputy Chairman of the West Coast Eagles.

DR DANIEL HEREDIA

Dr Daniel Heredia is the Executive General Manager of Health at HBF and was formerly the Deputy Chief Executive Officer and Medical Director at Hollywood Private Hospital. He has previously worked as a Medical Advisor to Medicare Australia and prior to this, worked in clinical medicine at various hospitals in WA. Daniel was appointed to the National Medical Board of Australia in 2022 and, prior to this, chaired the WA Registration Committee for the Medical Board of Australia.

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

Daniel is passionate about developing the next generation of leaders in the healthcare system. Outside work Daniel enjoys travelling and spending time with his young family.

Daniel chairs the WA Country Health Service Board Safety and Quality Committee.

WA Country Health Service Board

MS KELLY HOWLETT

Kelly Howlett is currently the Chief Executive Officer of Pilbara charity, Bloodwood Tree Association Inc. Bloodwood Tree is a wholly Aboriginal controlled organisation that provides services to those in need, disadvantaged, unemployed and affected by alcohol and drugs in the Port Hedland and broader Pilbara area.

Kelly has made her life and career in the Pilbara, and most notably served as Mayor of the Town of Port Hedland for almost seven years until 2016.

Kelly was inducted into the Western Australian Women's Hall of Fame in March 2018 in recognition of her lengthy contribution to the Pilbara environment and community. Kelly has extensive governance experience and a keen interest in the social, natural environment and sustainability.

Kelly has a Bachelor Science (Environment) / Bachelor Forest Science (Honours) and is a graduate of the Australian Institute of Company Directors.

Kelly is also a Board Member of the WA Waste Authority.

DR KIM ISAACS

Dr Kim Isaacs is a Yaruwu, Karajarri and Noongar woman and General Practitioner who has a strong background working in rural and remote medicine and Aboriginal primary health care.

Kim is the Aboriginal Health Clinical Lead for GP Training at WA General Practice Education and Training and Senior Lecturer at the University of Notre Dame Australia School of Medicine.

She is a Fellow of the Royal Australian College of General Practitioners and a Fellow of the Australian Rural Leadership Foundation.

Kim also has a Bachelor of Commerce with a major in Accounting and Finance from the University of Western Australia.

Kim is passionate about mentoring and training medical students and GP registrars, and has a strong interest in child health, mental health and advocating to improve the health service delivery for regional communities.

DR DIANE MOHEN

Dr Diane Mohen was the former Medical Director of the state-wide Obstetric Support Unit and former WA Country Health Service clinical lead in obstetrics and gynaecology.

She has had a career spanning more than 40-years, initially in general practice and then as a specialist obstetrician and gynaecologist and has worked tirelessly to improve the health of rural women and babies in Western Australia.

Diane was awarded the Public Service Medal in 2016 and was joint winner of the Western Australian Minister for Health's Award in 2017.

In addition to her role on the WA Country Health Service Board, Diane continues to work as a part time clinician and as a member of a number of committees supporting rural workforce initiatives.

Supporting and developing a sustainable rural health care workforce and quality health services for rural communities have been a career long interest.

WA Country Health Service Board

MS MARY ANNE STEPHENS

Mary Anne Stephens is a recently retired senior executive with more than 25 years' experience leading teams in the financial services, IT, aged care and not-for-profit sectors. She has extensive experience in strategy, finance, risk management, audit and governance. Mary Anne's most recent executive position was Chief Financial Officer for Amana Living Incorporated.

Mary Anne is Chair of Diabetes WA, Chair of Venues West, and Chair of Council on the Ageing (COTA) WA. She holds a Master of Accounting, is a Fellow of CPA Australia, a Fellow of the Governance Institute of Australia, a Fellow of the Australian Institute of Management (WA) and a graduate of the Australian Institute of Company Directors.

Mary Anne is passionate about the need to continually improve health outcomes within the WA community. Her goal is to leverage her skills and experience to contribute in a positive way to the WA Country Health Service.

Mary Anne chairs the WA Country Health Service Board Audit and Risk Committee.

MS MEREDITH WATERS*

Meredith Waters has lived in regional WA for over 20 years. With a background in the justice system as a Clerk of Courts in Victoria, Meredith commenced with the Esperance Court House in 2000 and later took up work as an adult corrections officer. During a gap in paid work to spend time caring for her three sons, Meredith held the role of coordinator with the adult literacy program Read Write Now.

Since 2010, Meredith has held a variety of roles in the community and volunteer sector including: Service Manager of Bay Of Isles Community Outreach, Project Officer with the Esperance Volunteer Resource Centre writing policies and procedures, Secretary of Esperance Care Services, Area Chaplain with YouthCARE in the Kalgoorlie-Esperance region, and a community education trainer.

Meredith is currently a Board member with Esperance Community Arts, a community drum circle facilitator with Esperance Drumming Group, a member of Esperance Alcohol & Other Drug Harm Reduction Group, a member of the Esperance Shire Recovery Community Committee and the Advanced Care Planning Reference Group, the Chairperson of the South East District Health Advisory Council with WACHS, and volunteer manager and board member with 103.9HopeFM community radio.

Meredith has a strong interest in social justice, community advocacy and creating positive change through providing information, training and education to people living in remote and regional Western Australia.

** Ceased as a WACHS Board Member as at 30 September 2021.*

WA Country Health Service Executive

The WA Country Health Service Executive is the principal advisory body and assists with the management of the organisation by providing advice to the Chief Executive on strategic, service and policy issues. The Executive provides an important unifying link between executive management across organisational divisions.

WACHS BOARD

Jeffrey Moffet
CHIEF EXECUTIVE

Melissa Vernon
Executive Director Operations Hub

Tracy Rainford
Director Office of the Chief Executive

James Thomas
Executive Director Health Programs

Margaret Denton
Chief Operating Officer

Kelly-Ann Hahn
Executive Director Nursing and Midwifery

Robert Pulsford
Executive Director Business Services

Sean Conlan
Executive Director Major Projects

Dr Helen van Gessel
Executive Director Clinical Excellence

Dr Andrew Jamieson
Executive Director Medical Services

Paula Chatfield
Executive Director Mental Health

Russell Simpson
Director Aboriginal Health Strategy

Robyn Sermon
Executive Director Innovation and Development

John Arkell
Director Finance

Sonia Ferla
Executive Director Infrastructure and Environment

Colette Young
Executive Director People Capability and Culture

WA Country Health Service Executive

WACHS BOARD

Jeffrey Moffet
CHIEF EXECUTIVE

Margaret Denton
CHIEF OPERATING OFFICER

Margi Faulkner
Regional Director
PILBARA

Bec Smith
Regional Director
KIMBERLEY

Russell Colyer-Cockburn
Regional Director
WHEATBELT

Rachele Ferrari
Regional Director
MIDWEST

Peter Tredinnick
Regional Director
GOLDFIELDS

Kerry Winsor
Regional Director
SOUTH WEST

Geraldine Ennis
Regional Director
GREAT SOUTHERN

Senior Officers and their area of responsibility for the 2021-22 year are listed in Other Legal Requirements on page 141.


THIS IS A
NO SMOKING
AREA

Agency performance

Outcome based management framework

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

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

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

KPIs and services delivered by WACHS to achieve WA Health outcomes are outlined in Table 5.

Performance against these outcomes and activities are summarised in the Summary of KPIs section on pages 52 to 53 and described in detail in the KPI section starting on page 105.

Performance Management Framework

Table 5: KPIs and services delivered by WACHS to achieve WA Health outcomes

WA Government Goal: strong communities safe communities and supported families.

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

OUTCOME 1: Public hospital based services that enable effective treatment and restorative healthcare for Western Australians.	OUTCOME 2: Prevention, health promotion and aged and continuing care services that help Western Australians to live healthy and safe lives.
Services delivered to achieve Outcome 1: 1. Public hospital admitted services 2. Public hospital emergency services 3. Public hospital non-admitted services 4. Mental health services	**Services delivered to achieve Outcome 2*:** 5. Aged and continuing care services 6. Public and community health services 9. Small rural hospital services

KEY PERFORMANCE INDICATORS FOR OUTCOME 1	
Effectiveness Indicators	Unplanned hospital readmissions for public hospital patients within 28 days for selected surgical procedures.
	Percentage of elective wait list patients waiting over boundary for reportable procedures.
	Healthcare-associated Staphylococcus aureus bloodstream infections (HA-SABSI) per 10,000 occupied bed-days.
	Survival rates for sentinel conditions.
	Percentage of patients who discharged against medical advice.
	Percentage of live-born term infants with an Apgar score of less than 7 at 5 minutes post delivery.
	Readmissions to acute specialised mental health inpatient services within 28 days of discharge.
	Percentage of post discharge community care within seven days following discharge from acute specialised mental health inpatient services.
Efficiency Indicators	Average admitted cost per weighted activity unit.
	Average Emergency Department cost per weighted activity unit.
	Average non-admitted cost per weighted activity unit.
	Average cost per bed-day in specialised mental health inpatient services.
	Average cost per treatment day of non-admitted care provided by mental health services.

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

*The WA Health OBM Framework also includes Service 7. pathology services and Service 8. community dental health services to achieve Outcome 2, however these services are not delivered by WACHS, being provided state-wide by PathWest and the North Metropolitan Health Service.


14 30 30

Financial summary

The total cost of providing health services to rural and regional areas in Western Australia in 2021-222 was $2.1 billion. Results for 2021–22 against agreed financial targets (based on Budget statements) are presented in Table 6. Full details of the WA Country Health Service's financial performance during 2021-22 are provided in the financial statements section of this report.

Table 6: Actual results versus budget targets for 2021-22

	2021-22 Target ($'000)(FTE))	2021-22 Actual ($'000)(FTE)	Variation (+/-) ($'000)(FTE)	Explanation of variance Key factors
Total cost of services	2,104,550	2,341,340	236,790	• Expenditure on continuing and new services, including COVID response and vaccination programs, for which funding had not been included in the initial target but were the subject of budget adjustments throughout the year and at Mid-Year Review. • Cost pressures associated with increasing reliance on high cost agency and locum staff. • Provision for Non Current Long Service Leave entitlements for casual employees under the new Industrial Agreement determination.
Net cost of services	1,926,070	2,064,976	138,906	• Total Cost of Service budget timing and operational issues as described above. • Commonwealth and Other Grants received for services not included in the initial target but were the subject of budget adjustments throughout the year and at Mid-Year Review. • Asset revaluation increment of $90.8 million.
Total Equity	2,623,113	2,722,218	99,105	• Asset Revaluation increments flowing through the Net Cost of Service ($90.8 million) and direct to Reserves ($47.0 million). • Offset by a $38 million net deficit (excluding Asset Revaluations) including expensing of payments from the Asset Investment Program ($16.1 million) and deferred capital grants from Commonwealth and Industry due to delays in capital works ($6.6 million).
Approved full time equivalent staff level	9329.4	9411.0	81.6	• Additional staff required to maintain services in rural and remote locations, and to ensure compliance with increasing clinical safety and quality standards.

Summary of key performance indicators

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

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

KPIs also provide a means to communicate to the community how WACHS is performing. A summary of the WACHS KPIs against targets is given in Table 7.

Table 7 should be read in conjunction with detailed information on each key performance indicator found in the disclosure and compliance section of this report. The KPIs are prepared based on the latest available information.

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

Table 7: Outcome 1 - Actual results versus KPI targets for 2021 calendar year or 2021-22 financial year

Key performance indicator	Target	Actual
Outcome 1: Public Hospital based services that enable effective treatment and restorative healthcare for Western Australians		
Unplanned hospital readmissions for patients within 28 days for selected surgical procedures (expressed per 1,000 separations)		
Knee replacement	≤ 23.0	31.5
Hip replacement	≤ 17.1	31.3
Tonsillectomy and Adenoidectomy	≤ 81.8	104.3
Hysterectomy	≤ 42.3	29.7
Prostatectomy	≤ 36.1	0.0
Cataract surgery	≤ 1.1	0.7
Appendicectomy	≤ 25.7	26.5
Percentage of elective waitlist patients waiting over boundary for reportable procedures:		
% Category 1 over 30 days	0%	13.6%
% Category 2 over 90 days	0%	13.0%
% Category 3 over 365 days	0%	4.2%
Total	0%	5.4%
Healthcare-associated Staphylococcus aureus bloodstream infections (HA-SABSI) per 10,000 occupied bed-days	≤ 1.0	0.79

Summary of key performance indicators

Table 7: Outcome 1 - Actual results versus KPI targets for 2021 calendar year or 2021-22 financial year *(continued)*

Key performance indicator	Target	Actual
Survival rates for sentinel conditions:		
Stroke		
0-49 years	≥ 95.2%	100%
50-59 years	≥ 94.9%	96.1%
60-69 years	≥ 94.1%	98.4%
70-79 years	≥ 92.3%	95.5%
80+ years	≥ 86.0%	88.9%
Acute Myocardial Infarction (AMI)		
0-49 years	≥ 99.1%	100%
50-59 years	≥ 98.8%	100%
60-69 years	≥ 98.1%	99.2%
70-79 years	≥ 96.8%	97.8%
80+ years	≥ 92.1%	91.6%
Fractured Neck of Femur (FNOF)		
70-79 years	≥ 98.9%	100%
80+ years	≥ 96.9%	98.6%
Percentage of patients who discharged against medical advice		
a. Aboriginal patients	≤2.78%	5.4%
b. Non-Aboriginal patients	≤0.99%	0.7%
Percentage of live-born term infants with an Apgar score of less than 7 at 5 minutes post delivery	≤1.8%	1.5%
Readmissions to acute specialised mental health inpatient services within 28 days of discharge	≤12%	13.2%
Percentage of post discharge community care within 7 days following discharge from acute specialised mental health inpatient services	≥ 75.0%	83.8%
Average admitted cost per weighted activity unit	$6907	$6684
Average Emergency Department cost per weighted activity unit	$6847	$7411
Average non-admitted cost per weighted activity unit	$6864	$4873
Average cost per bed-day in specialised mental health inpatient services	$2075	$2396
Average cost per treatment day of non-admitted care provided by mental health services	$544	$573

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

Table 8: Outcome 2 - Actual results versus KPI targets for 2021 calendar year or 2021-22 financial year

Response times for emergency air-based patient transport services (Percentage of emergency air-based inter-hospital transfers meeting the state-wide contract target response time for priority 1 calls)	≥ 80%	67.7%
Percentage of patients who access emergency services at a small rural or remote Western Australian hospital and are subsequently discharged home	85.0%	84.9%
Average cost per bed-day for specialised residential care facilities, flexible care (hostels) and nursing home type residents	$409	$724
Average cost per person of delivering population health programs by population health units	$245	$408
Cost per trip of patient emergency air-based transport, based on the total accrued costs of these services per the total number of trips	$7384	$7374
Average cost per trip of Patient Assisted Travel Scheme (PATS)	$505	$613
Average cost per rural and remote population (selected small rural hospitals)	$469	$468

Improvements towards emergency department access

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

When patients first enter an emergency department, they are assessed by specially trained nursing staff to determine how urgently treatment is required. The aim of this process, known as triage, is to ensure treatment is given in the appropriate time and should prevent adverse conditions arising from deterioration in the patient's condition.

The triage process and scores are recognised by the Australasian College for Emergency Medicine and are recommended for prioritising those who present to an emergency department. A patient is allocated a triage score between 1 (immediate) and 5 (least urgent) that indicates their treatment acuity. Treatment should commence within the recommended time of the triage category allocated (see Table 9).

Table 9: Triage category, treatment acuity and WA performance targets for 2021-22

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

Improvements towards emergency department access

PERCENTAGE OF EMERGENCY DEPARTMENT PATIENTS SEEN WITHIN RECOMMENDED TIMES

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

In 2021-22, the proportion of WA patients in major rural hospital emergency departments who were seen within recommended time was above the minimum benchmarks for one out of five triage categories (see Table 10).

Emergency Department performance is reflective of challenges in rural hospitals to manage increased demand across emergency and admitted care services.

Table 10: Percentage of hospital emergency department patients seen within recommended times by triage category for 2018-19 to 2021-22

Triage category	2018-19 Performance (%)	2019-20 Performance (%)	2020-21 Performance (%)	2021-22 Performance (%)	Target (%)
1	100	100	100	100	100
2	82.7	81	78.3	70.2	80
3	73.2	73.7	68.3	61.4	75
4	78.4	79.3	74.1	68.7	70
5	94	93.5	91.8	89.9	70

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

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

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

In 2021-22, the percentage of emergency department attendances triaged as category 4 and 5 and not admitted can be seen in Table 11.

Table 11: Percentage of hospital emergency attendances with a triage score of 4 and 5 not admitted for 2018-19 to 2021-22

Triage category	2018-19 (%)	2019-20 (%)	2020-21 (%)	2021-22 (%)	Target (%)
4 – Semi Urgent	91.7	92.0	92.7	92.8	92
5 – Non-Urgent	97.8	97.9	98.2	98.3	97.9

Note: The 2020-21 results have been restated to correct prior year data error.

Clinical governance and performance

Quality and standards

WA Country Health Service (WACHS) is committed to providing high, quality, safe care.

Clinical governance supports an environment where there is transparency, responsibility and accountability for maintaining the National Safety and Quality Health Service (NSQHS) Standards and being accredited against these standards.

All WACHS regions are currently accredited against the national standards and are scheduled to be re-assessed between November 2022 and May 2023.

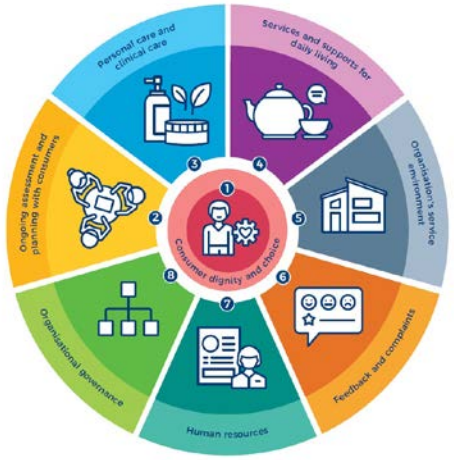
The eight NSQHS Standards are:

- Clinical Governance Standard
- Partnering with Consumers Standard
- Preventing and Controlling Infections Standard
- Medication Safety Standard
- Comprehensive Care Standard
- Communicating for Safety Standard
- Blood Management Standard
- Recognising and Responding to Acute Deterioration Standard

AGED CARE QUALITY STANDARDS

WACHS provides acute, subacute, community and residential care to older people throughout country WA.

The Royal Commission into Aged Care Safety and Quality has seen a stronger focus on governance and regulatory oversight of the quality of care delivered to older people. The Aged Care Quality Standards, that came into effect on 1 July 2019 for organisations providing Commonwealth subsidised aged care services provides a framework of core requirements for quality and safety, whether providing care to patients at home or in a government-funded aged care facility.



The Aged Care Quality Standards reflect the level of care and services the community expects. The Aged Care Quality and Safety Commission is responsible for assessing and monitoring the quality standards.

The eight Aged Care Quality Standards

Consumer Dignity and Choice
I am treated with dignity and respect and can maintain my identity. I can make informed choices about my care and services and live the life I choose.

Ongoing Assessment and Planning
I am a partner in ongoing assessment and planning that helps me get the care and services I need for my health and well-being.

Personal Care and Clinical Care
I get personal care, clinical care, or both that is safe and right for me.

Services and Supports for Daily Living
I get the services and supports for daily living that are important for my health and well-being and that enable me to do things that I want to do.

Organisation's Service Environment
I feel I belong and I am safe and comfortable in the organisation's service environment.

Feedback and Complaints
I feel safe and am encouraged and supported to give feedback and make complaints. I am engaged in processes to address my feedback and complaints and appropriate action is taken.

Human Resources
I get quality care and services when I need them from people who are knowledgeable, capable and caring.

Organisational Governance
I am confident the organisation is well run. I am a partner in improving the delivery of care and services.

Karlarra House Accreditation

In September 2021, Karlarra House underwent an accreditation against the Aged Care Quality Standards by the Aged Care Quality and Safety Commission. Under the Australian Government Service Compliance Rating Scheme, Karlarra House was reaccredited for a further three years.

Clinical governance and performance

Aishwarya's CARE Call

WA Country Health Service (WACHS) recognises the importance of both listening to and acting upon concerns raised by patients, their family members and/or carers in relation to the patient's health condition.

WACHS has had the Call and Respond Early (CARE) Call system in place since 2017 for patients, family and carers to alert health care staff if they are concerned.

Following the tragic death of Aishwarya Aswath at Perth Children's Hospital in April 2021, the WA Health system has rebranded the existing CARE Call system in Aishwarya's honour, to be known as Aishwarya's CARE Call.

WA Health worked closely with Aishwarya's parents to implement this change. All materials used to promote Aishwarya's CARE Call have been created in bright colours, with the logo in pink to reflect Aishwarya's favourite colour.

Aishwarya's CARE Call is a way for patients, families and carers to receive or call for urgent assistance when they are concerned about a patient's health and feel that the healthcare team has not fully recognised their changing health condition.

An Aishwarya's CARE Call can be made from a personal mobile telephone or a dedicated Aishwarya's CARE Call telephone located in Emergency Departments at larger WACHS hospitals.

Posters and flyers describing the Aishwarya's CARE Call process and the hospital's specific Aishwarya's CARE Call telephone number are now displayed in all WACHS hospitals and health services.

The HealthyWA website also includes Aishwarya's CARE Call flyers in languages other than English, and Aboriginal Liaison Officers and translation services are available for support where needed.

Aishwarya's CARE Call

Clinical governance and performance

Improving the quality of care

WA Country Health Service (WACHS) strives to deliver a high standard of care to patients, community, clients and aged care residents.

WACHS is proud of the improvements it continues to make to enhance the quality and safety of systems and processes.

REDUCING THE TIME TO ANTIBIOTIC ADMINISTRATION IN ADULT PATIENTS WITH SEPSIS IN THE EMERGENCY TELEHEALTH SERVICE

Sepsis is a time-critical medical emergency that arises when the body's response to an infection damages its own tissues and organs. It can lead to shock, failure of multiple organs, and death if not recognised early and not treated promptly[2].

The Emergency Telehealth Service (ETS) delivers telemedicine into 86 emergency departments and nursing posts across WACHS's seven regions. ETS aims to improve access to emergency medicine services for rural and remote patients, by allowing clinicians to deliver treatment, and manage patients remotely in collaboration with local clinicians.

During 2021-22, the WACHS Command Centre undertook a quality improvement project with a goal that all adult patients with a diagnosis of sepsis commence antibiotic treatment within 60 minutes of referral to the ETS.

The project implemented a number of high priority change ideas, including introduction of a referral documentation pack, a medical records sepsis stamp to prompt the use of the WACHS Adult Sepsis Pathway, and ensuring that all sites have access to a portable blood analysis device that can detect sepsis. The WACHS Command Centre has also provided simulations and education sessions on sepsis.

PROVIDING COMPASSIONATE PALLIATIVE CARE

WACHS has made tangible improvements in delivering palliative care closer to home, through significant growth of regionally based teams, expansion of telehealth, novel care pathways and improved governance. With 18 palliative care hubs across all WACHS regions, patients at the end of their lives can now access holistic care in their place of choice.

The WACHS Palliative Care Program plans and delivers care both directly and in partnership with General Practice, WACHS hospitals, community nursing services, private inpatient palliative care units, residential aged care facility staff and Aboriginal Medical Services. The community-focused multidisciplinary teams led by Regional Palliative Care Nurse Coordinators and supported by Palliative Medicine Specialists, are well equipped to address patients' clinical, cultural, spiritual and social needs. Aboriginal Health Liaison Officers are also now an integral member of multidisciplinary palliative care teams.

WACHS participates in the Palliative Care Outcomes Collaboration. This is a national program that uses standard clinical assessment tools to measure and benchmark patient outcomes in palliative care. The five assessment tools focus on patient experience and symptoms, direct routine clinical care, and are inclusive of the family and carer.

WACHS now has capacity to electronically capture these assessments at the bedside to be analysed for review. This process provides a profile of the patients that received care and the outcomes of their care, and support our continuous quality improvement activities.

2. https://www.australiansepsisnetwork.net.au

Clinical governance and performance

Improving the quality of care

DIGITAL SOLUTIONS TO SUPPORT CARE CLOSER TO HOME

The TelePalliative Care in the Home program has expanded to increase patient and family/carer access to palliative care staff and support at home. Using iPads, patients living remotely now have access to medical assessments and nursing and allied health support when needed. The newly commenced Palliative Care Afterhours Telehealth Service (PalCATS), provides WACHS clinicians with coordinated after-hours and weekend specialist nursing support and management advice from within the WACHS Command Centre using high-definition video consultation.

GOALS OF CARE

WACHS is supporting person-centred end of life care through two new goals of care initiatives. WACHS sites now use electronic *Goals of Patient Care* forms enabling digital storage, and access to clinicians across WA Health. With a patient's permission, the plan can also be uploaded to their My Health Record.

WACHS is leading the development and implementation of a new goals of care form specifically for aged care residents to support shared-decision making. The *Residential Goals of Care Form* is a way of ensuring a resident's goals, values and preferences remain central to their current health care treatment decisions. This will support all aged care staff to provide person-centred quality care and reduce the likelihood of residents receiving treatment that doesn't reflect their preferences.

REVIEW OF MENTAL HEALTH FACILITIES

In 2021 the Chief Psychiatrist of Western Australia initiated a review of the authorisation of mental health hospitals across WA to ensure compliance with the Chief Psychiatrists Standards for Authorisation of Hospitals under the *Mental Health Act 2014.*

The reauthorisation project included undertaking a self-assessment followed by a formal visit from the Office of the Chief Psychiatrist to each service for stakeholder and client consultation. These visits have been completed for Albany, Broome, and Kalgoorlie Hospitals.

MIDWIFERY AND OBSTETRICS EMERGENCY TELEHEALTH SERVICE

The Midwifery and Obstetrics Emergency Telehealth Service (MOETS) was launched on 14 February 2022 after two years of planning. MOETS provides 24/7 access to a clinical midwifery consultant via the WACHS Command Centre.

MOETS midwives work closely with our network of regional obstetricians. The MOETS Midwives and Obstetricians are available via telephone and videoconferencing to WACHS maternity services and Emergency Departments. MOETS provides collegiate support, clinical and policy advice, consultation, assessment, treatment, care planning, follow-up and referrals back into the WACHS Obstetric, Midwifery and Paediatric teams.

The implementation of new electronic foetal cardiotocography with artificial intelligence capability now enables regional maternity clinicians to obtain remote second clinician reviews via the MOETS midwives during the antenatal and intrapartum period.

Since the birth of MOETS in February 2022, 281 referrals have been received. The majority of care escalations now occur within WACHS, keeping care closer to home for families.

Consumer feedback

The WA Country Health Service strives to provide the highest quality healthcare to our patients. Feedback from consumers, including patients and carers, provides us with the opportunity to review the care we provide, either with a view to improve care or to learn from those things that we did well. In 2021-22, 56 per cent of the stories we received were either positive or complimentary. Here is a small sample of the stories received:

BOYUP BROOK SOLDIERS MEMORIAL HOSPITAL

I would like to thank all of the staff I dealt with for all their kind care. Looked after me very well. Every time I come to the hospital all the staff are so caring.

KALGOORLIE MEDICAL IMAGING

Thank you so much to my nurse for your kind care and being patient with me.

I had a corticosteroid injection in my knee in the radiology department. My nurse explained the first injection was going to hurt, she could see I was scared so she held my hand and talked to me. She was so caring, compassionate and her bedside manner was so comforting. In my opinion, I believe the Goldfields should feel so lucky to have a nurse like this looking after us.

NORTH MIDLANDS COMMUNITY HEALTH SERVICE

My family and I have recently had our immunisations for the winter flu season in Three Springs. The nurse that gave our immunisations was fantastic. My daughter is frightened of needles, but the nurse took her time, reassured her and made the experience less frightening. I think we are so lucky to have experienced, caring nurses at Three Springs who look after the local and surrounding communities.

Consumer feedback

KARRATHA HEALTH CAMPUS

Thank you to all the staff involved in the birth of our first baby and a special shout out to my midwife for making this once in a lifetime experience so special. I could not have asked for anything better than what we received as our first birthing experience.

The care that came afterwards was just as personal. Each and every midwife who came into my room while at Karratha was both professional and caring. The room was amazing I nearly didn't want to leave! Such a peaceful way to bring our baby into the world.

NORTHAM HEALTH SERVICE

I found the nursing staff to be very caring and at times they would make you laugh and feel pretty bloody good, and all round pleasant to be with.

ALBANY EMERGENCY DEPARTMENT

I recently had need of emergency care at the Albany Hospital and found the whole journey as good as I could ever have imagined. Starting from my Emergency Department presentation which necessitated emergency orthopaedic surgery and inpatient care, everything was handled by the staff in a very professional, helpful and caring manner for the whole time that I required their services. The Albany Hospital is a great facility and I wish to thank all the Albany Hospital staff I saw for taking such good care of me.

BROOME HEALTH CAMPUS

I had a procedure at the day procedure unit at the Broome Hospital and all staff I dealt with from the staff at the RAT testing centre, Admin Clerks, Nurses, Doctors and specialist Doctors were all world class! I'm a typically anxious person but their exceptional service made me feel safe and comfortable!

Thanks to everyone involved.

Clinical governance and performance

Clinical incident management

All clinical incidents are categorised according to their severity using the WA Health Severity Assessment Codes (SAC).

SAC1	Serious harm or death that is/could be specifically caused by health care rather than the patient's underlying condition or illness.
SAC2	Moderate harm that is/could be specifically caused by the health care rather than the patients underlying condition or illness.
SAC3	Minor or no harm that is/could be specifically caused by the health care rather than the patient's underlying condition or illness.

2021-22 SAC1 REPORTING

A total of 111 SAC1 clinical incidents were reported in 2021-22. Of these, 14 incidents reported as SAC1 were subsequently approved for declassification by the Department of Health.

Over 296 recommendations for improvement were implemented across WACHS as a result of clinical incident investigations demonstrating the value of undertaking thorough and rigorous incident investigations.

Table 12: SAC 1 incidents for 2021-22

Patient outcome	Number
Death	37
Serious harm	54
No harm (near miss that may have but did not cause harm, either by chance or through timely intervention)	6
Total	**97**

Note: Table 12 excludes 14 SAC1 clinical incidents approved for declassification by the Department of Health. One SAC1 clinical incident still under investigation at time of reporting.

Significant issues

Our COVID response

Throughout 2021-22, collaboration between WA Country Health Service (WACHS) and partners including the Aboriginal community controlled organisations, local governments and primary care providers demonstrated our joint capacity to continue the suppression and control of COVID in Western Australia and achieving high vaccination coverage across country WA.

In 2022, border controls and other public health strategies were amended by the WA Government, and we, along with our service partners moved from preparation to response to the surge in COVID cases across the State.

KEY ACHIEVEMENTS IN PREPARING COUNTRY HEALTH SERVICES

All of our sites regardless of size, were able to assess and care for COVID patients supported through extensive education programs that enabled clinical and non-clinical staff to confidently and safely care for patients and residents.

Online education sessions, simulation scenarios, and development of clinical guidelines were shared across our services. The WACHS COVID Clinical Council brought together clinical leaders from all sites and disciplines including our telehealth services and representatives from the primary care sector to ensure effective networking, communication and collaboration.

International and national modelling, evidence and learning, combined with the wisdom and intelligence of clinicians and operational leads helped to design, prioritise and implement our COVID response.

This combined intelligence was incorporated into our strengthened governance processes, providing assurance to staff, communities and service partners that WACHS had a well-planned, systematic approach to COVID preparedness and response.

We knew that many of our patients were in vulnerable groups at risk of severe COVID. Like many of our service teams, the renal teams worked incredibly hard with local infection control and facilities staff to ensure that we were doing all we could to provide local care for the approximately 400 people having kidney dialysis in country WA.

KEY ACHIEVEMENTS IN PREPARING COUNTRY COMMUNITIES

WACHS continued to play a significant role delivering the national COVID vaccination program during the year. Across country WA we focused on improving Aboriginal vaccination rates and ensuring staff were compliant with mandatory requirements. Our vaccination teams worked closely with GPs, Aboriginal Medical Services, Royal Flying Doctor Service (RFDS) and other partners, achieving 94 per cent double dose coverage by the time the State borders opened.

As the lead agency for the COVID Emergency Response, WACHS Executives continued to lead interagency work with partners from WA Police; local governments; Departments of Communities, Education and Corrective Services; the Aboriginal Community Controlled Health sector as well as the State Health Incident Control Centre.

Our COVID response

KEY ACHIEVEMENTS IN OUR HEALTH SERVICES

Public hospitals in WA were required to use the System Alert Response (SAR) framework to guide our response to different phases of the pandemic. Our teams undertook significant and rapid changes to achieve control, testing, Personal Protective Equipment (PPE) use and models of care including restriction of some elective services and transition to telehealth.

WACHS moved to quickly equip all hospitals and aged care entry points with a concierge station to test and screen all patients and visitors. Within weeks, a raft of temporary facilities were constructed using marquees, dongas and shipping containers to provide a safe environment to screen and safely test patients. Staff were also provided the opportunity to regularly test themselves.

A total of 1211 people with COVID were admitted to 41 different WACHS facilities between 1 March and 30 June 2022.

WACHS, with a respected history of innovation and well-established telehealth services, optimised access to safe care for all country communities. For example, the Inpatient Telehealth Service provided medical support in aged care settings when the local GP was not available. The Emergency, Mental Health, Maternity and Obstetrics, plus Outpatients Telehealth Services extended their services to ensure strong clinician and patient access and support.

While international experience earlier in the global pandemic had indicated that patients on kidney dialysis had very poor outcomes with up to 30 per cent mortality and 50 per cent hospitalisation, in country WA this year, less than 10 per cent of dialysis patients with COVID needed care in hospital and outcomes were excellent.

Access to rapid COVID test results was important, particularly early in the surge response. We continued to maintain close relations with PathWest and other partners to bolster access to rapid COVID Polymerase Chain Reaction (PCR) testing in all regional areas. PathWest posted a deployable laboratory and its support staff to Broome. Approximately 8000 tests were completed using the PathWest deployable laboratory from March to the end June 2022, dramatically reducing the time to receive a result for people in the Kimberley.

Our COVID response

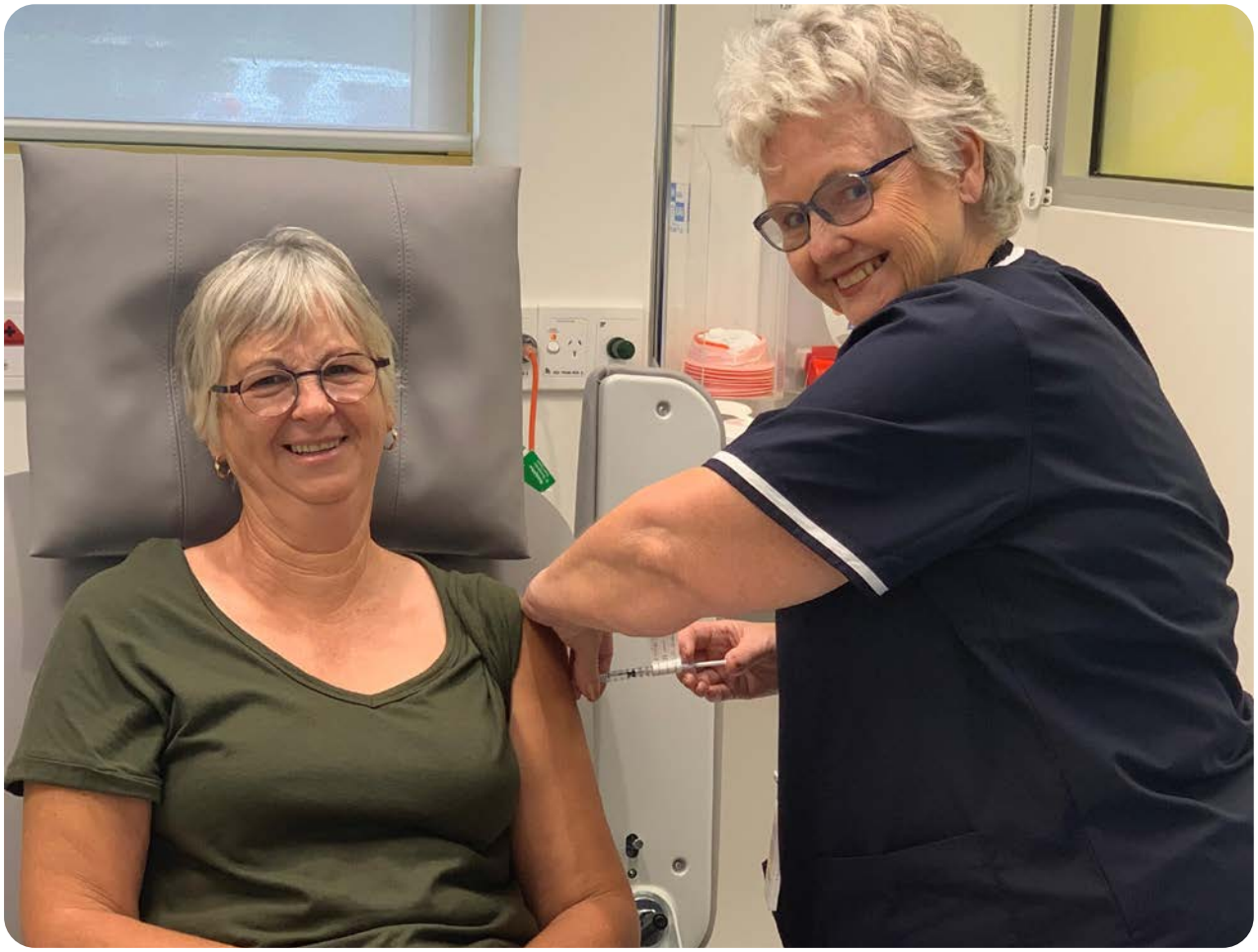
KEY ACHIEVEMENTS IN OUR WORKFORCE

The commitment and dedication of the entire workforce to meeting the health needs of country communities and patients enabled service continuity across country WA. COVID furlough numbers rose to 700 at one point and increased with influenza illness amongst staff.

Staff generously responded by working extended hours, deployments to communities and hospitals in urgent need of staff, within their region and to other regions. Nurse and health service managers and training staff worked continuously in clinical roles and tertiary students stepped in to support continued service access.

A metropolitan–country workforce collaboration commenced and saw 166 metropolitan hospital nurses and midwives deployed to 54 country sites and 322 agency (predominantly sourced from inter-state) deployed to 57 sites across country WA. In addition, 2134 NurseWest nurses, midwives, enrolled nurses and 1352 assistants in nursing placements have supported 86 regional and remote locations.

To enable WACHS to rapidly deploy clinicians and respond when needed, we recruited and deployed 246 nurses and midwives. These nurses and midwives were sourced from a newly established dedicated deployment pool, managed by the Operations Hub Workforce team.



Non-clinical staff from cleaners and administrative staff, to cooks, maintenance and trade staff, essential to keeping our hospitals and services functional and safe, also worked extended hours and were deployed across country WA.

Our COVID response

KEY ACHIEVEMENTS IN OUR COMMUNITIES

WACHS has an extensive network of social media platforms, providing credible and timely information to communities across WA's regions.

At each stage in the pandemic, social media posts were shared to communicate the steps country residents should take to limit the spread of COVID, where to get tested, vaccination updates and information about visiting our services.

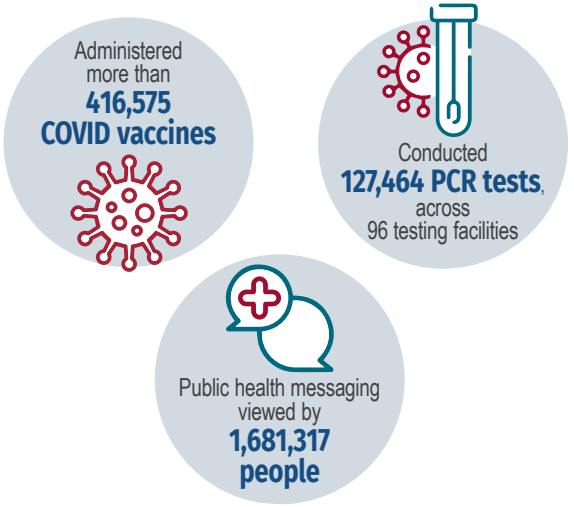
This messaging was shared with regional health promotion teams to localise and distribute. WACHS-approved public health messaging was also provided to partner agencies to adapt and localise for their audiences and channels.

Critical public health messaging was geotargeted to reach relevant communities when necessary. We posted 710 messages, which were viewed by 1,681,317 people.

As a range of COVID medications became available, WACHS Pharmacy and Operations ensured that eligible people in country WA had access regardless of geography. With prepositioned stock and using our distribution network, we facilitated supply of these new and potentially life-saving medications to over 800 people in all parts of the State. We administered more than 416,575 COVID vaccines.

Testing was an important community COVID control strategy. We recruited hundreds of country and metropolitan people to staff our newly established testing clinics. From taxi drivers to retired nurses and medical students, people across the State answered the call to help country WA's effort against COVID. WACHS conducted 127,464 PCR tests across 96 testing facilities.

As COVID clusters occurred across different regions, WACHS worked closely with PathWest and Aboriginal Community Controlled Health partners to provide extended access to temporary testing clinics, with our staff continuing to step up when their community needed them.



Maintaining services in our communities

Against a global healthcare worker shortage, complex travel restrictions and high demand for healthcare staff, WA Country Health Service (WACHS) continued to provide high-quality, patient-centred care to country communities.

The COVID pandemic continued to place pressure on services throughout 2021-22, especially in our small rural and remote sites. These pressures included:

- Staff furlough, quarantine requirements for close contacts, community and health service outbreaks.
- Border closure and uncertainty for nearly two years inhibiting the supply of interstate and international recruitment.
- A reduction in uptake of graduate programs and limited midwifery and nursing graduate positions throughout WA Health.
- Housing and accommodation shortages in rural areas resulting in inability to relocate staff to areas of need.
- A worldwide healthcare worker shortage.
- Competition for much needed health workers.

Despite these pressures, our preparatory work was thorough and service disruption has been minimised with local staff going above and beyond to maintain services. In these sites, staff are often part of the community and consistently go the extra mile to ensure

that their community has access to the healthcare they need. Services have been maintained thanks to the dedication and hard work of our front-line staff, who have done incredible things to look after their communities.

WACHS continues to ensure country communities have access to essential contemporary health services as close to home as possible through 24/7 virtual services in addition to local services. Staff have increased support available in specialist essential skill areas via telehealth services and support, pioneered by WACHS, which have become the norm for healthcare. 2021-22 saw the introduction of BACKUP, peer support and education for nurses working remotely. In addition to our longstanding Emergency Telehealth Service and Inpatient Telehealth Service, mental health and maternity/obstetrics services were launched. Mental Health Emergency Telehealth Service (MHETS), a specialised mental health virtual service staffed by experienced nurses, doctors and psychiatrists was launched, as well as the Midwifery and Obstetrics Emergency Telehealth Service (MOETS). This innovative service supports midwives and obstetric teams with a virtual clinical hub, triage support and skill development. The WACHS Command Centre is now well established as an invaluable resource for country clinicians in hospitals across the State, delivering digitally enabled, flexible and dedicated specialist clinical support and services to country hospitals and nursing posts in real time.

Maintaining services in our communities

WACHS is absolutely committed to maintaining services and supporting staff, which led to the development of the WACHS Operations Hub in late 2021. The Operations Hub provides system-wide situational awareness around service pressures and needs related to bed management, patient safety, security, emergency and disaster preparedness, logistics, workforce and infrastructure. The Operations Hub actively supports regional teams to respond to these pressures, as well as assisting in the management of incidents, emergencies and events.

Over this period, as the impact of staff furlough and critical worker shortages became a reality, WACHS enacted several strategies to bolster our dedicated and remarkable workforce. One of these strategies involved WACHS working in collaboration with metropolitan Health Service Providers to deploy more than 300 nurses and midwives from the city to the far corners of the State. This has been a catalyst for forging strong united workforce solutions into the future in partnership with our metropolitan counterparts. We have also increased our advertising, using social media to broadcast staff testimonials, using their personal experiences to encourage people to consider country work. Graduate placements have been significantly increased.

In partnership with external agencies Serco Australia and Healthcare Australia (HCA), we deployed hundreds of clinical agency staff to stabilise sites in critical need.

NurseWest have worked closely in partnership with WACHS over the past six months and have prioritised deployments to country, often at very short notice.

WACHS has always been driven by a passionate and dedicated workforce, and this has never been more evident as it was during 2022. Our workforce have pulled out all the stops to ensure country communities have continued to receive the highest quality of care during a challenging year.

Work health and safety

Staff accommodation and safety

WA Country Health Service (WACHS) provides accommodation to eligible staff in some rural and remote areas, helping us attract and retain staff. Over the past year WACHS has found that the availability of suitable and appropriate leased housing is constrained.

The COVID pandemic experience has reaffirmed the need for WACHS to be able to respond to staffing needs in an agile and responsive manner. Widespread workforce pressures are currently being observed by WACHS, which is impeding health service delivery, which in some cases is due to the lack of suitable staff accommodation.

Throughout Western Australia, WACHS has 834 owned dwellings, made up of a combination of hospital style nurses' quarters, standard domestic dwellings, duplexes and various sized unit complexes. In addition to this, WACHS currently leases approximately 800 dwellings.

WACHS has allocated $10.8 million to attend to the refurbishment of owned properties, including nursing quarters and individual dwellings, and embarked on a security risk assessment and upgrade program, to improve security features on all WACHS owned and leased properties.

During the 2022-23 WA State Budget process $5 million was allocated to address the urgent staff accommodation priorities to support the WACHS workforce required in regional and rural areas.

To address the future demand as well as the current availability of suitable and appropriate staff accommodation across the State, WACHS has launched a website which seeks to establish partnerships with private investors to secure suitable and appropriate staff accommodation under short and long term lease arrangements.

Work health and safety

Staff wellbeing and safety

Work Health and Safety (WHS) within Western Australia has undergone significant changes since the new *Work Health and Safety Act 2020 (WA)* was enacted on 31 March 2022.

At WA Country Health Service (WACHS) we understand that the wellbeing and safety of our staff is paramount. We are committed to ensuring they are kept safe and there are adequate systems in place to proactively manage and support their health and wellbeing in the workplace. We care about their safety and endeavour to ensure that at the end of each shift they work, they are returning to their family and friends safe and well.

Occupational Violence and Aggression (OVA) and lone worker situations remain key focus areas moving forward given the type of services we deliver in our sites and potential consequence that these types of incidents attract. There is a zero tolerance for aggressive behaviour to our staff and we have continued to explore ways to manage this risk proactively before events occur.

In continuation of the comprehensive work already undertaken to prevent OVA, to further increase the protection of frontline staff, WACHS have increased the number of security personnel operating at our sites, and increased security to 24 hours a day at some sites. Our workplace inspection and facility security audit programs have led to a raft of recommendations and action taken to improve the security and safety of our facilities such as redesigning work areas with added barriers, fencing, lighting, access control measures and upgrades to staff accommodation.

We have also utilised the $284 thousand State Government funding, from the Stop the Violence (STV) program to implement enhanced duress alarm systems and technology across our sites. In 2021-22, WACHS commissioned the use of 250 mobile personal mobile duress devices to be implemented for use in situations where there is potential for isolated work, particularly rural remote clinics or community home visiting services.

In 2021-22, the WACHS Prevention and Management of Aggression training delivery model was reviewed to ensure that best practice training is tailored to staff requirements, based on an assessment of workplace risk with clearly defined goals and measurable outcomes.

Through the STV funding we have also accessed around $83 thousand to be utilised towards the costs of the existing WACHS Aggression Prevention and Management training model so our staff are adequately trained to de-escalate behaviour that can lead to OVA.


SOFT-CUF
REF 2455

Disclosure and legal compliance

Audit opinion

Auditor General

INDEPENDENT AUDITOR'S REPORT
2022
WA Country Health Service

To the Parliament of Western Australia

Report on the audit of the financial statements

Opinion

I have audited the financial statements of the WA Country Health Service (Health Service) which comprise:

- the Statement of Financial Position at 30 June 2022, and the Statement of Comprehensive Income, Statement of Changes in Equity and Statement of Cash Flows for the year then ended
- Notes comprising a summary of significant accounting policies and other explanatory information.

In my opinion, the financial statements are:

- based on proper accounts and present fairly, in all material respects, the operating results and cash flows of the WA Country Health Service for the year ended 30 June 2022 and the financial position at the end of that period
- in accordance with Australian Accounting Standards, the *Financial Management Act 2006* and the Treasurer's Instructions.

Basis for opinion

I conducted my audit in accordance with the Australian Auditing Standards. My responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of my report.

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

Responsibilities of the Board for the financial statements

The Board is responsible for:

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

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In preparing the financial statements, the Board is responsible for:

- assessing the entity's ability to continue as a going concern
- disclosing, as applicable, matters related to going concern
- using the going concern basis of accounting unless the Western Australian Government has made policy or funding decisions affecting the continued existence of the Health Service.

Auditor's responsibilities for the audit of the financial statements

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

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations or the override of internal control.

A further description of my responsibilities for the audit of the financial statements is located on the Auditing and Assurance Standards Board website. This description forms part of my auditor's report and can be found at https://www.auasb.gov.au/auditors_responsibilities/ar4.pdf.

Report on the audit of controls

Basis for qualified opinion

I identified significant weaknesses in network security and unauthorised device access controls at the WA Country Health Service. The combined weaknesses could undermine the confidentiality and integrity of sensitive information and data across all systems, including the financial system and disruptions to services.

Qualified opinion

I have undertaken a reasonable assurance engagement on the design and implementation of controls exercised by the WA Country Health Service. The controls exercised by the Board are those policies and procedures established to ensure that the receipt, expenditure and investment of money, the acquisition and disposal of property, and the incurring of liabilities have been in accordance with legislative provisions (the overall control objectives).

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

In my opinion, except for the possible effects of the matters described in the Basis for qualified opinion paragraph, in all material respects, the controls exercised by the WA Country Health Service are sufficiently adequate to provide reasonable assurance that the receipt, expenditure and investment of money, the acquisition and disposal of property and the incurring of liabilities have been in accordance with legislative provisions during the year ended 30 June 2022.

Audit opinion

The Board's responsibilities

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

Auditor General's responsibilities

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

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

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

Limitations of controls

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

Report on the audit of the key performance indicators

Opinion

I have undertaken a reasonable assurance engagement on the key performance indicators of the WA Country Health Service for the year ended 30 June 2022. The key performance indicators are the Under Treasurer-approved key effectiveness indicators and key efficiency indicators that provide performance information about achieving outcomes and delivering services.

In my opinion, in all material respects, the key performance indicators of the WA Country Health Service are relevant and appropriate to assist users to assess the Health Service's performance and fairly represent indicated performance for the year ended 30 June 2022.

The Board's responsibilities for the key performance indicators

The Board is responsible for the preparation and fair presentation of the key performance indicators in accordance with the Financial Management Act 2006 and the Treasurer's Instructions and for such internal control as the Board determines necessary to enable the preparation of key performance indicators that are free from material misstatement, whether due to fraud or error.

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

Auditor General's responsibilities

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

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

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

My independence and quality control relating to the reports on financial statements, controls and key performance indicators

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

Other information

Those charged with governance are responsible for the other information. The other information is the information in the entity's annual report for the year ended 30 June 2022, but not the financial statements, key performance indicators and my auditor's report.

My opinion on the financial statements, controls and key performance indicators does not cover the other information and, accordingly, I do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, controls and key performance indicators, my responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements and key performance indicators, or our knowledge obtained in the audit or otherwise appears to be materially misstated.

Audit opinion

If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact. I did not receive the other information prior to the date of this auditor's report. When I do receive it, I will read it and if I conclude that there is a material misstatement in this information, I am required to communicate the matter to those charged with governance and request them to correct the misstated information. If the misstated information is not corrected, I may need to retract this auditor's report and re-issue an amended report

Matters relating to the electronic publication of the audited financial statements and key performance indicators

This auditor's report relates to the financial statements and key performance indicators of the WA Country Health Service for the year ended 30 June 2022 included in the annual report on the Health Service's website. The Health Service's management is responsible for the integrity of the Health Service's website. This audit does not provide assurance on the integrity of the Health Service's website. The auditor's report refers only to the financial statements, controls and key performance indicators described above. It does not provide an opinion on any other information which may have been hyperlinked to/from the annual report. If users of the financial statements, and key performance indicators are concerned with the inherent risks arising from publication on a website, they are advised to contact the entity to confirm the information contained in the website version.

Sandra Labuschagne
Deputy Auditor General
Delegate of the Auditor General for Western Australia
Perth, Western Australia
20 September 2022

Certification of financial statements

WA COUNTRY HEALTH SERVICE CERTIFICATION OF FINANCIAL STATEMENTS FOR THE REPORTING PERIOD ENDED 30 JUNE 2022

The accompanying financial statements of the WA Country Health Service have been prepared in compliance with the provisions of the *Financial Management Act 2006* from proper accounts and records to represent fairly the financial transactions for the reporting period ending 30 June 2022 and financial position as at 30 June 2022.

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

Mr John Arkell
Chief Finance Officer
WA Country Health Service
16 September 2022

Dr Neale Fong
Chair
WA Country Health Service Board
16 September 2022

Mr Alan Ferris
Board Member
WA Country Health Service Board
16 September 2022

Financial statements

Statement of Comprehensive Income

For the year ended 30 June 2022

	Note	2022 $000	2021 $000
COST OF SERVICES			
Expenses			
Employee benefits expense	3.1	1,345,970	1,192,799
Patient support costs	3.2	597,392	556,300
Finance costs	7.1	359	351
Depreciation and amortisation expense	5.1, 5.2, 5.3, 5.4	82,566	82,342
Loss on disposal of non-current assets	5.1	239	440
Repairs, maintenance and consumable equipment	3.3	75,303	52,532
Other expenses	3.4	239,511	189,552
Total cost of services		**2,341,340**	**2,074,316**
INCOME			
Revenue			
Patient charges	4.3	72,941	71,791
Commonwealth grants	4.2	79,251	68,902
Other grants	4.2	15,115	14,524
Donation revenue		290	321
Asset revaluation increment	5.1	90,829	20,302
Other revenue	4.4	17,938	20,609
Total revenue		276,364	196,449
Total income other than income from State Government		**276,364**	**196,449**
NET COST OF SERVICES		**2,064,976**	**1,877,867**
INCOME FROM STATE GOVERNMENT			
Income from public sector entities	4.1	1,926,909	1,711,724
Resources received	4.1	95,343	74,694
Royalties for Regions Fund	4.1	110,007	94,760
Total income from State Government		**2,132,259**	**1,881,178**
SURPLUS FOR THE PERIOD		**67,283**	**3,311**
OTHER COMPREHENSIVE INCOME			
Items not reclassified subsequently to profit or loss			
Changes in asset revaluation reserve	9.10	47,019	-
TOTAL COMPREHENSIVE INCOME FOR THE PERIOD		**114,302**	**3,311**

Following update of Treasury Instruction 1103 Statements of Financial Position, insurance premiums (expenses) should be measured at the amount payable on the invoice. Prior year performance adjustments should be accounted for against the insurance premiums (that is within the same expense account).To facilitate comparision of 2021-22 and 2020-21 performance results, relevant prior year revenue items have been reclassified in this statement and the Statement of Cash Flows. Accompanying notes 2.2, 3.4, 4.1, 7.3 and 9.12 have also been reclassified accordingly.

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

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

Statement of Financial Position

As at 30 June 2022

	Note	2022 $000	2021 $000
ASSETS			
Current Assets			
Cash and cash equivalents	7.3	28,114	30,609
Restricted cash and cash equivalents	7.3	40,408	26,042
Receivables	6.1	26,346	20,828
Right-of-use assets	5.2	153	24
Other current assets	6.3	10,268	10,507
Total Current Assets		105,289	88,010
Non-Current Assets			
Restricted cash and cash equivalents	7.3	18,545	16,470
Amounts receivable for services	6.2	1,084,615	1,000,555
Property, plant and equipment	5.1	1,935,311	1,795,884
Right-of-use assets	5.2	16,603	13,689
Intangible assets	5.3	14,114	16,251
Service concession assets	5.4	9,825	10,061
Total Non-Current Assets		3,079,013	2,852,910
Total Assets		**3,184,302**	**2,940,920**
LIABILITIES			
Current Liabilities			
Payables	6.4	161,601	154,089
Contract liabilities	6.5	18,610	10,571
Lease liabilities	7.2	4,535	4,932
Employee related provisions	3.1	211,392	188,643
Other current liabilities		2,027	1,959
Total Current Liabilities		398,165	360,194
Non-Current Liabilities			
Contract liabilities	6.5	14,931	11,731
Lease liabilities	7.2	9,445	7,570
Employee related provisions	3.1	39,543	35,010
Total Non-Current Liabilities		63,919	54,311
Total Liabilities		**462,084**	**414,505**
NET ASSETS		**2,722,218**	**2,526,415**
EQUITY			
Contributed equity	9.9	2,806,950	2,725,449
Reserves	9.10	47,019	-
Accumulated deficit		(131,751)	(199,034)
TOTAL EQUITY		**2,722,218**	**2,526,415**

Unclaimed money has been reclassified from Cash and cash equivalents to Other current liabilities in 2021-22. To facilitate comparision of 2021-22 and 2020-21 financial positions, relevant prior year unclaimed money has been reclassified in this statement and the Statement of Cash Flows. Accompanying notes 7.3 and 9.12 have also been reclassified accordingly.

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

Financial statements

Statement of Changes in Equity
For the year ended 30 June 2022

	Note	2022 $000	2021 $000
CONTRIBUTED EQUITY	9.9		
Balance at start of period		2,725,449	2,679,558
Transactions with owners in their capacity as owners:			
Capital appropriations administered by the Department of Health		12,927	10,092
Royalties for Regions Fund		68,574	36,001
Distributions to owners		-	(202)
Balance at end of period		2,806,950	2,725,449
RESERVES	9.10		
Asset Revaluation Reserve			
Balance at start of period		-	-
Comprehensive income for the period		47,019	-
Balance at end of period		47,019	-
ACCUMULATED SURPLUS/(DEFICIT)			
Balance at start of period		(199,034)	(202,345)
Surplus for the period		67,283	3,311
Balance at end of period		(131,751)	(199,034)
TOTAL EQUITY			
Balance at start of period		2,526,415	2,477,213
Comprehensive income for the period		47,019	-
Surplus for the period		67,283	3,311
Transactions with owners in their capacity as owners		81,501	45,891
Balance at end of period		**2,722,218**	**2,526,415**

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

Statement of Cash Flows
For the year ended 30 June 2022

	Note	2022 $000 Inflows (Outflows)	2021 $000 Inflows (Outflows)
CASH FLOWS FROM STATE GOVERNMENT			
Income from public sector entities		1,849,642	1,630,853
Capital appropriations administered by the Department of Health		12,927	10,092
Royalties for Regions Fund		178,136	130,832
Net cash provided by State Government		**2,040,705**	**1,771,777**
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Employee benefits		(1,311,342)	(1,166,217)
Supplies and services		(807,255)	(710,048)
Finance costs		(359)	(351)
Receipts			
Receipts from customers		72,924	69,230
Commonwealth grants		86,369	71,079
Other grants		12,970	11,703
Donations received		282	321
Other receipts		13,520	20,483
Net cash used in operating activities	7.3	**(1,932,891)**	**(1,703,800)**
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments			
Purchase of non-current physical assets		(83,041)	(57,694)
Net cash used in investing activities		**(83,041)**	**(57,694)**
CASH FLOWS FROM FINANCING ACTIVITIES			
Payments			
Principal elements of lease		(10,827)	(8,083)
Net cash used in financing activities		**(10,827)**	**(8,083)**
Net increase in cash and cash equivalents		13,946	2,200
Cash and cash equivalents at the beginning of the period		73,121	70,921
CASH AND CASH EQUIVALENTS AT THE END OF PERIOD	7.3	**87,067**	**73,121**

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

Financial statements

Notes to the Financial Statements
For the year ended 30 June 2022

Note 1 Basis of preparation

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

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

These annual financial statements were authorised for issue by the Accountable Authority of the WA Country Health Service on 16 September 2022.

Statement of compliance

These general purpose financial statements are prepared in accordance with:

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

The *Financial Management Act 2006* and the Treasurer's Instructions take precedence over the Australian Accounting Standards. Several Australian Accounting Standards are modified by the Treasurer's Instructions to vary application, disclosure format and wording. Where modification is required and has had a material or significant financial effect upon the reported results, details of that modification and the resulting financial effect are disclosed in the notes to the financial statements.

Basis of preparation

These financial statements are presented in Australian dollars applying the accrual basis of accounting and using the historical cost convention. Certain balances will apply a different measurement basis (such as the fair value basis). Where this is the case the different measurement basis is disclosed in the associated note. All values are rounded to the nearest thousand dollars ($'000).

Judgements and estimates

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

Accounting for Goods and Services Tax (GST)

Income, expenses and assets are recognised net of the amount of goods and services tax (GST), except that the:

(a) amount of GST incurred by WA Country Health Service as a purchaser that is not recoverable from the Australian Taxation Office (ATO) is recognised as part of an asset's cost of acquisition or as part of an item of expense; and

(b) receivables and payables are stated with the amount of GST included.

Cash flows are included in the Statement of cash flows on a gross basis. However, the GST components of cash flows arising from investing and financing activities which are recoverable from, or payables to, the ATO are reclassified as operating cash flows.

Contributed equity

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

Note 2 WA Country Health Service outputs

How WA Country Health Service operates

This section includes information regarding the nature of funding the WA Country Health Service receives and how this funding is utilised to achieve its objectives.

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

2.1 WA Country Health Service objectives

Mission

To deliver and advance high quality care for country WA communities.

Notes to the Financial Statements
For the year ended 30 June 2022

Note 2 WA Country Health Service outputs (continued)

2.1 WA Country Health Service objectives (continued)

Services

The key services of WA Country Health Service are:

1. Public Hospital Admitted Services

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

2. Public Hospital Emergency Services

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

3. Public Hospital Non-admitted Services

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

4. Mental Health Services

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

5. Aged and Continuing Care Services

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

6. Public and Community Health Services

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

7. Small Rural Hospital Services

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

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Notes to the Financial Statements
For the year ended 30 June 2022

Note 2 WA Country Health Service outputs (continued)

2.2 Schedule of income and expenses by service

	Public Hospital Admitted Services		Public Hospital Emergency Services		Public Hospital Non-Admitted Services		Mental Health Services (a)	
	2022 $000	2021 $000	2022 $000	2021 $000	2022 $000	2021 $000	2022 $000	2021 $000
COST OF SERVICES								
Expenses								
Employee benefits expense	452,264	409,852	216,306	186,999	76,531	71,274	111,140	103,359
Patient support costs	218,271	208,994	74,319	68,968	37,853	36,754	6,794	7,397
Finance costs	75	70	33	28	12	12	62	68
Depreciation and amortisation expense	31,172	30,274	9,923	9,494	4,467	4,603	1,338	1,173
Loss on disposal of non-current assets	135	196	34	31	14	23	0	2
Repairs, maintenance and consumable equipment	27,289	19,891	8,468	5,688	4,804	3,470	2,249	2,156
Other expenses	65,369	49,270	30,353	21,998	12,031	9,621	22,678	20,657
Total cost of services	794,575	718,547	339,436	293,206	135,712	125,757	144,261	134,812
Income								
Patient charges	24,579	23,077	3,656	3,559	23,222	23,573	429	381
Commonwealth grants	1,082	213	433	78	198	36	275	932
Other grants	6,786	5,252	2,416	2,643	2,370	1,821	1,109	1,922
Donation revenue	45	128	8	7	2	2	14	8
Asset revaluation increment	40,440	3,149	12,658	511	5,054	230	373	394
Other revenue	6,538	8,265	2,406	2,336	2,029	2,239	841	714
Total income other than income from State Government	79,470	40,084	21,577	9,134	32,875	27,901	3,041	4,351
NET COST OF SERVICES	**715,105**	**678,463**	**317,859**	**284,072**	**102,837**	**97,856**	**141,220**	**130,461**
INCOME FROM STATE GOVERNMENT								
Income from public sector entities	704,566	649,720	298,047	262,789	95,185	88,165	138,654	130,028
Resources received	37,276	30,109	15,255	12,201	6,540	5,231	4,678	3,361
Royalties for Regions Fund	5,197	4,426	12,448	11,281	6,023	5,814	-	-
Total income from State Government	747,039	684,255	325,750	286,271	107,748	99,210	143,332	133,389
SURPLUS FOR THE PERIOD	**31,934**	**5,792**	**7,891**	**2,199**	**4,911**	**1,354**	**2,112**	**2,928**

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

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

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Notes to the Financial Statements
For the year ended 30 June 2022

Note 2 WA Country Health Service outputs (continued)

2.2 Schedule of income and expenses by service (continued)

	Aged and Continuing Care Services		Public and Community Health Services		Small Rural Hospital Services		Total	
	2022 $000	2021 $000	2022 $000	2021 $000	2022 $000	2021 $000	2022 $000	2021 $000
COST OF SERVICES								
Expenses								
Employee benefits expense	136,067	115,868	199,486	163,998	154,176	141,449	1,345,970	1,192,799
Patient support costs	19,959	12,842	181,643	172,387	58,553	48,958	597,392	556,300
Finance costs	34	34	93	89	50	50	359	351
Depreciation and amortisation expense	5,580	5,465	7,119	7,256	22,967	24,077	82,566	82,342
Loss on disposal of non-current assets	7	2	4	5	45	181	239	440
Repairs, maintenance and consumable equipment	4,977	3,593	9,581	5,379	17,935	12,355	75,303	52,532
Other expenses	22,469	17,822	51,619	40,434	34,992	29,750	239,511	189,552
Total cost of services	189,093	155,626	449,545	389,548	288,718	256,820	2,341,340	2,074,316
Income								
Patient charges	12,183	12,026	5,250	5,432	3,622	3,743	72,941	71,791
Commonwealth grants	68,036	58,207	8,838	9,366	389	70	79,251	68,902
Other grants	1,161	284	1,109	2,228	164	374	15,115	14,524
Donation revenue	73	82	50	36	98	58	290	321
Asset revaluation increment	5,788	327	1,823	4,903	24,693	10,788	90,829	20,302
Other revenue	1,839	1,987	2,195	2,394	2,090	2,674	17,938	20,609
Total income other than income from State Government	89,080	72,913	19,265	24,359	31,056	17,707	276,364	196,449
NET COST OF SERVICES	**100,013**	**82,713**	**430,280**	**365,189**	**257,662**	**239,113**	**2,064,976**	**1,877,867**
INCOME FROM STATE GOVERNMENT								
Income from public sector entities	96,894	78,497	357,502	309,028	236,061	193,497	1,926,909	1,711,724
Resources received	5,404	3,883	13,371	9,655	12,819	10,254	95,343	74,694
Royalties for Regions Fund	1,456	1,229	53,632	46,398	31,251	25,612	110,007	94,760
Total income from State Government	103,754	83,609	424,505	365,081	280,131	229,363	2,132,259	1,881,178
SURPLUS FOR THE PERIOD	**3,741**	**896**	**(5,775)**	**(108)**	**22,469**	**(9,750)**	**67,283**	**3,311**

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

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Notes to the Financial Statements
For the year ended 30 June 2022

Note 3 Use of our funding

Expenses incurred in the delivery of services

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

	Notes	2022 $000	2021 $000
Employee benefits expense	3.1(a)	1,345,970	1,192,799
Employee benefits provisions	3.1(b)	250,935	223,653
Patient support costs	3.2	597,392	556,300
Repairs, maintenance and consumable equipment	3.3	75,303	52,532
Other expenses	3.4	239,511	189,552

3.1(a) Employee benefits expense

	2022 $000	2021 $000
Salaries and wages	1,247,217	1,105,712
Superannuation - defined contribution plans	98,753	87,087
Total employee benefits expense	1,345,970	1,192,799
Add: AASB 16 Non-monetary benefits	3,698	3,176
Less: Employee Contribution towards leases within scope of AASB 16	(1,205)	(1,269)
Net employee benefits expense	1,348,463	1,194,706

Salaries and wages

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

Superannuation expenses

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

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

AASB 16 Non-monerary benefits

Employee benefits in the form of non-monetary benefits, such as the provision of motor vehicles or housing, are measured at cost.

3.1(b) Employee related provisions

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

	2022 $000	2021 $000
Current		
Employee benefits provisions		
Annual leave (a)	101,083	91,789
Time off in lieu leave (a)	35,137	32,556
Long service leave (b)	69,481	57,978
Gratuities (c)	1,740	2,141
Deferred salary scheme (d)	3,951	4,179
	211,392	188,643
Non-current		
Employee benefits provisions		
Long service leave (b)	38,724	34,518
Gratuities (c)	819	492
	39,543	35,010
	250,935	223,653

Notes to the Financial Statements
For the year ended 30 June 2022

Note 3 Use of our funding (continued)

3.1(b) Employee related provisions (continued)

	2022 $000	2021 $000

(a) Annual leave liabilities and time off in lieu leave liabilities are classified as current liabilities as WA Country Health Service does not have an unconditional right to defer settlement of the liability for at least 12 months after the end of the reporting period.

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

Within 12 months of the end of the reporting period	96,763	96,848
More than 12 months after the end of the reporting period	39,457	27,497
	136,220	124,345

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

(b) Unconditional long service leave provisions are classified as current liabilities as WA Country Health Service does not have an unconditional right to defer settlement of the liability for at least 12 months after the end of the reporting period.

Pre-conditional and conditional long service leave provisions are classified as non-current liabilities because WA Country Health Service has an unconditional right to defer settlement of the liability until the employee has completed the requisite years of service.

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

Within 12 months of the end of the reporting period	28,048	17,830
More than 12 months after the end of the reporting period	80,157	74,666
	108,205	92,496

The provision for long service leave is calculated at present value as WA Country Health Service does not expect to wholly settle the amounts within 12 months. The present value is measured taking into account the present value of expected future payments to be made in relation to services provided by employees up to the reporting date. These payments are estimated using the remuneration rate expected to apply at the time of settlement, and discounted using market yields at the end of the reporting period on national government bonds with terms to maturity that match, as closely as possible, the estimated future cash outflows.

(c) The provision for gratuity relates to WA Country Health Service's employees who become qualified for gratuity payment upon completion of continuous services as specified in industrial awards. The payment will be made in the first pay period on or after the date the entitlement falls due.

(d) The provision for the deferred salary scheme relates to WA Country Health Service's employees who have entered into an agreement to self-fund an additional twelve months leave to be taken in the fifth year of the agreement. Deferred salary scheme liabilities are classified as current liabilities as WA Country Health Service does not have an unconditional right to defer settlement for at least 12 months after the end of the reporting period.

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

Within 12 months of the end of the reporting period	2,146	2,335
More than 12 months after the end of the reporting period	1,805	1,844
	3,951	4,179

Key sources of estimation uncertainty – long service leave

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

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

- Expected future salaries rates
- Discount rates
- Employee retention rates; and
- Expected future payments

Changes in these estimations and assumptions may impact on the carrying amount of the long service leave provision.

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

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Notes to the Financial Statements
For the year ended 30 June 2022

Note 3 Use of our funding (continued)

	2022 $000	2021 $000
3.2 Patient support costs		
Fees for visiting medical practitioners	102,511	101,752
Medical supplies and services	105,452	93,766
Domestic charges	19,470	16,681
Fuel, light and power	36,132	34,194
Food supplies	13,181	12,037
Patient transport costs	104,925	104,820
Aboriginal health services	40,677	40,855
Pathology services	56,193	50,382
Purchase of health care services	20,011	21,393
Purchase of outsourced medical services	39,600	34,537
Purchase of other outsourced services	43,777	42,045
Grant payments	15,463	3,838
Total patient support costs	597,392	556,300

Patient support costs are recognised as an expense in the reporting period in which they are incurred.

The carrying amounts of any materials held for distribution are expensed when the materials are distributed.

Pathology services represent the value of pathology services provided by Pathwest. $24.0 million (2021: $23.7 million) of these services are provided free of charge and the corresponding revenue is reflected under Resources received.

3.3 Repairs, maintenance, consumable equipment		
Repairs, maintenance and consumable equipment		
Repairs and maintenance	38,562	34,510
Consumable equipment	36,741	18,022
Total repairs, maintenance and consumable equipment expenses	75,303	52,532

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

3.4 Other expenses		
Other expenses		
Communications	8,981	8,595
Computer services	3,148	2,573
Workers compensation insurance	14,787	8,780
Other employee related expenses	42,764	31,606
Insurance	8,922	8,125
Legal expenses	406	203
Motor vehicle expenses	5,791	5,359
Lease expenses (a)	26,252	19,593
Printing and stationery	6,049	4,672
Expected credit losses expense (b)	834	885
Waived debts	180	60
Purchase of outsourced services	32,066	23,943
Shared services costs (c)	61,667	50,493
Other	27,664	24,665
Total other expenses	239,511	189,552

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

(a) Lease expenses include
(i) variable lease payments, short term and low value leases of up to $5,000 with private sector lessors, and
(ii) lease payments for periodic Government Regional Officer Housing and Government Office Accommodation schemes.

(b) Expected credit losses expense is recognised as the movement in the allowance for expected credit losses. Allowance for expected credit losses of trade receivables is measured at the lifetime expected credit losses at each reporting date. WA Country Health service has established a provision matrix that is based on its historical credit loss experience, adjusted for forward-looking factors specific to the debtors and the economic environment. Refer to note 6.1.1 'Movement in the allowance for impairment of trade receivables'.

(c) Shared services costs represent the value of services related to Information technology, Human resources, Supply and Finance provided by the Health Support Services during the financial year. These services are provided free of charge and the corresponding revenue is reflected under Resources received.

Notes to the Financial Statements
For the year ended 30 June 2022

Note 4 Our funding sources

How we obtain our funding

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

	Notes	2022 $000	2021 $000
Income from State Government	4.1	2,132,259	1,881,178
Commonwealth grants	4.2.1	79,251	68,902
Other grants	4.2.2	15,115	14,524
Patient charges	4.3	72,941	71,791
Other revenue	4.4	17,938	20,609

4.1 Income from State Government

4.1.1 Income from public sector entities

Indirect appropriations from the Department of Health	1,233,105	1,073,115
National Health Reform Agreement via the Department of Health	507,128	483,191
National Health Reform Agreement via the Mental Health Commission	40,188	33,738
Mental Health Commission - service delivery agreement	88,817	83,859
Mental Health Commission - specific programs	7,230	8,658
Commonwealth recurrent grants via the Department of Health	21,625	17,263
National partnership on COVID-19 response agreement via the Department of Health	25,407	9,382
Disability Services Commission - Community aids and equipment program	500	755
Other	2,909	1,763
Total income from public sector entities	1,926,909	1,711,724

Indirect appropriations from the Department of Health are recognised as revenue at the fair value of consideration received in the period in which WA Country Health Service gains control of the funds. WA Country Health Service gains control of the funds at the time those funds are deposited in the bank account or credited to the holding account held at Treasury.

Commonwealth and other grants are recognised as revenue when WA Country Health Service has satisfied its performance obligations under the grant agreements. If there is no performance obligation, revenue will be recognised when the grant is received or receivable.

When evaluating when WA Country Health Service satisfies its obligations under capital grant agreements, it relies on percentage of completion confirmed by the project manager, Building Management and Works, Department of Finance.

4.1.2 Resources received

Resources received from other public sector entities during the period:

Department of Finance - government accommodation	149	166
State Solicitor's Office - legal advice and representation	292	-
Pathwest (Note 3.2)	24,027	23,695
Health Support Services (Note 3.4)	61,667	50,493
Rapid Antigen Test kits from Department of Health	9,071	-
Plant equipment from Department of Health	16	-
Land from Department of Planning, Lands and Heritage	-	18
Building from Department of Planning, Lands and Heritage	-	275
Medical equipment from Department of Health	121	47
Total resources received	95,343	74,694

Resources received free of charge or for nominal cost, are recognised as revenue (and assets or expenses) equivalent to the fair value of the assets, or the fair value of those services that can be reliably determined and which would have been purchased if not donated.

Resources received free of charge from the Health Support Service are corporate services including Finance, Human Resources, Supply and Information Technology. Pathwest provides some pathology services free of charge and the total pathology costs is recorded in Patient support costs (Note 3.2).

4.1.3 Royalties for Regions Fund:

Regional Community Services Account:		
Regional Workers Incentives Allowance Payments	7,631	7,679
Expand the ear bus program	-	1,194
Digital Innovation, Transport and Access to Care - Recurrent	25,500	24,122
Digital Innovation, Transport and Access to Care - Patient Assisted Travel Scheme	37,629	35,192
Renal Dialysis - Recurrent	229	-
Renal support team	493	-
Renal Hostels	3,385	3,463
Meet and Greet Service	306	309
Kimberley Mobile Dialysis Unit	331	-
Royal Flying Doctors asset replacement	7,860	-
Pilbara Health Initiatives	3,460	3,460
Regional Infrastructure Headworks Account:		
Residential Aged and Dementia Care Investment Program	1,092	1,028
District Medical Workforce Program	22,091	18,313
Total Royalties for Regions Fund	110,007	94,760

The Regional Community Services Account and the Regional Infrastructure and Headworks Account are sub-funds within the over-arching 'Royalties for Regions Fund'. Funding is committed to projects and programs in WA regional areas.

Total Income from State Government	2,132,259	1,881,178

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Notes to the Financial Statements
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Note 4 Our funding sources (continued)

4.2 Grants

	2022 $000	2021 $000
4.2.1 Commonwealth grants		
Recurrent		
Multi Purpose Service funding	48,478	38,092
Commonwealth Home Support Programme	11,858	12,130
Nursing Home Benefits	3,079	2,940
Other	15,836	15,740
	79,251	68,902
4.2.2 Other grants		
Recurrent		
Rural Health West	3,537	2,877
The Australasian College for Emergency Medicine	1,590	1,798
WA Primary Health Alliance	3,000	2,197
Royal Australian College of Physicians	1,461	2,134
McGrath Foundation Limited	658	649
Royal Australian and New Zealand college of Psychiatrists	639	142
Royal Australian College of Surgeons	390	390
The Royal Australian and New Zealand College of Obstetricians and Gynaecologists	-	250
Other	840	817
Capital		
Newman Hospital Redevelopment	3,000	3,270
	15,115	14,524

Refer to Note 4.1.1 for accounting policy to recognise grant revenue.

4.3 Patient charges

Inpatient charges	21,634	23,336
Outpatient charges	51,307	48,455
	72,941	71,791

Patient charges at gazetted rates are recognised as revenue when health care is provided to patients.

4.4 Other revenue

Services to external organisations	5,676	7,960
Use of hospital facilities	2,614	2,467
Rent from commercial properties	868	828
Rent from residential properties	208	453
Employee contributions	6,234	6,367
Home and Community Care client fees	1,015	1,092
Other	1,323	1,442
	17,938	20,609

Revenue on provision of services or goods is recognised at a point of time when services or goods are transferred to customers.

Notes to the Financial Statements
For the year ended 30 June 2022

Note 5 Key assets

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

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

	Notes	2022 $000	2021 $000
Property, plant and equipment	5.1	1,935,311	1,795,884
Right-of-use assets	5.2	16,756	13,713
Intangible assets	5.3	14,114	16,251
Service concession assets	5.4	9,825	10,061
Total key assets		1,976,006	1,835,909

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Notes to the Financial Statements
For the year ended 30 June 2022

Note 5 Key assets (continued)

5.1 Property, plant and equipment

	Land $000	Buildings $000	Buildings under constructions $000	Site Infrastructure $000	Leasehold improvements $000	Computer equipment $000	Furniture and fittings $000	Motor vehicles $000	Medical equipment $000	Other plant and equipment $000	Other works in progress $000	Artworks $000	Total $000
Year ended 30 June 2022													
1 July 2021													
Gross carrying amount	92,115	1,411,531	51,400	229,644	1,349	8,096	2,112	2,011	67,987	23,523	708	379	1,890,855
Accumulated depreciation	-	-	-	(49,272)	(613)	(5,611)	(821)	(1,686)	(28,879)	(8,089)	-	-	(94,971)
Carrying amount at start of period	**92,115**	**1,411,531**	**51,400**	**180,372**	**736**	**2,485**	**1,291**	**325**	**39,108**	**15,434**	**708**	**379**	**1,795,884**
Additions	-	-	62,105	10	-	641	1,193	83	7,866	6,408	1,127	-	79,433
Transfers from/(to) other reporting entities	-	-	-	-	-	-	-	-	-	17	-	-	17
Transfers between asset classes	-	68,634	(73,113)	8,320	253	823	(762)	-	299	(3,614)	(840)	-	(0)
Other disposals	-	(10)	-	-	-	-	(5)	-	(130)	(95)	-	-	(240)
Revaluation increments/(decrements)	5,270	132,578	-	-	-	-	-	-	-	-	-	-	137,848
Depreciation	-	(51,509)	-	(9,388)	(251)	(1,103)	(172)	(242)	(5,481)	(2,411)	-	-	(70,557)
Write-down of assets	-	-	(6,397)	-	-	(140)	(145)	(5)	(187)	(99)	(101)	-	(7,074)
Carrying amount at 30 June 2022	**97,385**	**1,561,224**	**33,995**	**179,314**	**738**	**2,706**	**1,400**	**161**	**41,475**	**15,640**	**894**	**379**	**1,935,311**
Gross carrying amount	97,385	1,561,224	33,995	237,974	1,602	9,190	2,386	2,089	74,727	25,911	894	379	2,047,756
Accumulated depreciation	-	-	-	(58,660)	(864)	(6,484)	(986)	(1,928)	(33,252)	(10,271)	-	-	(112,445)
	97,385	**1,561,224**	**33,995**	**179,314**	**738**	**2,706**	**1,400**	**161**	**41,475**	**15,640**	**894**	**379**	**1,935,311**
													(0)
Year ended 30 June 2021													
1 July 2020													
Gross carrying amount	88,977	1,427,577	28,310	226,832	1,735	6,802	1,807	2,011	61,445	22,533	2,254	379	1,870,662
Accumulated depreciation	-	-	-	(39,175)	(812)	(4,502)	(668)	(1,369)	(23,973)	(5,961)	-	-	(76,460)
Carrying amount at start of period	**88,977**	**1,427,577**	**28,310**	**187,657**	**923**	**2,300**	**1,139**	**642**	**37,472**	**16,572**	**2,254**	**379**	**1,794,202**
Additions		16	47,224	-	-	3	738	-	6,954	1,460	570	-	56,965
Transfers from/(to) other reporting entities	(184)	275	-	-	-	-	-	-	41	-	-	-	132
Transfers between asset classes	-	19,160	(21,341)	2,882	-	1,318	(233)	-	307	(382)	(1,689)	-	22
Other disposals	-	(258)	-	-	-	-	(4)	-	(148)	(30)	-	-	(440)
Revaluation increments/(decrements)	3,322	16,980	-	-	-	-	-	-	-	-	-	-	20,302
Depreciation	-	(52,219)	-	(10,167)	(187)	(1,136)	(190)	(317)	(5,517)	(2,186)	-	-	(71,919)
Write-down of assets	-	-	(2,793)	-	-	-	(159)	-	(1)	-	(427)	-	(3,380)
Carrying amount at 30 June 2021	**92,115**	**1,411,531**	**51,400**	**180,372**	**736**	**2,485**	**1,291**	**325**	**39,108**	**15,434**	**708**	**379**	**1,795,884**
Gross carrying amount	92,115	1,411,531	51,400	229,644	1,349	8,096	2,112	2,011	67,987	23,523	708	379	1,890,855
Accumulated depreciation	-	-	-	(49,272)	(613)	(5,611)	(821)	(1,686)	(28,879)	(8,089)	-	-	(94,971)
	92,115	**1,411,531**	**51,400**	**180,372**	**736**	**2,485**	**1,291**	**325**	**39,108**	**15,434**	**708**	**379**	**1,795,884**

Information on fair value measurements is provided in Note 8.3

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Notes to the Financial Statements
For the year ended 30 June 2022

Note 5 Key assets (continued)

5.1 Property, plant and equipment (continued)

Initial recognition

Items of property, plant and equipment and infrastructure, costing $5,000 or more are measured initially at cost. Where an asset is acquired for no or nominal cost, the cost is valued at its fair value at the date of acquisition. Items of property, plant and equipment and infrastructure costing less than $5,000 are immediately expensed direct to the Statement of Comprehensive Income (other than where they form part of a group of similar items which are significant in total).

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

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

Subsequent measurement

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

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

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

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

Land and buildings were revalued as at 1 July 2021 by the Western Australian Land Information Authority (Valuation and Property Analytics). The valuations were performed during the year ended 30 June 2022 and recognised at 30 June 2022. In undertaking the revaluation, fair value was determined by reference to the market value for land: $32.717 million (2021: $31.975 million) and buildings: $77.278 million (2021: $69.475 million). For the remaining balance, fair value of buildings was determined on the basis of current replacement cost and fair value of land was determined on the basis of comparison with market evidence for land with low level utility (high restricted use land).

Revaluation model:

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

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

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

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

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

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

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

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

Notes to the Financial Statements
For the year ended 30 June 2022

Note 5 Key assets (continued)

5.1.1 Depreciation and impairment

Charge for the period	2022 $000	2021 $000
Depreciation		
Buildings	51,509	52,219
Site Infrastructure	9,388	10,167
Leasehold improvements	251	187
Computer equipment	1,103	1,136
Furniture and fittings	172	190
Motor vehicles	242	317
Medical equipment	5,481	5,517
Other plant and equipment	2,411	2,186
Total depreciation for the period	70,557	71,919

As at 30 June 2022 there were no indications of impairment to property, plant and equipment.

Please refer to note 5.3.1 for guidance in relation to the impairment assessment that had been performed for intangible assets.

Finite useful lives

All property, plant and equipment having a limited useful life are systematically depreciated over their estimated useful lives in a manner that reflects the consumption of their future economic benefits. The exceptions to this rule include assets held for sale, land and investment properties.

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

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

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

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

Impairment

Non-financial assets, including items of property, plant and equipment, are tested for impairment whenever there is an indication that the asset may be impaired. Where there is an indication of impairment, the recoverable amount is estimated. Where the recoverable amount is less than the carrying amount, the asset is considered impaired and is written down to the recoverable amount and an impairment loss is recognised.

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

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

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

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

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

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Notes to the Financial Statements
For the year ended 30 June 2022

Note 5 Key assets (continued)

	2022 $000	2021 $000
5.1.2 Revaluation decrements/(increments)		
Land	(5,270)	(3,322)
Buildings	(85,559)	(16,980)
	(90,829)	(20,302)
5.1.3 Loss on disposal of non-current assets		
Net proceeds from disposal of non-current assets:		
Property, plant and equipment	1	-
Carrying amount of non-current assets:		
Property, plant and equipment	240	440
Net loss	239	440

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

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

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

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Notes to the Financial Statements
For the year ended 30 June 2022

Note 5 Key assets (continued)

5.2 Right-of-use assets

	Buildings - Accommodation $000	Buildings - Non-accommodation $000	Plant and equipment $000	Motor vehicles $000	Total $000
Year ended 30 June 2022					
1 July 2021					
Gross carrying amount	5,480	4,477	460	13,157	23,574
Accumulated depreciation	(2,727)	(1,523)	(231)	(5,380)	(9,861)
Carrying amount at start of period	**2,753**	**2,954**	**229**	**7,777**	**13,713**
Additions	9,160	1,521	43	1,835	12,559
Disposals	(108)	-	-	(146)	(254)
Depreciation	(4,685)	(1,209)	(131)	(3,237)	(9,262)
Carrying amount at 30 June 2022	**7,120**	**3,266**	**141**	**6,229**	**16,756**
Gross carrying amount	11,648	5,207	411	13,252	30,518
Accumulated depreciation	(4,528)	(1,941)	(270)	(7,023)	(13,762)
	7,120	**3,266**	**141**	**6,229**	**16,756**
Year ended 30 June 2021					
1 July 2020					
Gross carrying amount	4,896	4,629	382	12,991	22,898
Accumulated depreciation	(2,049)	(986)	(108)	(3,304)	(6,447)
Carrying amount at start of period	**2,847**	**3,643**	**274**	**9,687**	**16,451**
Additions	3,051	829	90	2,560	6,530
Disposals	(151)	(480)	-	(892)	(1,523)
Depreciation	(2,994)	(1,038)	(135)	(3,578)	(7,745)
Carrying amount at 30 June 2021	**2,753**	**2,954**	**229**	**7,777**	**13,713**
Gross carrying amount	5,480	4,477	460	13,157	23,574
Accumulated depreciation	(2,727)	(1,523)	(231)	(5,380)	(9,861)
	2,753	**2,954**	**229**	**7,777**	**13,713**

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Notes to the Financial Statements
For the year ended 30 June 2022

Note 5 Key assets (continued)

5.2 Right-of-use assets (continued)

Initial recognition

Right-of-use assets are measured at cost including the following:

- the amount of the initial measurement of lease liability,
- any lease payments made at or before the commencement date less any lease incentives received,
- any initial direct cost, and
- restoration costs, including dismatling and removing the underlying asset.

WA Country Health Service has elected not to recognise right-of-use assets and lease liabilities for short-term lease (with a lease term of 12 months or less) and low value leases (with an underlying value of $5,000 or less) except where the lease is with another wholly-owned public sector entity lessor agency. Lease payments associated with these leases are expensed over a straight-line basis over the lease term.

Subsequent measurement

The cost model is applied for subsequent measurement of right-of-use assets, requiring the asset to be carried at cost less any accumulated depreciation and accumulated impairment losses and adjusted for any re-measurement of lease liability.

Depreciation and impairment of right-of-use assets

Right-of-use assets are depreciated on a straight-line basis over the shorter of the lease term and the estimated useful lives of the underlying assets.

If ownership of the leased asset transfers to WA Country Health Service at the end of the lease term or the costs reflects the exercise of a purchase option, depreciation is calculated using the estimated useful life of the asset.

Right-of-use assets are tested for impairment when an indication of impairment is identified. The policy in connection with testing for impairment is outlined in note 5.1.1

Key sources of estimation uncertainty

Key judgements to be made include identifying leases within contracts, determine whether there is reasonable certainity around exercising extension and termination options, identifying whether payments are variable or fixed in substance and determining the stand-alone selling prices for lease and non-lease components.

Estimation uncertainty that may arise includes the estimation of the lease term, determination of the appropriate discount rate to discount the lease payments and assessing whether the right-of-use assets needs to be impaired.

WA Country Health Service has leases for residential accommodation, office, clinics, vehicle and equipment.

	2022 $000	2021 $000
Current	153	24
Non-current	16,603	13,689
Total Right-of-use assets	16,756	13,713
The following amounts relating to leases have been recognised in the Statement of Comprehensive Income:		
Depreciation expense of right-of-use assets		
Buildings - Accommodation	4,685	2,994
Buildings - Non-accommodation	1,209	1,038
Plant and equipment	131	135
Motor vehicles	3,237	3,578
Lease interest expense	359	351
Expenses relating to variable lease payments not included in lease	137	292
Short-term leases	14,208	9,064
Low-value leases	12	19
Income from sub-leasing right-of-use assets (Note 3.1(a))	(1,205)	(1,269)
Total amount recognised in the statement of comprehensive income	22,773	16,202

The total cash outflow for leases in 2022 was $24.32 million (2021: $17.86 million).

WA Country Health Service has also entered into a Memorandum of Understanding (MOU) with the Department of Finance for the leasing of office accommodation. These are not recognised under AASB 16 because of substitution rights held by the Department of Finance and are accounted for as an expense as incurred.

Notes to the Financial Statements
For the year ended 30 June 2022

Note 5 Key assets (continued)

5.3 Intangible assets

	Computer software $000	Works in progress $000	Total $000
Year ended 30 June 2022			
1 July 2021			
Gross carrying amount	24,040	2,581	26,621
Accumulated amortisation	(10,370)	-	(10,370)
Carrying amount at start of period	**13,670**	**2,581**	**16,251**
Additions	-	383	383
Transfers from work in progress	819	(819)	-
Amortisation expense	(2,511)	-	(2,511)
Write-down of assets	-	(9)	(9)
Carrying amount at 30 June 2022	**11,978**	**2,136**	**14,114**
Gross carrying amount	24,859	2,136	26,995
Accumulated amortisation	(12,881)	-	(12,881)
	11,978	**2,136**	**14,114**
Year ended 30 June 2021			
1 July 2020			
Gross carrying amount	24,040	228	24,268
Accumulated depreciation	(7,928)	-	(7,928)
Carrying amount at start of period	**16,112**	**228**	**16,340**
Additions	-	2,389	2,389
Transfers from work in progress	-	(22)	(22)
Amortisation expense	(2,442)	-	(2,442)
Write-down of assets	-	(14)	(14)
Carrying amount at 30 June 2021	**13,670**	**2,581**	**16,251**
Gross carrying amount	24,040	2,581	26,621
Accumulated amortisation	(10,370)	-	(10,370)
	13,670	**2,581**	**16,251**

Initial recognition

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

Costs incurred below these thresholds are immediately expensed directly to the Statement of Comprehensive Income.

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

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

(a) the technical feasibility of completing the intangible asset so that it will be available for use or sale;
(b) an intention to complete the intangible asset and use or sell it;
(c) the ability to use or sell the intangible asset;
(d) the intangible asset will generate probable future economic benefit;
(e) the availability of adequate technical, financial and other resources to complete the development and to use or sell the intangible asset; and
(f) the ability to measure reliably the expenditure attributable to the intangible asset during its development.

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

Subsequent measurement

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

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Notes to the Financial Statements
For the year ended 30 June 2022

Note 5 Key assets (continued)

5.3 Intangible assets (continued)

5.3.1 Amortisation and impairment

Charge for the period	2022 $000	2021 $000
Computer software	2,511	2,442
Total amortisation for the period	2,511	2,442

As at 30 June 2022 there were no indications of impairment to intangible assets.

WA Country Health Service held no goodwill or intangible assets with an indefinite useful life during the reporting period. At the end of the reporting period there were no intangible assets not yet available for use.

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

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

Computer software	5 - 10 years

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

Impairment

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

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

5.4 Service concession assets

Service concession arrangements (SCAs) are contracts between a grantor and an operator where an operator provides public services related to a service concession asset on behalf of a public sector grantor for a specified period of time and manages at least some of those services.

WA Country Health Service has identified three contracts with private providers that fall within the scope of AASB 1059. These private contractors provide medical imaging and radiation oncology services in the South West and Great Southern regions.

Under all three contracts, services provided by private contractors are delivered within buildings owned by WA Country Health Service. Upon adoption of AASB 1059, WA Country Health Service has reclassified service areas leased to these private contractors from Property, plant and equipment to Service concession assets.

	2022 $000	2021 $000
Opening net carrying amount	10,061	10,297
Additions	-	-
Disposals	-	-
Depreciation	(236)	(236)
Revaluation increments/(decrements)	-	
Closing carrying amount	**9,825**	**10,061**

Initial recognition

Upon initial recognition, partial areas of these three buildings have been reclassified from Property, plant and equipent to Service concession assets, measured at their fair values (being the current replacement cost), in accordance with the cost approach to fair value at the date of reclassification.

Subsequent measurement

Subsequently, the revaluation model is used for the measurement of service concession buildings.

Refer to Note 5.1 for the revaluation and impairment policy.

Depreciation

Depreciation is calculated on a straight line basis, at rates that allocate the asset's value, less any estimated residual value, over its estimated useful life.

Refer to Note 5.1 for the depreciation policy.

Notes to the Financial Statements
For the year ended 30 June 2022

Note 6 Other assets and liabilities

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

	Notes	2022 $000	2021 $000
Receivables	6.1	26,346	20,828
Amounts receivable for services	6.2	1,084,615	1,000,555
Other current assets	6.3	10,268	10,507
Payables	6.4	161,601	154,089
Contract liabilities	6.5	33,541	22,302

6.1 Receivables

Current		
Trade receivables		
Patient fee debtors	6,925	8,341
Non patient fee debtors	3,454	2,963
Total trade receivables	10,379	11,304
Allowance for impairment of trade receivables	(2,897)	(3,496)
Other receivables	2,279	1,456
Contract receivables	713	309
Accrued revenue	7,780	5,199
GST receivable	8,092	6,056
Total receivables	26,346	20,828

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

Other receivables are mainly bond payments on leased properties and are recognised at original value. These are not impaired as the bonds are expected to be refunded upon end of leases.

Contract receivables are recognised when specific performance obligations within funding agreements are satisfied. These are not impaired as payments are expected.

6.1.1. Movement in the allowance for impairment of trade receivables

Reconciliation of changes in the allowance for impairment of trade receivables:		
Balance at start of period	3,496	5,720
Expected credit losses expense	834	885
Amounts written off during the period	(1,449)	(3,109)
Amounts recovered during the period	16	-
Balance at end of period	2,897	3,496

The maximum exposure to credit risk at the end of the reporting period for trade receivables is the carrying amount of the asset inclusive of any allowance for impairment as shown in the table at Note 8.1 (c) 'Credit risk exposure'.

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

6.2 Amounts receivable for services (Holding Account)

Non-current	1,084,615	1,000,555
Balance at end of period	1,084,615	1,000,555

Amounts receivable for services represent the non-cash component of service appropriations. It is restricted in that it can only be used for asset replacement; payment of leave liability; or funding depreciation expense for lease arrangements.

Amounts receivable for services are not considered to be impaired (that is there is no expected credit loss of the holding accounts).

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Notes to the Financial Statements
For the year ended 30 June 2022

Note 6 Other assets and liabilities (continued)

	2022 $000	2021 $000
6.3 Other current assets		
Current		
Supply inventories	3,316	3,101
Pharmaceutical inventories	3,505	3,000
Other inventories	132	128
Prepayments	3,315	3,081
Other	-	1,197
Balance at end of period	10,268	10,507

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

Inventories not held for resale are measured at cost unless they are no longer required, in which case they are measured at net realisable value.

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

6.4 Payables		
Current		
Trade payables	17,565	31,382
Accrued expenses	111,004	95,025
Accrued salaries	33,032	27,682
Balance at end of period	161,601	154,089

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

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

6.5 Contract liabilities		
Current	18,610	10,571
Non-current	14,931	11,731
Total contract liabilities	33,541	22,302

6.5.1 Movement in contract liabilities		
Reconciliation of changes in contract liabilities:		
Balance at start of period	22,302	22,397
Additions	15,012	4,676
Revenues recognised in the reporting period	(3,773)	(4,771)
Balance at end of period	33,541	22,302

6.5.2 Expected satisfaction of contract liabilities		
Revenue recognition		
1 year	18,610	10,571
1 to 5 years	14,931	11,731
Over 5 years	-	-
	33,541	22,302

Notes to the Financial Statements
For the year ended 30 June 2022

Note 7 Financing

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

	Notes
Finance costs	7.1
Lease liabilities	7.2
Cash and cash equivalents	7.3
Reconciliation of cash	7.3.1
Reconciliation of operating activities	7.3.2
Capital commitments	7.4

	2022 $000	2021 $000
7.1 Finance costs		
Lease interest expense	359	351
	359	351

7.2 Lease liabilities		
Current	4,535	4,932
Non-current	9,445	7,570
Total lease liabilities	13,980	12,502

WA Country Health Service measures a lease liability, at the commencement date, at the present value of the lease payments that are not paid at that date. The lease payments are discounted using the interest rate implicit in the lease. If that rate cannot be readily determined, WA Country Health Service uses the incremental borrowing rate provided by Western Australia Treasury Corporation.

Lease payments included by WA Country Health Service as part of the present value calculation of lease liability include:

- Fixed payments (including in-substance fixed payments), less any lease incentives receivable;
- Variable lease payments that depend on an index or a rate initially measured using the index or rate as at the commencement date;
- Amounts expected to be payable by the lessee under residual value guarantees;
- The exercise price of purchase options (where these are reasonably certain to be exercised);
- Payments for penalties for terminating a lease, where the lease term reflects WA Country Health Service exercising an option to terminate the lease.

The interest on the lease liability is recognised in the Statement of Comprehensive Income over the lease term so as to produce a constant periodic rate of interest on the remaining balance of the liability for each period. Lease liabilities do not include any future changes in variable lease payment (that depend on an index or rate) until they take effect, in which case the lease liability is assessed and adjusted against the right-of-use asset.

Periods covered by extension or termination options are only included in the lease term by WA Country Health Service if it is reasonably certain the lease will be extended (or not terminated).

Variable lease payments, not included in the measurement of lease liability, that are dependent on sales are recognised by WA Country Health Service in the Statement of Comprehensive Income in the period in which the condition that triggers those payment occurs.

This section should be read in conjunction with note 5.2.

Subsequent measurement

Lease liabilities are measured by increasing the carrying amount to reflect interest on the lease liabilities; reducing the carrying amount to reflect the lease payments made; and remeasuring the carry amount at amortised cost, subject to adjustments that reflect any reassessment or lease modifications.

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Notes to the Financial Statements
For the year ended 30 June 2022

Note 7 Financing (continued)

	Notes	2022 $000	2021 $000
7.3 Cash and cash equivalents			
7.3.1 Reconciliation of cash			
Cash and cash equivalents		28,114	30,609
Restricted cash and cash equivalents (a)			
Royalties for Regions Fund		254	881
Capital grant (b)		17,798	10,978
Patient receipts under section 19 (2) of the Health Insurance Act 1973		5,058	4,600
Bequests		405	647
Mental Health Commission Funding (note 9.7)		1,256	1,339
Other		15,637	7,597
Accrued salaries suspense account (c)		18,545	16,470
Balance at end of period		87,067	73,121

(a) Restricted cash and cash equivalents are assets, the uses of which are restricted, by specific legal or other externally imposed requirements.

(b) Unspent funds from the Commonwealth Government and private sector industry are committed to projects and programs in WA regional areas.

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

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

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

	Notes	2022 $000	2021 $000
Net cost of services		2,064,976	1,877,867
Non-cash items			
Depreciation and amortisation expense	5.1.1, 5.2, 5.3.1, 5.4	(82,566)	(82,342)
Asset revaluation increment	5.1.2	90,829	20,302
Loss from disposal of non-current assets	5.1.3	(239)	(440)
Resources received	4.1.2	(95,327)	(74,354)
Write down of property, plant and equipment	5.1, 5.3	(7,082)	(3,394)
Increase/(decrease) in assets			
Receivables (a)		5,550	2,808
Other assets		(238)	1,715
(Increase)/decrease in liabilities			
Payables (a)		(10,747)	(15,467)
Contract liabilities		(4,922)	644
Current provisions		(22,749)	(20,472)
Non-current provisions		(4,534)	(1,440)
Other current liabilities		(68)	(1,627)
Net cash used in operating activities		1,932,891	1,703,800

(a) Note that the sale/purchase of non-current assets are not included in these items as they do not form part of the reconciling items.

7.4 Capital commitments

	2022 $000	2021 $000
The commitments below are inclusive of GST where relevant.		
Capital expenditure commitments, being contracted capital expenditure additional to the amounts reported in the financial statements, are payable as follows:		
Within 1 year	96,214	87,118
Later than 1 year and not later than 5 years	120,575	112,900
Later than 5 years	-	-
	216,789	200,018

Notes to the Financial Statements
For the year ended 30 June 2022

Note 8 Risks and Contingencies

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

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

8.1 Financial risk management

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

(a) Summary of risks and risk management

Credit risk

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

Credit risk associated with WA Country Health Service's financial assets is minimal because the main receivable is the amounts receivable for services (holding account). For receivables other than Government, WA Country Health Service trades only with recognised, creditworthy third parties. WA Country Health Service has policies in place to ensure that sales of products and services are made to customers with an appropriate credit history. In addition, receivable balances are monitored on an ongoing basis with the result that WA Country Health Service's exposure to bad debts is minimal. Debt will be written off against the allowance account when it is improbable or uneconomical to recover the debt. At the end of the reporting period there were no significant concentrations of credit risk.

Liquidity risk

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

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

WA Country Health Service has appropriate procedures to manage cash flows including drawdown of appropriations by monitoring forecast cash flows to ensure that sufficient funds are available to meet its commitments.

Market risk

Market risk is the risk that changes in market prices such as foreign exchange rates and interest rates will affect WA Country Health Service's income or the value of its holdings of financial instruments. WA Country Health Service does not trade in foreign currency and is not materially exposed to other price risks. WA Country Health Service's exposure to market risk for changes in interest rates is nil as it does not have long-term debt obligations.

(b) Categories of financial instruments

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

	2022 $000	2021 $000
Financial assets		
Cash and cash equivalents	87,067	73,121
Financial assets measured at amortised cost (a)	1,102,869	1,015,327
Total financial assets	1,189,936	1,088,448
Financial liabilities		
Financial liabilities measured at amortised cost	175,581	166,591
Total financial liability	175,581	166,591

(a) The amounts of Financial assets measured at amortised cost exclude GST recoverable from the ATO (statutory receivable).

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Notes to the Financial Statements
For the year ended 30 June 2022

Note 8 Risks and Contingencies (continued)

8.1 Financial risk management (continued)

(c) Credit risk exposure

The following table details the credit risk exposure on WA Country Health Service's trade receivables using a provision matrix.

			Days past due			
	Total $000	Current $000	<30 days $000	31-60 days $000	61-90 days $000	>91 days $000
30 June 2022						
Expected credit loss rate		5%	10%	29%	10%	61%
Estimated total gross carrying amount at default	10,379	3,727	1,371	371	1,083	3,828
Expected credit losses	(2,897)	(189)	(136)	(106)	(112)	(2,354)
30 June 2021						
Expected credit loss rate		6%	8%	27%	35%	58%
Estimated total gross carrying amount at default	11,304	3,666	1,755	679	442	4,762
Expected credit losses	(3,496)	(231)	(143)	(183)	(155)	(2,784)

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Notes to the Financial Statements
For the year ended 30 June 2022

Note 8 Risks and Contingencies (continued)

8.1 Financial risk management (continued)

(d) Liquidity risk and interest rate exposure

The following table details WA Country Health Service's interest rate exposure and the contractual maturity analysis of financial assets and financial liabilities. The maturity analysis section includes interest and principal cash flows. The interest rate exposure section analyses only the carrying amounts of each item.

Interest rate exposure and maturity analysis of financial assets and financial liabilities

		Interest rate exposure				Maturity dates				
	Weighted average effective interest rate	Carrying amount	Fixed interest rate	Variable interest rate	Non-interest bearing	Nominal Amount	Up to 1 month	1-3 months	3 months to 1 year	1-5 years	More than 5 years
	%	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000
2022											
Financial Assets											
Cash and cash equivalents	-	87,067	-	-	87,067	87,067	87,067	-	-	-	-
Receivables (a)	-	18,254	-	-	18,254	18,254	18,254	-	-	-	-
Amounts receivable for services	-	1,084,615	-	-	1,084,615	1,084,615	-	-	-	-	1,084,615
		1,189,936	-	-	1,189,936	1,189,936	105,321	-	-	-	1,084,615
Financial Liabilities											
Payables	-	161,601	-	-	161,601	161,601	161,601	-	-	-	-
Lease liabilities	2.08%	13,980	13,980	-	-	17,413	870	2,505	5,488	8,292	258
		175,581	13,980	-	161,601	179,014	162,471	2,505	5,488	8,292	258

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

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Notes to the Financial Statements
For the year ended 30 June 2022

Note 8 Risks and Contingencies (continued)

8.1 Financial risk management (continued)

(d) Liquidity risk and interest rate exposure (continued)

Interest rate exposure and maturity analysis of financial assets and financial liabilities

			Interest rate exposure				Maturity dates				
	Weighted average effective interest rate	Carrying amount	Fixed interest rate	Variable interest rate	Non-interest bearing	Nominal Amount	Up to 1 month	1-3 months	3 months to 1 year	1-5 years	More than 5 years
	%	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000
2021											
Financial Assets											
Cash and cash equivalents	-	73,121	-	-	73,121	73,121	73,121	-		-	-
Receivables (a)	-	14,772	-	-	14,772	14,772	14,772	-	-	-	-
Amounts receivable for services	-	1,000,555	-	-	1,000,555	1,000,555	-	-	-	-	1,000,555
		1,088,448	-	-	1,088,448	1,088,448	87,893	-	-	-	1,000,555
Financial Liabilities											
Payables	-	154,089	-	-	154,089	154,089	154,089	-		-	-
Lease liabilities	2.46%	12,502	12,502		-	14,325	643	1,226	4,574	7,417	465
		166,591	12,502	-	154,089	168,414	154,732	1,226	4,574	7,417	465

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

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Notes to the Financial Statements
For the year ended 30 June 2022

Note 8 Risks and Contingencies (continued)

8.2 Contingent assets and liabilities

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

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

8.2.1 Contingent assets

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

8.2.2 Contingent liabilities

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

	2022 $000	2021 $000
Litigation in progress:		
Pending litigation that are not recoverable from RiskCover insurance and may affect the financial position of WA Country Health Service.	3,738	1,963
Number of claims	10	4

Contaminated sites

Under the Contaminated Sites Act 2003, WA Country Health Service is required to report known and suspected contaminated sites to the Department of Water and Environmental Regulation (DWER). In accordance with the Act, DWER classifies these sites on the basis of the risk to human health, the environment and environmental values. Where sites are classified as contaminated – remediation required or possibly contaminated – investigation required.

WA Country Health Service has two sites that require remediation and one suspected contaminated site, but it is not possible to estimate the potential financial effect due to the uncertainties relating to the amount or timing of any outflow.

Significant infrastructure projects

WA Country Health Service has a number of significant infrastrucure projects that have reached or are reaching completion. There may be claims that arise in relation to works or activities associated with such projects. Claims will generally be subject to a period of negotiaiton and may either be withdrawn, settled at an agreed value, or proceed to some alternative process for resolution such as through legal action. Where costs are negotiated and claims settled, these are reflected in the financial statements.

Notes to the Financial Statements
For the year ended 30 June 2022

Note 8 Risks and Contingencies (continued)

8.3 Fair value measurement

(a) Fair value hierarchy

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

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

	Level 1 $000	Level 2 $000	Level 3 $000	Fair value at end of period $000
Assets measured at fair value 2022				
Land				
Vacant land	-	1,614	-	1,614
Residential	-	31,102	-	31,102
Specialised	-	-	64,669	64,669
Buildings				
Residential	-	77,278	-	77,278
Specialised	-	-	1,483,946	1,483,946
	-	109,994	1,548,615	1,658,609
Assets measured at fair value 2021				
Land				
Vacant land	-	1,958	-	1,958
Residential	-	30,017	-	30,017
Specialised	-	-	60,140	60,140
Buildings (Restated)				
Residential	-	69,475	-	69,475
Specialised	-	-	1,342,056	1,342,056
	-	101,450	1,402,196	1,503,646

(b) Valuation technique to derive Level 2 fair values

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

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

	Land $000	Buildings $000
2022		
Fair value at start of period	60,140	1,342,056
Additions (including transfer from works in progress)	-	68,303
Revaluation increments/(decrements) recognised in Profit or Loss	3,552	80,036
Revaluation increments/(decrements) recognised in Other Comprehensive Income	-	43,987
Transfers from/(to) Level 2 (a), (b)	977	(439)
Disposals	-	(110)
Depreciation expense	-	(49,887)
Fair value at end of period	64,669	1,483,946
2021		
Fair value at start of period	57,635	1,360,697
Additions (including transfer from works in progress)	18	19,261
Revaluation increments/(decrements) recognised in Profit or Loss	2,490	12,396
Transfers from/(to) Level 2 (c)	29	363
Disposals	(32)	-
Depreciation expenses	-	(50,661)
Fair value at end of period	60,140	1,342,056

(a) Fair value measurements hierarchy changes from level 2 to level 3 for land represent vacant land and land that was previously reflected at market values for which a current use value was provided in 2021-22.

(b) Fair value measurements hierarchy changes from level 3 to level 2 for buildings represent residential accommodation buildings constructed in previous periods and reflected at value for which market values were provided in 2021-22.

(c) Fair value measurements hierarchy changes from level 2 to level 3 represent land and buildings previously reflected at market values for which a current use value was provided in 2020-21.

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Notes to the Financial Statements
For the year ended 30 June 2022

Note 8 Risks and Contingencies (continued)

8.3 Fair value measurement (continued)

Valuation processes

There were no changes in valuation techniques during the period.

Land (Level 3 fair values)

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

Buildings (Level 3 fair values)

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

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

Basis of valuation

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

Note 9 Other disclosures

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

9.1 Events occurring after the end of the reporting period

On 31 July 2022, the Western Australia government announced enhancements to the public sector wages policy to include a one-off $2,500 cost of living payment. As a result of this announcement, the members of the Australian Medical Association working for the Health Service will receive an aggregate estimated payout of $1.575m in the new financial year.

9.2 Future impact of Australian Accounting Standards not yet operative

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

		Operative for reporting periods beginning on/after
AASB 17	*Insurance Contracts* This Standard establishes principles for the recognition, measurement, presentation and disclosure of insuance contracts. WA Country Health Service has not assessed the impact of the Standard.	01 Jan 2023

Notes to the Financial Statements
For the year ended 30 June 2022

Note 9 Other disclosures (continued)

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

		Operative for reporting periods beginning on/after
AASB 2020-1	*Amendments to Australian Accounting Standards - Classification of Liabilities as Current or Non-current* The Standard amends AASB 101 to clarify requirements for the presentation of liabilities in the statement of financial position as current or non-current. There is no financial impact.	01 Jan 2023
AASB 2020-3	*Amendments to Australian Accounting Standards – Annual Improvements 2018–2020 and Other Amendments* This Standard amends: (a) AASB 1 to simplify the application of AASB 1; (b) AASB 3 to update a reference to the Conceptual Framework for Financial Reporting; (c) AASB 9 to clarify the fees an entity includes when assessing whether the terms of a new or modified financial liability are substantially different from the terms of the original financial liability; (d) AASB 116 to require an entity to recognise the sales proceeds from selling items produced while preparing property, plant and equipment for its intended use and the related cost in profit or loss, instead of deducting the amounts received from the cost of the asset; (e) AASB 137 to specify the costs that an entity includes when assessing whether a contract will be loss-making; and (f) AASB 141 to remove the requirement to exclude cash flows from taxation when measuring fair value. There is no financial impact.	01 Jan 2022
AASB 2020-6	*Amendments to Australian Accounting Standards – Classification of Liabilities as Current or Non-current – Deferral of Effective Date* This Standard amends AASB 101 to defer requirements for the presentation of liabilities in the statement of financial position as current or non-current that were added to AASB 101 in AASB 2020-1. There is no financial impact.	01 Jan 2022
AASB 2021-2	*Amendments to Australian Accounting Standards – Disclosure of Accounting Policies and Definition of Accounting Estimates* This Standard amends: (a) AASB 7, to clarify that information about measurement bases for financial instruments is expected to be material to an entity's financial statements; (b) AASB 101, to require entities to disclose their material accounting policy information rather than their significant accounting policies; (c) AASB 108, to clarify how entities should distinguish changes in accounting policies and changes in accounting estimates; (d) AASB 134, to identify material accounting policy information as a component of a complete set of financial statements; and (e) AASB Practice Statement 2, to provide guidance on how to apply the concept of materiality to accounting policy disclosures. There is no financial impact.	01 Jan 2023
AASB 2021-6	*Amendments to Australian Accounting Standards – Disclosures of Accounting Policies: Tier 2 and Other Australian Accounting Standards* This Standard amends: (a) AASB 1049 to require entities to disclose their material accounting policy information rather than their significant accounting policies; (b) AASB 1054 to reflect the updated accounting policy terminology used in AASB 101 Presentation of Financial Statements; and (c) AASB 1060 to require entities to disclose their material accounting policy information rather than their significant accounting policy and to clarify that information about measurement bases for financial instruments is expected to be material to an entity's financial statements. There is no financial impact.	01 Jan 2023
AASB 2021-7	*Amendments to Australian Accounting Standards – Effective Date of Amendments to AASB 10 and AASB 128 and Editorial Corrections* This Standard further deferrs (to 1 January 2025) the amendments to AASB 10 and AASB 128 relating to the sale or contribution of assets between an investor and its associated or joint venture. The stadnard also includes editorial corrections. There is no financial impact.	01 Jan 2022

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Notes to the Financial Statements
For the year ended 30 June 2022

Note 9 Other disclosures (continued)

9.3 Key management personnel

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

Compensation of members of the accountable authority

Compensation Band	2022	2021
$ 0 - $ 10,000	1	1
$ 10,001 - $ 20,000	1	-
$ 40,001 - $ 50,000	7	8
$ 80,001 - $ 90,000	1	1
	10	10

	2022 $000	2021 $000
Short-term employee benefits	382	410
Post-employment benefits	38	39
Other long-term benefits	-	-
Termination benefits	-	-
Total remuneration of members of the accountable authority	420	449

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

Compensation of Senior officers
The number of senior officers other than senior officers reported as members of the Accountable Authority, whose total fees, salaries, superannuation, non-monetary benefits and other benefits for the financial year, falling within the following bands are:

Compensation Band ($)	2022	2021
$ 80,001 - $ 90,000	-	1
$ 90,001 -$100,000	1	-
$100,001 - $110,000	-	1
$120,001 - $130,000	1	-
$140,001 - $150,000	-	1
$150,001 - $160,000	1	-
$160,001 - $170,000	2	-
$170,001 - $180,000	-	1
$180,001 - $190,000	2	1
$190,001 - $200,000	2	1
$200,001 - $210,000	-	1
$210,001 - $220,000	2	5
$220,001 - $230,000	-	6
$230,001 - $240,000	5	2
$240,001 - $250,000	3	-
$250,001 - $260,000	-	1
$280,001 - $290,000	1	-
$300,001 - $310,000	1	-
$320,001 - $330,000	-	1
$400,001 - $410,000	-	1
$440,001 - $450,000	-	1
$450,001 - $460,000	1	-
$530,001 - $540,000	1	-
	23	24

	2022 $000	2021 $000
Short-term employee benefits	4,446	4,467
Post-employment benefits	478	469
Other long-term benefits	458	471
Termination benefits	-	-
Total remuneration of senior officers	5,382	5,407

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

Notes to the Financial Statements
For the year ended 30 June 2022

Note 9 Other disclosures (continued)

9.4 Related party transactions

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

Related parties of WA Country Health Service include:

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

Significant transactions with Government-related entities

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

	2022 $000	2021 $000
Income from State Government - Indirect appropriations from the Department of Health (Note 4.1.1)	1,233,105	1,073,115
Equity contribution (Note 9.9):		
- capital funding from State Government	12,927	10,092
- equity injections from Royalties for Regions Fund	68,574	36,001
Resources received (Note 4.1.2):		
- corporate services from Health Support Services	61,667	50,493
- Rapid Antigen Test kits from Department of Health	9,071	-
- pathology services from PathWest	24,027	23,695
Income from Royalties for Regions Fund (Note 4.1.3)	110,007	94,760
Commonwealth grant funding received under the National Health Reform Agreement (Note 4.1.1):		
- via the Department of Health	507,128	483,191
- via Mental Health Commission	40,188	33,738
Commonwealth recurrent grants via the Department of Health (Note 4.1.1)	21,625	17,263
National partnership on COVID-19 response agreement via the Department of Health (Note 4.1.1)	25,407	9,382
Other grant funding received from the Mental Health Commission (Note 4.1.1)	96,047	92,517
Insurance payments to the Insurance Commission and RiskCover fund	24,576	17,759
Department of Finance (Capital construction, repair and maintenance, and fleet lease)	79,667	57,715

Material transactions with other related parties

Superannuation payments to GESB	85,343	75,291

Transactions with key management personnel

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

9.5 Related bodies

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

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

9.6 Affiliated bodies

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

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

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Notes to the Financial Statements
For the year ended 30 June 2022

Note 9 Other disclosures (continued)

	2022 $000	2021 $000
9.7 Special purpose accounts		
Mental Health Commission Fund (WA Country Health Service) Account		
The purpose of the special purpose account is to receive funds from the Mental Health Commission, to fund the provision of mental health services as jointly endorsed by the Department of Health and the Mental Health Commission, in the WA Country Health Service, in accordance with the annual Service Agreement and subsequent agreements.		
The special purpose account has been established under section 16(1)(d) of the *Financial Management Act 2006* .		
Balance at start of period	1,339	790
Add Receipts:		
Service delivery agreement		
State contributions	96,047	92,518
Commonwealth contributions	40,188	33,738
	136,235	126,256
Less Payments	(136,318)	(125,707)
Balance at end of period	1,256	1,339
9.8 Remuneration of auditors		
Remuneration paid or payable to the Auditor General in respect of the audit for the current financial year is as follows:		
Auditing the accounts, financial statements controls, and key performance indicators	616	600
9.9 Contributed equity		
The Western Australian Government holds the equity interest in WA Country Health Service on behalf of the community. Equity represents the residual interest in the net assets of WA Country Health Service.		
Balance at start of period	2,725,449	2,679,558
Contributions by owners		
Capital appropriations administered by the Department of Health (a)	12,927	10,092
Royalties for Regions Fund – Regional Infrastructure and Headworks Account	68,574	36,001
	81,501	46,093
Distributions to owners		
Transfer of net assets to other agencies (b):		
Land transferred to the Health Ministerial Body	-	(202)
	-	(202)
Balance at end of period	2,806,950	2,725,449

(a) Treasurer's Instruction (TI) 955 'Contributions by Owners Made to Wholly Owned Public Sector Entities' designates capital funding as contributions by owners in accordance with AASB Interpretation 1038 *'Contributions by Owners Made to Wholly-Owned Public Sector Entities'*.

(b) AASB 1004 '*Contributions*' requires transfers of net assets as a result of a restructure of administrative arrangements to be accounted for as contributions by owners and distributions to owners.

TI 955 designates non-discretionary and non-reciprocal transfers of net assets between state government agencies as contributions by owners in accordance with AASB Interpretation 1038. Where the transferee agency accounts for a non-discretionary and non-reciprocal transfer of net assets as a contribution by owners, the transferor agency accounts for the transfer as a distribution to owners.

9.10 Reserves		
Asset revaluation reserve (a)		
Balance at start of period	-	-
Net revaluation increments (b) :		
Land	-	-
Buildings	47,019	-
Balance at end of period	47,019	-

(a) The asset revaluation reserve is used to record increments and decrements on the revaluation of non-current assets.

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

Notes to the Financial Statements
For the year ended 30 June 2022

Note 9 Other disclosures (continued)

9.11 Supplementary financial information

(a) Write-offs

During the financial year, $1.449 million (2021: $3.110 million) was written off WA Country Health Service's receivables under the authority of:

	2022 $000	2021 $000
The accountable authority	1,449	3,110
The Minister	-	-
Executive Council	-	-
	1,449	3,110
(b) Losses through theft, defaults and other causes		
Losses of public money and property through theft or default	-	6
Amount recovered		
Net losses	-	6
(c) Forgiveness of debts		
'Forgiveness (or waiver) of debts by WA Country Health Service	180	60
	180	60
(d) Gifts of public property		
Gifts of public property provided by WA Country Health Service	-	-
	-	-

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Notes to the Financial Statements

For the year ended 30 June 2022

Note 9 Other disclosures (continued)

9.12 Explanatory statement

All variances between estimates (original budget) and actual results for 2022, and between the actual results for 2022 and 2021 are shown below. Narratives are provided for key major variances, which are greater than:

- 10% and **$20.7** million for the Statements of Comprehensive Income and Cash Flows, and
- 10% and **$29.4** million for the Statement of Financial Position.

9.12.1 Statement of Comprehensive Income variances

	Variance note	Estimate 2022 $000	Actual 2022 $000	Actual 2021 $000	Variance between estimate and actual $000	Variance between actual results for 2022 and 2021 $000
COST OF SERVICES						
Expenses						
Employee benefits expense	(a)	1,213,662	1,345,970	1,192,799	132,308	153,171
Patient support costs		568,332	597,392	556,300	29,060	41,092
Finance costs		304	359	351	55	8
Depreciation and amortisation expense		81,950	82,566	82,342	616	224
Loss on disposal of non-current assets		-	239	440	239	(201)
Repairs, maintenance and consumable equipment	(b)	56,362	75,303	52,532	18,941	22,771
Other expenses	(c)	183,940	239,511	189,552	55,571	49,959
Total cost of services		**2,104,550**	**2,341,340**	**2,074,316**	**236,790**	**267,024**
Income						
Patient charges		68,962	72,941	71,791	3,979	1,150
Commonwealth grants		66,251	79,251	68,902	13,000	10,349
Other grants		17,632	15,115	14,524	(2,517)	591
Donation revenue		258	290	321	32	(31)
Asset revaluation increment		-	90,829	20,302	90,829	70,527
Other revenue		25,377	17,938	20,609	(7,439)	(2,671)
Total Revenue		**178,480**	**276,364**	**196,449**	**97,884**	**79,915**
Total income other than income from State Government		**178,480**	**276,364**	**196,449**	**97,884**	**79,915**
NET COST OF SERVICES		**1,926,070**	**2,064,976**	**1,877,867**	**138,906**	**187,109**
INCOME FROM STATE GOVERNMENT						
Income from public sector entities	(d)	1,769,095	1,926,909	1,711,724	157,814	215,185
Resources received	(e)	61,218	95,343	74,694	34,125	20,649
Royalties for Regions Fund		112,312	110,007	94,760	(2,305)	15,247
Total income from State Government		**1,942,625**	**2,132,259**	**1,881,178**	**189,634**	**251,081**
SURPLUS FOR THE PERIOD		**16,555**	**67,283**	**3,311**	**50,728**	**63,972**
OTHER COMPREHENSIVE INCOME/(LOSS)						
Items not reclassified subsequently to profit or loss						
Changes in asset revaluation reserve	(f)	-	47,019	-	47,019	47,019
Total other comprehensive income		**-**	**47,019**	**-**	**47,019**	**47,019**
TOTAL COMPREHENSIVE INCOME/(LOSS) FOR THE PERIOD		**16,555**	**114,302**	**3,311**	**97,747**	**110,991**
			-	-		

Notes to the Financial Statements

For the year ended 30 June 2022

Note 9 Other disclosures (continued)

9.12 Explanatory statement (continued)

9.12.2 Statement of Financial Position variances

	Variance note	Estimate 2022 $000	Actual 2022 $000	Actual 2021 $000	Variance between estimate and actual $000	Variance between actual results for 2022 and 2021 $000
ASSETS						
Current Assets						
Cash and cash equivalents		24,946	28,114	30,609	3,168	(2,495)
Restricted cash and cash equivalents		30,410	40,408	26,042	9,998	14,366
Receivables		20,828	26,346	20,828	5,518	5,518
Right-of-Use Assets		24	153	24	129	129
Other current assets		10,507	10,268	10,507	(239)	(239)
Total Current Assets		**86,715**	**105,289**	**88,010**	**18,574**	**17,279**
Non-Current Assets						
Restricted cash and cash equivalents		18,545	18,545	16,470	-	2,075
Amounts receivable for services		1,082,504	1,084,615	1,000,555	2,111	84,060
Property, plant and equipment		1,788,715	1,935,311	1,795,884	146,596	139,427
Right-of-Use Assets		13,689	16,603	13,689	2,914	2,914
Intangible assets		16,251	14,114	16,251	(2,137)	(2,137)
Service concession assets		10,061	9,825	10,061	(236)	(236)
Total Non-Current Assets		**2,929,765**	**3,079,013**	**2,852,910**	**149,248**	**226,103**
Total Assets		**3,016,480**	**3,184,302**	**2,940,920**	**167,822**	**243,382**
LIABILITIES						
Current Liabilities						
Payables		139,402	161,601	154,089	22,199	7,512
Contract liabilities		11,055	18,610	10,571	7,555	8,039
Lease liabilities		4,932	4,535	4,932	(397)	(397)
Provisions		188,643	211,392	188,643	22,749	22,749
Other current liabilities		387	2,027	1,959	1,640	68
Total Current Liabilities		**344,419**	**398,165**	**360,194**	**53,746**	**37,971**
Non-Current Liabilities						
Contract liabilities		6,368	14,931	11,731	8,563	3,200
Lease liabilities		7,570	9,445	7,570	1,875	1,875
Provisions		35,010	39,543	35,010	4,533	4,533
Total Non-Current Liabilities		**48,948**	**63,919**	**54,311**	**14,971**	**9,608**
Total Liabilities		**393,367**	**462,084**	**414,505**	**68,717**	**47,579**
NET ASSETS		**2,623,113**	**2,722,218**	**2,526,415**	**99,105**	**195,803**
EQUITY						
Contributed equity		2,805,592	2,806,950	2,725,449	1,358	81,501
Reserves	(g)	-	47,019	-	47,019	47,019
Accumulated deficit	(h)	(182,479)	(131,751)	(199,034)	50,728	67,283
TOTAL EQUITY		**2,623,113**	**2,722,218**	**2,526,415**	**99,105**	**195,803**
			-	-		

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Notes to the Financial Statements
For the year ended 30 June 2022

Note 9 Other disclosures (continued)

9.12 Explanatory statement (continued)

9.12.3 Statement of Cash Flows variances

	Variance note	Estimate 2022 $000	Actual 2022 $000	Actual 2021 $000	Variance between estimate and actual $000	Variance between actual results for 2022 and 2021 $000
CASH FLOWS FROM STATE GOVERNMENT						
Income from public sector entities	(i)	1,694,909	1,849,642	1,630,853	154,733	218,789
Capital appropriations administered by the Department of Health		13,583	12,927	10,092	(656)	2,835
Royalties for Regions Fund	(j)	171,109	178,136	130,832	7,027	47,304
Net cash provided by State Government		**1,879,601**	**2,040,705**	**1,771,777**	**161,104**	**268,928**
Utilised as follows:						
CASH FLOWS FROM OPERATING ACTIVITIES						
Payments						
Employee benefits	(k)	(1,213,663)	(1,311,342)	(1,166,217)	(97,679)	(145,125)
Supplies and services	(l)	(762,104)	(807,255)	(710,048)	(45,151)	(97,207)
Finance costs		(304)	(359)	(351)	(55)	(8)
Receipts						
Receipts from customers		68,962	72,924	69,230	3,962	3,694
Commonwealth grants		68,652	86,369	71,079	17,717	15,290
Other grants		17,632	12,970	11,703	(4,662)	1,267
Donations received		258	282	321	24	(39)
Other receipts		25,377	13,520	20,483	(11,857)	(6,963)
Net cash used in operating activities		**(1,795,190)**	**(1,932,891)**	**(1,703,800)**	**(137,701)**	**(229,091)**
CASH FLOWS FROM INVESTING ACTIVITIES						
Payments						
Purchase of non-current physical assets	(m)	(74,780)	(83,041)	(57,694)	(8,261)	(25,347)
Net cash used in investing activities		**(74,780)**	**(83,041)**	**(57,694)**	**(8,261)**	**(25,347)**
CASH FLOWS FROM FINANCING ACTIVITIES						
Payments						
Principal elements of lease		(7,763)	(10,827)	(8,083)	(3,064)	(2,744)
Net cash used in financing activities		**(7,763)**	**(10,827)**	**(8,083)**	**(3,064)**	**(2,744)**
Net increase / (decrease) in cash and cash equivalents		1,868	13,946	2,200	12,078	11,746
Cash and cash equivalents at the beginning of the period		73,121	73,121	70,921	-	2,200
CASH AND CASH EQUIVALENTS AT THE END OF PERIOD		**74,989**	**87,067**	**73,121**	**12,078**	**13,946**
			(0)	-		

Notes to the Financial Statements
For the year ended 30 June 2022

Note 9 Other disclosures (continued)

9.12 Explanatory statement (continued)

Significant variances between estimates and actuals for 2022 and/or between actuals for 2022 and 2021

9.12.1 Statement of Comprehensive Income variances

(a) Employee benefits expense

Increases in funded Employee Benefits expenditure totalling $134.9m included the impact of changes to industrial agreements and increased staffing to support new and expanded services, particularly in relation to the COVID-19 response and vaccination programs, hospital services and mental health programs. The balance of Employee Benefit cost increases related to increasing cost of reliance on agency and locum staff to maintain services, the impact of staff furloughing, and requirements to increase staffing in response to standards for clinical safety and aged case services.

The variance from estimates included employee benefits totalling $106.0m for which budgets and funding were received following finalisation of the s40 Estimates relating to COVID-19 response and vaccination programs, hospital activity above initial budgets, workforce cost pressures, and the establishment of Long service leave provisions for casual employees. The balance of expenditures above the adjusted budgets included increasing cost of reliance on agency and locum staff to maintain services, the impact of Staff furloughing, and requirements to increase staffing in response to standards for clinical safety and aged case services.

(b) Repairs, maintenance and consumable equipment

The increase in Repairs, Maintenance and Consumable Equipment in comparison with 2020-21 is primarily associated with increases in the Government's Priority Maintenance Programs ($6.4m), the expensing of payments from the Asset Investment Program ($0.7m), increased repairs and maintenance on staff accommodation ($2.5m) and other medical and non medical equipment purchases ($7.5m). Other factors contributing to the increase include aging infrastructure and higher costs for contractors.

(c) Other expenses

Issues contributing to cost increases beyond general price movements include Workers Compensation and other insurances ($6.8m), Resources and Services Received free of charge from Health Support Services ($11.2m), contracted security services ($7.9m), increased cost of staff accommodation and other short term leases ($5.8m).

The variance from estimates related primarily to expenditures on programs and services for which budgets were received during the year ($34.6m), with the balance increased costs for Workers compensation and other insurances, increased security costs, increased costs for short term accommodation leases, and increased travel and accommodation costs.

(d) Income from other public sector entities

As detailed in Note 4.1.1, Income from Public Sector Entities increased by $215.2m in comparison with 2020-21. The increase reflects additional budgets and funding provided by Government to support increased costs of existing, expanded and new services in 2021-22. These include the COVID-19 response and vaccination programs ($38.6m), hospital services ($104.0m), Mental Health ($11.2m), Priority Maintenance Program ($5.3m) and other non hospital Services ($56.1m).

(e) Resources received

The cost of Resources Received Free of Charge increased by $34.6m in comparison with the original estimates. Of this amount, $9.1m relates to Rapid Antigen Tests received from the Department of Health with the balance relating to higher than initially estimated costs of services received from Health Support Services and Pathwest. Changes from the original estimates were matched by budget adjustments during the year.

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Notes to the Financial Statements
For the year ended 30 June 2022

(f) Changes in asset revaluation reserve

As described in Note 5.1, land and buildings were revalued as at 1 July 2021 resulting in a revaluation increment totalling $137.8m. Of this amount $90.8m was recognised as revenue in the Statement of Comprehensive Income to offset revaluation decrements expensed in prior financial years. The $47.0m balance of the 2021-22 revaluations has been transferred to an Asset Revaluation

9.12.2 Statement of Financial Position variances

(g) Reserves

As described in Note 5.1, land and buildings were revalued as at 1 July 2021 resulting in a revaluation increment totalling $137.8m. Of this amount $90.8m was recognised as revenue in the Statement of Comprehensive Income to offset revaluation decrements expensed in prior financial years. The $47.0m balance of the 2021-22 revaluations has been transferred to an Asset Revaluation

(h) Accumulated deficit

The reduction in accumulated deficit from 2020-21 and variance from estimates is primarily due to asset revaluations recognised as revenue in the 2021-22 financial year.

Notes to the Financial Statements
For the year ended 30 June 2022

Note 9 Other disclosures (continued)

9.12 Explanatory statement (continued)

Significant variances between estimates and actuals for 2022 and/or between actuals for 2022 and 2021

9.12.3 Statement of Cash Flow variances

(i) Income from other public sector entities

As detailed in Note 4.1.1, Income from Public Sector Entities increased by $215.2m in comparison with 2020-21. The increase associated cash inflows reflects additional budgets and funding provided by Government to support increased costs of existing, expanded and new services in 2021-22. These include the COVID-19 response and vaccination programs ($38.6m), hospital services ($104.0m), Mental Health ($11.2m), Priority Maintenance Program ($5.3m) and other non hospital Services ($56.1m). The remaining year on year cashflow increase of $3.6m was a result of accounting adjustments.

(i) Royalties for Regions Fund

Capital and recurrent projects funded from Royalties for Regions fund experienced delays in 2020-21 primarily due to the limited availability of suitable contractors. Consequently, cash drawdowns from the Royalties for Regions Fund were deferred until 2021-22 and over the forward estimates, and 2021-22 drawdowns for capital projects totalled $68.6m compared with $36.0m in 2020-21. 2021-22 drawdowns also included a $7.9m grant to RFDS for aircraft upgrades.

(k) Employee benefits

Increases in funded Employee Benefits expenditure included the impact of changes to industrial agreements and increased staffing to support new and expanded services, particularly in relation to the COVID-19 response and vaccination programs, hospital services and mental health programs. The balance of Employee Benefit cost increases relate to increasing cost of reliance on agency and locum staff to maintain services, the impact of staff furloughing, and requirements to increase staffing in response to standards for clinical safety and aged care services.

(l) Supplies and services

Issues contributing to cost increases beyond general price movements and funded for new and expanded services include increased Workers Compensation and other insurance charges ($6.8m), contracted security services ($7.9m), funding for RFDS engine upgrades ($7.9m), increased cost of staff accommodation and other short term leases ($5.8m). Increased Repairs, Maintenance and Consumable Equipment included the Government's Priority Maintenance Program ($6.4m), increased repairs and maintenance on staff accommodation ($2.5m) and other medical and non medical equipment purchases and upgrades ($7.5m).

(m) Purchase of non-current physical assets

Capital projects experienced delays in 2020-21 primarily due to the limited availability of suitable contractors. Consequently, payments in relation to various projects were deferred until 2021-22 and over the forward estimates, with the most notable increase in 2021-22 payments relating to completion of the Newman Health Service Redevelopment.

9.13 Trust accounts

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

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

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

	2022 $000	2021 $000
Balance at the start of period	1,013	1,006
Add Receipts	207	253
	1,220	1,259
Less Payments	(285)	(246)
Balance at the end of period	935	1,013

Certification of key performance indicators

WA COUNTRY HEALTH SERVICE CERTIFICATION OF THE KEY PERFORMANCE INDICATORS FOR THE YEAR ENDED 30 JUNE 2022

We hereby certify the key performance indicators are based on proper records, are relevant and appropriate for assisting users to assess the WA Country Health Service's performance and fairly represent the performance of the Health Service for the financial year ending 30 June 2022.

Dr Neale Fong
Chair
WA Country Health Service Board
16 September 2022

Mr Alan Ferris
Board Member
WA Country Health Service Board
16 September 2022

Key performance indicators

Outcome 1 - Public Hospital based services that enable effective treatment and restorative healthcare for Western Australians.

Table 13: Outcome 1 – Key Performance Indicators

	KEY PERFORMANCE INDICATOR DESCRIPTION			
Effectiveness Indicators	Unplanned hospital readmissions for patients within 28 days for selected surgical procedures:	a) Knee replacement b) Hip replacement c) Tonsillectomy and adenoidectomy d) Hysterectomy e) Prostatectomy f) Cataract surgery g) Appendicectomy	*Note: expressed as a rate per 1,000 separations*	
	Percentage of elective wait list patients waiting over boundary for reportable procedures:	a) % Category 1 over 30 days b) % Category 2 over 90 days c) % Category 3 over 365 days		
	Healthcare-associated Staphylococcus aureus bloodstream infections (HA-SABSI) per 10,000 occupied bed-days			
	Survival rates for sentinel conditions:	a) Stroke i. 0-49 Years ii. 50-59 Years iii. 60-69 Years iv. 70-79 Years v. 80+ Years	b) Acute Myocardial Infarction (AMI) i. 0-49 Years ii. 50-59 Years iii. 60-69 Years iv. 70-79 Years v. 80+ Years	c) Fractured Neck of Femur (FNOF) i. 70-79 Years ii. 80+ Years
	Percentage of admitted patients who discharged against medical advice: a) Aboriginal patients and b) Non-Aboriginal patients			
	Percentage of live-born term infants with an Apgar score of less than 7 at 5 minutes post delivery.			
	Readmissions to acute specialised mental health inpatient services within 28 days of discharge.			
	Percentage of post discharge community care within 7 days following discharge from acute specialists mental health inpatient services.			
Efficiency Indicators	Average admitted cost per weight activity unit.			
	Average Emergency Department cost per weight activity unit.			
	Average non-admitted cost per weighted activity unit.			
	Average cost per bed day in specialised mental health inpatient services.			
	Average cost per treatment day of non-admitted care provided by mental health services.			

The latest available data has been used to report performance, in some instances results are from the 2021 calendar year.

Key performance indicators

Outcome 1 - Effectiveness indicators

UNPLANNED HOSPITAL READMISSIONS FOR PATIENTS WITHIN 28 DAYS FOR SELECTED SURGICAL PROCEDURES

Rationale

Unplanned hospital readmissions may reflect less than optimal patient management and ineffective care pre-discharge, post discharge and/or during the transition between acute and community-based care.

These readmissions necessitate patients spending additional periods of time in hospital as well as utilising additional hospital resources.

Readmission rate is considered a global performance measure, as it potentially points to deficiencies in the functioning of the overall healthcare system.

Along with providing appropriate interventions, good discharge planning can help decrease the likelihood of unplanned hospital readmissions by providing patients with the care instructions they need after a hospital stay, and helping patients recognise symptoms that may require medical attention.

The seven surgeries selected for this indicator are based on those in the current National Health Agreement Unplanned Readmission performance indicator (NHA PI 23).

The 2021 (calendar year) targets can be seen in Table 14, with the results shown in Table 15.

Target

Table 14: Unplanned hospital readmissions targets within 28 days for selected surgical procedures for 2021

Surgical Procedure	Target (per 1000)
Knee replacement	≤ 23.0
Hip replacement	≤ 17.1
Tonsillectomy and adenoidectomy	≤ 81.8
Hysterectomy	≤ 42.3
Prostatectomy	≤ 36.1
Cataract surgery	≤ 1.1
Appendicectomy	≤ 25.7

Key performance indicators

Outcome 1 - Effectiveness indicators

Results

Table 15: Unplanned hospital readmissions results within 28 days for selected surgical procedures for 2021

Surgical Procedure	2017 (per 1000)	2018 (per 1000)	2019 (per 1000)	2020 (per 1000)	2021 (per 1000)	Target (per 1,000)
Knee replacement	37.9	37.7	29.9	7.8	31.5	≤ 23.0
Hip replacement	21.8	23.5	35.6	27.6	31.3	≤ 17.1
Tonsillectomy and adenoidectomy	61.6	86.6	57.2	84.0	104.3	≤ 81.8
Hysterectomy	15.8	87.4	36.6	47.6	29.7	≤ 42.3
Prostatectomy	40.4	44.2	70.7	39.2	0.0	≤ 36.1
Cataract surgery	0.4	3.1	3.6	4.0	0.7	≤ 1.1
Appendicectomy	39.2	50.3	39.2	48.8	26.5	≤ 25.7

WACHS has not met target readmission rates except for hysterectomy, prostatectomy and cataract surgery.

Every readmission is reviewed. Analysis has detected that some readmissions are related to complications of surgery and improvement actions are required.

The low number of cases may lead to significant fluctuation in year on year results as evidenced by the raw numbers of procedures followed by readmission:

- Knee Replacement = 9 readmissions from 286 procedures
- Hip Replacement = 9 readmissions from 288 procedures
- Tonsillectomy and adenoidectomy = 39 readmissions from 374 procedures
- Hysterectomy = 6 readmissions from 202 procedures
- Prostatectomy = 0 readmissions from 93 procedures
- Cataract surgery = 2 readmissions from 2801 procedures
- Appendicectomy = 22 readmissions from 829 procedures

Key performance indicators

Outcome 1 - Effectiveness indicators

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

Rationale

Elective surgery refers to planned surgery that can be booked in advance following specialist assessment that results in placement on an elective surgery waiting list.

Elective surgical services delivered in the WA health system are those deemed to be clinically necessary. Excessive waiting times for these services can lead to deterioration of the patient's condition, quality of life, or even death. Waiting lists must be actively managed by hospitals to ensure fair and equitable access to limited services, and that all patients are treated within clinically appropriate timeframes.

Patients are prioritised based on their assigned clinical urgency category:

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

For reportable procedures, the target requires that no patients (0%) on the elective waiting lists wait longer than the clinically recommended time for their procedure, according to their urgency category.

The 2021-22 target is explained below, with the results shown in Table 16.

Target

The 2021-22 target is 0% which is aligned to the WA state-wide performance target.

WACHS did not meet target in any category. The cumulative impacts of the COVID pandemic have had a deleterious effect on waiting times for elective surgery, resulting in a significant increase in over boundary cases.

Results

Table 16: Percentage of elective wait list patients waiting over boundary for reportable procedures results for 2021-22

Category	2017-18 (%)	2018-19 (%)	2019-20 (%)	2020-21 (%)	2021-22 (%)	Target (%)
Category 1 (within 30 days)	8.7	3.8	5.8	5.2	13.6	0
Category 2 (within 90 days)	9.4	3.0	6.1	6.5	13.0	0
Category 3 (within 365 days)	4.8	2.2	1.5	2.6	4.2	0

Whilst WACHS continues to exert effort to reduce the over boundary cases, challenges remaining include:

- Significant workforce shortages, specifically nursing and sterilisation technicians. Sites are reviewing elective lists daily to ascertain the procedures that are safe to proceed, and which procedures will need to be cancelled.
- The eight-week elective surgical reductions that were in place from 14 March to 8 May 2022.
- Increasing transmission of COVID across the State.
- Increasing numbers of furloughing staff across all workforce groups.
- Increased demand for all health services and prioritisation of essential and emergency requirements.
- Overnight bed availability, winter bed pressures, increasing demand for health services, and beds required for emergent patients.
- Specialist availability, particularly competing demands of a largely Visiting Medical Practitioner workforce model, where many specialists work across the private sector and other HSPs leading to limited availability to undertake extra lists.

Key performance indicators

Outcome 1 - Effectiveness indicators

HEALTHCARE-ASSOCIATED STAPHYLOCOCCUS AUREUS BLOODSTREAM INFECTIONS (HA-SABSI) PER 10,000 OCCUPIED BED-DAYS

Rationale

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

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

This KPI has been selected for inclusion as it is a robust measure of the safety and quality of WA public hospitals and aligns to the principle of increased transparency and accountability of performance information provided to the public.

A low or decreasing HA-SABSI rate is desirable and a target for WA based on historical data has been set.

The 2021 (calendar year) target is explained below, with the results shown in Table 17.

Target

The 2021 target is ≤ 1.0 per 10,000 bed days.

Results

Table 17: HA-SABSI per 10,000 occupied bed-days results for 2021

	2017 (per 10,000)	2018 (per 10,000)	2019 (per 10,000)	2020 (per 10,000)	2021 (per 10,000)	Target (per 10,000)
Infection rate	0.64	0.97	0.33	0.45	0.79	≤ 1.0

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

All instances of HA-SABSI are thoroughly investigated to determine the cause of infection.

Key performance indicators

Outcome 1 - Effectiveness indicators

SURVIVAL RATES FOR SENTINEL CONDITIONS

Rationale

This indicator measures performance in relation to restoring the health of people who have suffered a sentinel condition - specifically a stroke, acute myocardial infarction (AMI), or fractured neck of femur (FNOF).

These three conditions have been chosen as they are particularly significant for the health care of the community and are leading causes of death and hospitalisation in Australia. Patient survival after being admitted for one of these three sentinel conditions can be affected by many factors including the diagnosis, the treatment given or procedure performed, age, co-morbidities at the time of the admission and complications which may have developed while in hospital. However, survival is more likely when there is early intervention and appropriate care on presentation to an emergency department and on admission to hospital.

By reviewing and analysing survival rates, targeted strategies can be developed that aim to increase patient survival after being admitted for a sentinel condition. Therefore, this indicator can potentially assist hospitals in monitoring changes over time to facilitate effective restoration of patients' health.

The 2021 (calendar year) targets can be seen in Table 18, with the results shown in Tables 19, 20 and 21.

Target

Table 18: Survival rate for sentinel conditions targets for 2021

Age Group	Stroke (%)	AMI (%)	FNOF (%)
0-49 Years	≥ 95.2	≥ 99.1	N/A
50-59 Years	≥ 94.9	≥ 98.8	N/A
60-69 Years	≥ 94.1	≥ 98.1	N/A
70-79 Years	≥ 92.3	≥ 96.8	≥ 98.9
80+ Years	≥ 86.0	≥ 92.1	≥ 96.9

Results

Table 19: Survival rates for sentinel condition: Stroke results for 2021

Age Group	2017 (%)	2018 (%)	2019 (%)	2020 (%)	2021 (%)	Target (%)
0-49 Years	100	97.5	95.8	90.9	100	≥ 95.2
50-59 Years	97.0	100	98.7	98.6	96.1	≥ 94.9
60-69 Years	95.9	97.4	96.2	93.7	98.4	≥ 94.1
70-79 Years	96.5	94.6	92.8	92.7	95.5	≥ 92.3
80+ Years	85.2	83.8	84.8	89.0	88.9	≥ 86.0

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

During 2021, survival rates for stroke has met target for all age cohorts. WACHS reported 45 deaths attributed to stroke out of 708 episodes.

This is an overall survival rate of 93.6%.

WACHS has implemented the WA Stroke Services rural clinical care pathway for stroke, developed in line with best practice standards and prompts for time critical escalation to quaternary stroke specialist services inclusive of telestroke consultations in larger regional centres, where applicable.

Key performance indicators

Outcome 1 - Effectiveness indicators

SURVIVAL RATES FOR SENTINEL CONDITIONS *(cont.)*

Table 20: Survival rates for sentinel condition: AMI results for 2021

Age Group	2017 (%)	2018 (%)	2019 (%)	2020 (%)	2021 (%)	Target (%)
0-49 Years	100	100	100	100	100	≥ 99.1
50-59 Years	100	100	100	100	100	≥ 98.8
60-69 Years	100	98.2	99.0	99.1	99.2	≥ 98.1
70-79 Years	96.8	97.9	98.0	94.2	97.8	≥ 96.8
80+ Years	90.1	93.2	90.0	92.3	91.6	≥ 92.1

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

Survival rates for AMI for 2021 met target performance for all age cohorts, except the 80+ Years group, although this difference was not statistically significant. WACHS reported 15 deaths attributed to AMI out of 513 episodes, representing an overall survival rate of 97.1%.

WACHS has a standardised chest pain pathway, designed in line with best practice clinical standards, which promotes sound escalation processes for patients diagnosed as having an acute myocardial infarction. This is particularly relevant for remote and regional services, where access to an intensive care unit may not be immediately available.

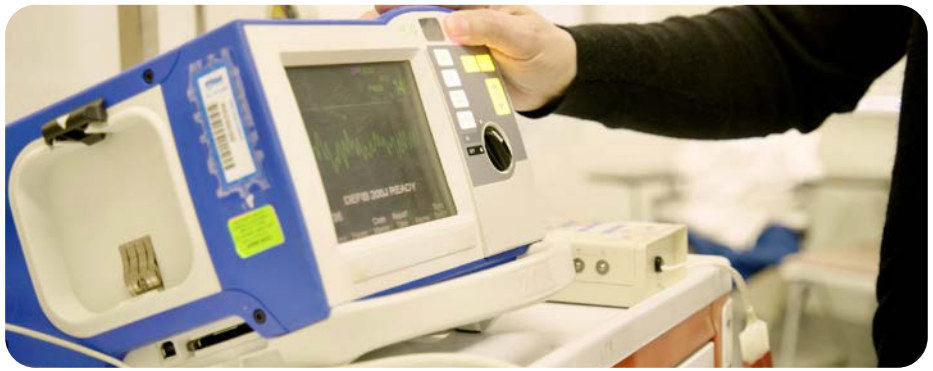
Table 21: Survival rates for sentinel condition: FNOF results for 2021

Age Group	2017 (%)	2018 (%)	2019 (%)	2020 (%)	2021 (%)	Target (%)
70-79 Years	100	100	97.7	100	100	≥ 98.9
80+ Years	96.0	97.8	96.7	96.5	98.6	≥ 96.9

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

Survival rates for FNOF for 2021 met target performance for all group. WACHS reported 2 deaths attributed to FNOF out of 211 episodes, representing an overall survival rate of 99.1%.

A WACHS Hip Fracture Clinical Care Practice guideline has been developed to ensure best practice care for patients with a suspected hip fracture who present to a Multi-Purpose Service site or are admitted to a small hospital. Selected WACHS sites participate in the Australian Hip Fracture Registry which supports benchmarking and improvement.



Key performance indicators

Outcome 1 - Effectiveness indicators

PERCENTAGE OF ADMITTED PATIENTS WHO DISCHARGED AGAINST MEDICAL ADVICE

Rationale

Discharge against medical advice (DAMA) refers to patients leaving hospital against the advice of their treating medical team or without advising hospital staff (i.e. absconding or missing and not found). Patients who do so have a higher risk of readmission and mortality and have been found to cost the health system 50% more than patients who are discharged by their physician.

This indicator provides a measure of the safety and quality of inpatient care. Reporting the results by Aboriginal status measures the effectiveness of initiatives within the WA health system to deliver culturally secure services to Aboriginal people.

While the aim is to achieve equitable treatment outcomes, the targets reflect the need for a long-term approach to progressively closing the gap between Aboriginal and non-Aboriginal patient cohorts.

The 2021 (calendar year) target is explained below, with the results shown in Table 22.

Target

The 2021 target is

a) Aboriginal patients ≤ 2.78%.

b) Non-Aboriginal patients ≤ 0.99%

Results

Table 22: Percentage of admitted patients who DAMA for 2021

Cohort	2017 (%)	2018 (%)	2019 (%)	2020 (%)	2021 (%)	Target (%)
Aboriginal	5.2	4.7	4.7	5.2	5.4	≤ 2.78
Non-Aboriginal	0.8	0.6	0.7	0.8	0.7	≤ 0.99

The 2021 DAMA rate did not meet target for the Aboriginal cohort, but met target for the Non-Aboriginal cohort. WACHS continues to implement the Discharge Against Medical Advice Policy to actively follow up patients at risk of adverse outcome after discharge to both mitigate risk and seek to understand underlying reasons.

This metric is regularly monitored at the Executive level in regions and organisationally. All WACHS regions are developing local strategies to reduce rates of DAMA by Aboriginal people including engagement with and increased access to Aboriginal Liaison Officers.

Key performance indicators

Outcome 1 - Effectiveness indicators

PERCENTAGE OF LIVE-BORN TERM INFANTS WITH AN APGAR SCORE OF LESS THAN 7 AT 5 MINUTES POST DELIVERY

Rationale

This indicator of the condition of newborn infants immediately after birth provides an outcome measure of intrapartum care and newborn resuscitation.

The Apgar score is an assessment of an infant's health at birth based on breathing, heart rate, colour, muscle tone and reflex irritability. An Apgar score is applied at one, five and (if required by the protocol) ten minutes after delivery to determine how well the infant is adapting outside the mother's womb.

Apgar scores range from zero to two for each condition with a maximum final total score of ten. The higher the Apgar score the better the health of the newborn infant.

This outcome measure can lead to the development and delivery of improved care pathways and interventions to improve the health outcomes of Western Australian infants and aligns to the National Core Maternity Indicators, 2019 Health Standard 19/06/2019.

The 2021 (calendar year) target is explained below, with the results shown in Table 23.

Target

The 2021 target is ≤1.8%.

Results

Table 23: Percentage of live-born term infants with an Apgar score of less than 7 at 5 minutes post delivery for 2021

	2017 (%)	2018 (%)	2019 (%)	2020 (%)	2021 (%)	Target (%)
Liveborn term infants Apgar <7 at 5 minutes	1.6	1.4	1.4	1.3	1.5	≤ 1.8

In 2021, the percentage of live-born term infants with an Apgar score of less than 7, 5 minutes post-delivery met target.

WACHS continues to introduce initiatives to support strong neonatal outcomes, these include:

- In October 2021 WACHS implemented a new electronic cardiotocograph (CTG) system (K2 Guardian) with artificial intelligence (K2 Infant) to support interpretation and clinical decision making. This also enables offsite access to CTG by obstetric medical practitioners and improves response time to foetal heart rate abnormalities
- With the reopening of the borders WACHS has reintroduced the face to face CTG education program offered by RANZCOG Foetal Surveillance Education Program (FSEP)
- WACHS has regular telehealth education session for all maternity sites on CTG skills and drills including escalation.

WACHS is also continuing to develop a clinical audit tool to proactively review Apgar outcomes at sites recording significant deviations from the Western Australian average.

Key performance indicators

Outcome 1 - Effectiveness indicators

READMISSIONS TO ACUTE SPECIALISED MENTAL HEALTH INPATIENT SERVICES WITHIN 28 DAYS OF DISCHARGE

Rationale

Readmission rate is a global performance measure as it potentially points to deficiencies in the functioning of the overall mental healthcare system.

While multiple hospital admissions over a lifetime may be necessary for someone with ongoing illness, a high proportion of readmissions shortly after discharge may indicate that inpatient treatment was either incomplete or ineffective, or that follow-up care was not adequate to maintain the patient's recovery out of hospital.

These readmissions mean that patients spend additional time in hospital and utilise additional resources. A low readmission rate suggests that good clinical practice is in operation. Readmissions are attributed to the facility at which the initial separation (discharge) occurred rather than the facility to which the patient was readmitted.

By monitoring this indicator, key areas for improvement can be identified. This can facilitate the development and delivery of targeted care pathways and interventions aimed at improving the mental health and quality of life of Western Australians.

The 2021 (calendar year) target is explained below, with the results shown in Table 24.

Target

The 2021 target is ≤12%.

Results

Table 24: Rate of readmissions to acute specialised mental health inpatient services within 28 days of discharge for 2021

	2017 (%)	2018 (%)	2019 (%)	2020 (%)	2021 (%)	Target (%)
Total hospital readmissions	17.8	19.4	17.8	15.0	13.2	≤ 12

In 2021, the rate of total readmissions within 28 days to an acute designated mental health inpatient unit did not meet target. WACHS has identified that due to limited options and access to other primary or secondary care service providers and supported step down or sub-acute accommodation in rural and remote WA, readmissions may be the only option for some patients. Analysis of readmissions for this period have identified the majority cohort of people needing re-admission are people with an Emotionally Unstable Personality Disorder (also known as borderline personality disorder) and people affected by substance misuse with complex social problems. These people experience repeated crises and as part of appropriate care and treatment are encouraged to return and receive short term re-admissions prior to the emotional crises escalating (which may otherwise result in increased self-harming behaviours).

WACHS Mental Health ensures that readmissions are monitored closely and occur where clinically appropriate and not as the first solution. Intensive post discharge follow up continues to be offered to patients however re-admission will occur for highly complex patients, including those with a mood disorder and co-morbid substance misuse. The close monitoring of this indicator by WACHS has resulted in a downward trend of the percentage of people requiring readmission within 28 days over the last four years.

Key performance indicators

Outcome 1 - Effectiveness indicators

PERCENTAGE OF POST DISCHARGE COMMUNITY CARE WITHIN 7 DAYS FOLLOWING DISCHARGE FROM ACUTE SPECIALISED MENTAL HEALTH INPATIENT SERVICES

Rationale

The Australian Bureau of Statistics National Health Survey 2017-18 estimated that 1 in 5 (20%) Australian adults reported that they had a mental or behavioural condition during that twelve-month period. Therefore, it is crucial to ensure effective and appropriate care is provided not only in a hospital setting but also in the community.

Discharge from hospital is a critical transition point in the delivery of mental health care. People leaving hospital after an admission for an episode of mental illness have increased vulnerability and, without adequate follow up, may relapse or be readmitted.

The standard underlying this measure is that continuity of care requires prompt community follow-up in the period following discharge from hospital.

A responsive community support system for persons who have experienced a psychiatric episode requiring hospitalisation is essential to maintain their clinical and functional stability and to minimise the need for hospital readmissions. Patients leaving hospital after a psychiatric admission with a formal discharge plan that includes links with public community-based services and support are less likely to need avoidable hospital readmissions.

The 2021 (calendar year) target is explained below, with the results shown in Table 25.

Target

The 2021 target is ≥ 75%.

Results

Table 25: Percentage of post discharge community care within 7 days following discharge from acute specialised mental health inpatient services for 2021

	2017 (%)	2018 (%)	2019 (%)	2020 (%)	2021 (%)	Target (%)
Post-discharge community-based contacts	75.6	79.1	79.2	84.2	83.8	≥ 75

In 2021, contacts with community-based public mental health non-admitted services within 7 days post discharge from an acute public mental health inpatient unit met target.

Throughout the last five years WACHS regions have consistently exceeded the target of 75%. Improved communication between the Mental Health Inpatient Units and the Community Mental Health teams has contributed to this upward trend in rates of follow up.

The Mental Health Services have processes in place to follow up all patients discharged from a mental health inpatient unit however not all patients can be contacted within the seven-day time frame. Reasons for this include some patients when discharged, do not want further contact and refuse to engage with the Mental Health Service.

Others may decline to attend or not show up for appointments. Other challenges include that patients may have moved out of the area, or do not have mobile access to contact.

Key performance indicators

Outcome 1 - Efficiency indicators

AVERAGE ADMITTED COST PER WEIGHTED ACTIVITY UNIT

Rationale

This indicator is a measure of the cost per weighted activity unit (WAU) compared with the State (aggregated) target, as approved by the Department of Treasury and published in the 2021-22 Budget Paper No. 2, Volume 1.

The measure ensures a consistent methodology is applied to calculating and reporting the cost of delivering inpatient activity against the state's funding allocation. As admitted services received nearly half of the overall 2021-22 budget allocation, it is important that efficiency of service delivery is accurately monitored and reported.

The 2021-22 target is explained below, with the results shown in Table 26.

Target

The 2021-22 target is $6907 per WAU.

Results

Table 26: Average admitted cost per WAU for 2021-22

	2017-18	2018-19	2019-20	2020-21	2021-22	Target ($)
Average admitted cost per WAU	$5730	$5975	$6293	$5937	$6684	$6907

Note: Prior years have been adjusted to remove financial products (depreciation, write off, finance costs) in response to definition changes to 2021-22 Outcome Based Management Key Performance Indicator Data Definition Manual for KPIs to reflect Operational Costs more accurately.

In 2021-22, the average admitted cost per WAU met target. WACHS inpatient activity is generally less acute and specialised, as more complex patients are typically referred to metropolitan health services.

The average cost in 2021-22 is also affected by increases in operating costs related to staffing, security, infection prevention control and personal protective equipment during the COVID pandemic.

Key performance indicators

Outcome 1 - Efficiency indicators

AVERAGE EMERGENCY DEPARTMENT COST PER WEIGHTED ACTIVITY UNIT

Rationale

This indicator is a measure of the cost per WAU compared with the State (aggregated) target as approved by the Department of Treasury, which is published in the 2021-22 Budget Paper No. 2, Volume 1.

The measure ensures that a consistent methodology is applied to calculating and reporting the cost of delivering Emergency Departments (ED) activity against the state's funding allocation.

With the increasing demand on EDs and health services, it is important that ED service provision is monitored to ensure the efficient delivery of safe and high-quality care.

The 2021-22 target is explained below, with the results shown in Table 27.

Target

The 2021-22 target is $6847 per weighted activity unit.

Results

Table 27: Average Emergency Department (ED) cost per WAU for 2021-22

	2017-18	2018-19	2019-20	2020-21	2021-22	Target ($)
Average ED cost per WAU	$6954	$6424	$6650	$6292	$7411	$6847

Note: Prior years have been adjusted to remove financial products (depreciation, write off, finance costs) in response to definition changes to 2021-22 Outcome Based Management Key Performance Indicator Data Definition Manual for KPIs to reflect Operational Costs more accurately.

In 2021-22, the average emergency department cost per WAU did not meet target. The increased average cost in 2021-22 is attributed to an increase in operating costs related to staffing, security, personal protective equipment, infection prevention and control as a result of the ongoing COVID pandemic.

Key performance indicators

Outcome 1 - Efficiency indicators

AVERAGE NON-ADMITTED COST PER WEIGHTED ACTIVITY UNIT

Rationale

This indicator is a measure of the cost per WAU compared with the State (aggregated) target, as approved by the Department of Treasury, which is published in the 2021-22 Budget Paper No. 2, Volume 1.

The measure ensures that a consistent methodology is applied to calculating and reporting the cost of delivering non-admitted activity against the State's funding allocation. Non-admitted services play a pivotal role within the spectrum of care provided to the WA public; therefore, it is important that non-admitted service provision is monitored to ensure the efficient delivery of safe and high-quality care.

The 2021-22 target is explained below, with the results shown in Table 28.

Target

The 2021-22 target is $6864 per weighted activity unit.

Results

Table 28: Average Non-Admitted cost per WAU for 2021-22

	2017-18	2018-19	2019-20	2020-21	2021-22	Target ($)
Average non-admitted cost per WAU	$5718	$5495	$5561	$4910	$4873	$6864

Note: Prior years have been adjusted to remove financial products (depreciation, write off, finance costs) in response to definition changes to 2021-22 Outcome Based Management Key Performance Indicator Data Definition Manual for KPIs to reflect Operational Costs more accurately.

In 2021-22 the average non-admitted cost per WAU met target. Outpatient activity is predominately allied health and nursing services, with less specialist outpatient services, resulting in a lower cost per WAU. A significant increase in outpatient activity has driven an improvement in this indicator.

Key performance indicators

Outcome 1 - Efficiency indicators

AVERAGE COST PER BED-DAY IN SPECIALISED MENTAL HEALTH INPATIENT SERVICES

Rationale

Specialised mental health inpatient services provide patient care in authorised hospitals and designated mental health units located within hospitals.

In order to ensure quality of care and cost effectiveness, it is important to monitor the unit cost of admitted patient care in specialised mental health inpatient services.

The efficient use of hospital resources can help minimise the overall costs of providing mental health care and enable the reallocation of funds to appropriate alternative non-admitted care.

The 2021-22 target is explained below, with the results shown in Table 29.

Target

The 2021-22 target is $2075 per bed-day.

Results

Table 29: Average cost per bed-day in specialised mental health inpatient services for 2021-22

	2017-18	2018-19	2019-20	2020-21	2021-22	Target ($)
Average cost per bed-day in specialised mental health inpatient unit	$1720	$1664	$2108	$2047	$2396	$2075

Note: Prior years have been adjusted to remove financial products (depreciation, write off, finance costs) in response to definition changes to 2021-22 Outcome Based Management Key Performance Indicator Data Definition Manual for KPIs to reflect Operational Costs more accurately.

In 2021-22, average cost per bed-day in specialised mental health inpatient services did not met target.

There was a slight reduction in inpatient activity due to a combination of workforce issues, temporary closure of some beds for refurbishment and increased patient complexity which has resulted in an increase cost this year.

Key performance indicators

Outcome 1 - Efficiency indicators

AVERAGE COST PER TREATMENT DAY OF NON-ADMITTED CARE PROVIDED BY MENTAL HEALTH SERVICES

Rationale

Public community mental health services consist of a range of community-based services such as emergency assessment and treatment, case management, day programs, rehabilitation, psychosocial, residential services and continuing care.

The aim of these services is to provide the best health outcomes for the individual through the provision of accessible and appropriate community mental health care. Efficient functioning of public community mental health services is critical to ensure that finite funds are used effectively to deliver maximum community benefit.

Public community-based mental health services are generally targeted towards people in the acute phase of a mental illness who are receiving post-acute care.

This indicator provides a measure of the cost effectiveness of treatment for public psychiatric patients under public community mental healthcare (non-admitted/ ambulatory patients).

The 2021-22 target is explained below, with the results shown in Table 30.

Target

The 2021-22 target is $544 per treatment day.

Results

Table 30: Average cost per treatment day of non-admitted care provided by mental health services for 2021-22

	2017-18	2018-19	2019-20	2020-21	2021-22	Target ($)
Average cost per treatment day of non-admitted care provided by mental health services	$588	$569	$531	$555	$573	$544

Note: Prior years have been adjusted to remove financial products (depreciation, write off, finance costs) in response to definition changes to 2021-22 Outcome Based Management Key Performance Indicator Data Definition Manual for KPIs to reflect Operational Costs more accurately.

In 2021-22 the WACHS average cost per treatment day of non-admitted care provided by mental health services has not met the targe. WACHS continues to invest into mental health services in the community to meet growing demand.

The high cost associated with the location of rural services impacts WACHS ability to meet average cost targets for this indicator.

Key performance indicators

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

Table 31: Outcome 2 – Key Performance Indicators

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

Key performance indicators

Outcome 2 - Effectiveness indicators

RESPONSE TIMES FOR EMERGENCY AIR-BASED PATIENT TRANSPORT SERVICES (PERCENTAGE OF EMERGENCY AIR-BASED INTER-HOSPITAL TRANSFER MEETING THE STATEWIDE CONTRACT TARGET RESPONSE TIME FOR PRIORITY 1 CALLS)

Rationale

To ensure Western Australians receive the care and medical transport services they need, when they need it, WACHS has entered into a contractual relationship to deliver emergency air-based patient transport services to the WA public. This collaboration ensures that patients have access to an effective aeromedical and inter-hospital patient transfer service to ensure the best possible health outcomes for patients requiring urgent medical treatment through rapid response.

Response times for patient transport services have a direct impact on the speed with which a patient receives appropriate medical care and provide a good indication of the efficiency and effectiveness of patient transport services. Adverse effects on patients and the community are reduced if response times are reduced.

Calls are assigned a priority (1 to 3) by the service provider, to ensure that conflicting flight requests are dealt with in order of medical need and to allow operations coordinators to task aircraft and crews in the most efficient means possible to meet these needs. The priority system in place is as follows:

- Priority 1 refers to life-threatening emergencies, where the flight departs in the shortest possible time (subject to weather and essential safety requirements).
- Priority 2 refers to urgent medical transfer, where the flight departs promptly with flight planning requirements met on the ground.
- Priority 3 refers to elective transfer, where the flight is tasked to make best use of resources and crew hours.

Through surveillance of this measure over time, the effectiveness of patient transport services can be determined. This facilitates further development of targeted strategies and improvements to operational management practices aimed at ensuring optimal restoration to health for patients in need of urgent medical care.

The 2021-22 target is explained below, with the results shown in Table 32.

Target

The 2021-22 target is ≥ 80%.

Results

Table 32: Response times for emergency air-based patient transport services for 2021-22

	2017-18	2018-19	2019-20	2020-21	2021-22	Target ($)
Percentage of response times for priority 1 calls meeting target	78.9%	81.8%	77.2%	77.0%	67.7%	≥ 80%

In 2021-22 WACHS did not meet the target. Despite an overall decrease in activity, there was a 14% increase in priority 1 patients, including from more regional and remote locations including those without a proximal aeromedical base.

The COVID pandemic case numbers across the state also impacted response times and capacity including access to specialised workforces, as well as operationally extending preparation and decontamination times. Single patient transfers were maintained as an important infection control.

WACHS continues to actively engage with the contracted provider in emergency air-based inter-hospital transfers to ensure the best care is provided to rural and remote communities.

Key performance indicators

Outcome 2 – Effectiveness indicators

PERCENTAGE OF PATIENTS WHO ACCESS EMERGENCY SERVICES AT A SMALL RURAL OR REMOTE WESTERN AUSTRALIAN HOSPITAL AND ARE SUBSEQUENTLY DISCHARGED HOME

Rationale

Small country hospitals provide emergency care services, residential aged care services and limited acute medical and minor surgical services in locations close to home for country residents and the many visitors to the regions.

This indicator measures whether small rural and remote hospital emergency services provide the level of care required to meet the needs of the community.

Accessing health services with the outcome of returning home (where clinically justified) is indicative of effective service delivery.

The 2021-22 target is explained below, with the results shown in Table 33.

Target

The 2021-22 target is 85.0%.

Results

Table 33: Percentage of patients who access emergency services at a small rural or remote WA hospital and are subsequently discharged home for 2021-22

	2017-18	2018-19	2019-20	2020-21	2021-22	Target ($)
Percentage of patients discharged home	84.5%	84.7%	85.0%	84.8%	84.9%	85.0%

In 2021-22, WACHS did not meet the target. The health needs of the patient are the top priority in any decision on treatment location.

Key performance indicators

Outcome 2 – Efficiency indicators

AVERAGE COST PER BED-DAY FOR SPECIALISED RESIDENTIAL CARE FACILITIES, FLEXIBLE CARE (HOSTELS) AND NURSING HOME TYPE RESIDENTS

Rationale

WACHS provides long-term care facilities for rural patients requiring 24-hour nursing care. This healthcare service is delivered to high and low dependency residents in nursing homes, hospitals, hostels and flexible care facilities, and constitutes a significant proportion of the activity within WACHS jurisdictions where access to non-government alternatives is limited.

The 2021-22 target is explained below, with the results shown in Table 34.

Target

The 2021-22 target is $409.

Results

Table 34: Average cost per bed-day for specialised residential care facilities, flexible care (hostels) and nursing home type residents for 2021-22

	2017-18	2018-19	2019-20	2020-21	2021-22	Target ($)
Average cost per bed-day	$524	$566	$582	$631	$724	$409

Note: Prior years have been adjusted to remove financial products (depreciation, write off, finance costs) in response to definition changes to 2021-22 Outcome Based Management Key Performance Indicator Data Definition Manual for KPIs to reflect Operational Costs more accurately.

In 2021-22 the average cost per bed-day for specialised residential care facilities, flexible care (hostels) and nursing home type residents did not meet target. As shown Performance in this indicator can be variable based on demand for aged care residential placements. There is a community expectation that residential aged care facilities operated by the WACHS will remain open and maintained, regardless of occupancy.

The increased average cost in 2021-22 is attributed to an increase in the proportion of high care residents and increases in operating costs related to staffing, infection prevention and control and personal protective equipment as a result of the ongoing COVID pandemic.

Key performance indicators

Outcome 2 – Efficiency indicators

AVERAGE COST PER PERSON OF DELIVERING POPULATION HEALTH PROGRAMS BY POPULATION HEALTH UNITS

Rationale

Population health units support individuals, families and communities to increase control over and improve their health.

Population health aims to improve health by integrating all activities of the health sector and linking them with broader social and economic services and resources as described in the WA Health Promotion Strategic Framework 2017–2021. This is based on the growing understanding of the social, cultural and economic factors that contribute to a person's health status.

The 2021-22 target is explained below, with the results shown in Table 35.

Target

The 2021-22 target for WA Country Health Service is $245.

Results

Table 35: Average cost per person of delivering population health programs by population health units for 2021-22

	2017-18	2018-19	2019-20	2020-21	2021-22	Target ($)
Average cost per person for population health	$268	$242	$270	$320	$408	$245

Note: Prior years have been adjusted to remove financial products (depreciation, write off, finance costs) in response to definition changes to 2021-22 Outcome Based Management Key Performance Indicator Data Definition Manual for KPIs to reflect Operational Costs more accurately.

In 2021-22, average cost per person of delivering population health programs by population health units did not meet target. Population Health comprises health promotion, primary care, education and research.

The 2021-22 result is impacted by costs related to COVID vaccination, response and preparation programs, contributing to a higher average cost per person.

Key performance indicators

Outcome 2 – Efficiency indicators

COST PER TRIP OF PATIENT EMERGENCY AIR-BASED TRANSPORT, BASED ON THE TOTAL ACCRUED COSTS OF THESE SERVICES PER THE TOTAL NUMBER OF TRIPS

Rationale

To ensure Western Australians in rural and remote areas receive the care they need, when they need it, strong partnerships have been forged within the healthcare community through a collaborative agreement between WACHS and the contracted service provider. This collaboration ensures that patients in rural and remote areas have access to an effective emergency air-based transport service that aims to ensure the best possible health outcomes for country patients requiring urgent medical treatment and transport services.

The 2021-22 target is explained below, with the results shown in Table 36.

Target

The 2021-22 target is $7384.

Results

Table 36: Cost per trip of patient emergency air-based transport, based on the total accrued costs of these services per the total number of trips for 2021-22

	2017-18	2018-19	2019-20	2020-21	2021-22	Target ($)
Cost per trip of emergency air-based transport	$6958	$6998	$6877	$7137	$7374	$7384

Note: Prior years have been adjusted to remove financial products (depreciation, write off, finance costs) in response to definition changes to 2021-22 Outcome Based Management Key Performance Indicator Data Definition Manual for KPIs to reflect Operational Costs more accurately.

In 2021-22, the cost per trip of patient emergency air-based transport based on the total accrued costs of these services per the total number of trips meet target. Increased costs for 2021-22 are a result of increased transport requirements from more regional or remote locations, particularly in the Pilbara and Midwest. This is influenced by increased intra-regional travel and other impacts of COVID on workforce availability in regional areas.

There has also been a notable increase in high acuity, complex inter-hospital patient transfers and a proliferation of COVID patients which have required a higher number of flights with medical officer escorts, driving the cost of per flight higher.

Key performance indicators

Outcome 2 – Efficiency indicators

AVERAGE COST PER TRIP OF PATIENT ASSISTED TRAVEL SCHEME (PATS)

Rationale

The WA health system aims to provide safe, high-quality healthcare to ensure healthier, longer, and better quality lives for all Western Australians.

PATS provides a subsidy towards the cost of travel and accommodation for eligible patients travelling long distances to seek certain categories of specialist medical services. The aim of PATS is to help ensure that all Western Australians can access safe, high-quality healthcare when needed.

The 2021-22 target is explained below, with the results shown in Table 37.

Target

The 2021-22 target is $505.

Results

Table 37: Average cost per trip of (PATS) for 2021-22

	2017-18	2018-19	2019-20	2020-21	2021-22	Target ($)
Average cost per trip of PATS	$430	$443	$463	$524	$613	$505

Note: Prior years have been adjusted to remove financial products (depreciation, write off, finance costs) in response to definition changes to 2021-22 Outcome Based Management Key Performance Indicator Data Definition Manual for KPIs to reflect Operational Costs more accurately.

In 2021-22 the average cost per trip of PATS did not meet target. The increase in the average cost this year is due to:

- The total number of PATS assisted trips was further reduced in 2021-22 attributed to the ongoing COVID pandemic health response with cancellation of some non-urgent medical treatment and conversion to telehealth where appropriate
- The commercial accommodation subsidy increased on 13 September 2021 from $60/night to $100/night per patient.
- Escort eligibility expanded from 31 January 2022 resulting in more escorts supported for travel and accommodation subsidies per patient.
- Increased cost of domestic air travel associated with airline COVID pressures.
- Accommodation costs above the subsidised rate for Aboriginal patients who have been accommodated in commercial accommodation due to the shortage of Aboriginal Hostel accommodation across the state.

Key performance indicators

Outcome 2 – Efficiency indicators

AVERAGE COST PER RURAL AND REMOTE POPULATION (SELECTED SMALL RURAL HOSPITALS)

Rationale

The WA health system aims to provide safe, high-quality healthcare to ensure healthier, longer, and better-quality lives for all Western Australians.

The Independent Hospital Pricing Authority's (IHPA) key role is to determine the annual National Efficient Price (NEP) and National Efficient Cost (NEC) for Australian public hospital services. The NEC is used when activity levels are not sufficient for funding based on activity, such as in the case of small rural hospitals. In these cases, services are funded by a block allocation based on size and location. Public hospitals are block funded where there is an absence of economies of scale that mean some services would not be financially viable under Activity Based Funding.

Small rural hospitals provide an essential level of access to services for rural and remote communities. These hospitals have relatively low patient activity and have high fixed costs therefore it is appropriate to measure efficiency based on population numbers as opposed to unit of patient activity.

In the calculation of this indicator, 'rural and remote' population has been calculated using the total WACHS population.

The 2021-22 target is explained below, with the results shown in Table 38.

Target

The 2021-22 target is $469.

Results

Table 38: Average cost per rural and remote population (selected small rural hospitals) for 2021-22

	2017-18	2018-19	2019-20	2020-21	2021-22	Target ($)
Average cost per rural and remote population	$354	$352	$368	$411	$468	$469

Note: Prior years have been adjusted to remove financial products (depreciation, write off, finance costs) in response to definition changes to 2021-22 Outcome Based Management Key Performance Indicator Data Definition Manual for KPIs to reflect Operational Costs more accurately.

In 2021-22, average cost per rural and remote population (selected small rural hospitals) met target.

The increased average cost in 2021-22 is attributed to an increase in operating costs related to staffing, security, personal protective equipment, infection prevention and control as a result of the ongoing COVID pandemic.

Ministerial directives

Treasurer's Instruction 903 (12) requires disclosing information about Ministerial directions relevant to the setting of desired outcomes or operational objectives, the achievement of desired outcomes or operational objectives, investment activities and financing activities.

Pursuant to section 61(1)(f) of the *Financial Management Act 2006,* the Minister for Health directed all Health Service Providers to disclose all gifts and payments over $100,000 made under section 36 (5) of the Health Services Act 2016 within their Annual Reports. The direction was applied from 1 July 2020.

WA Country Health Service has not made any payments that require disclosure under this directive.

Other statutory information

PRICING POLICY

The National Health Reform Agreement sets the policy framework for the charging of public hospital fees and charges. Under the Agreement, an eligible person who receives public hospital services as a public patient in a public hospital or a publicly contracted bed in a private hospital is treated 'free of charge'. This arrangement is consistent with the Medicare principles which are embedded in the *Health Services Act 2016 (WA).*

The majority of hospital fees and charges for public hospitals are set under Schedule 1 of the *Health Services (Fees and Charges) Order 2016* and are reviewed annually. The following informs WA public hospital patient fees and charges for:

Nursing Home Type Patients

The State charges public patients who require nursing care and/or accommodation after the 35th day of their stay in hospital, providing they no longer need acute care and they are deemed to be Nursing Home Type Patients. The total daily amount charged is no greater than 87.5 per cent of the current daily rate of the single aged pension and the maximum daily rate of rental assistance.

Compensable or ineligible patients

Patients who are either 'compensable' or Medicare ineligible (overseas residents) may be charged an amount for public hospital services as determined by the State. The setting of compensable and ineligible hospital accommodation fees is set close to, or at, full cost recovery.

Private patients (Medicare eligible Australian residents)

The Commonwealth Department of Health regulates the Minimum Benefit payable by health funds to privately insured patients for private shared ward and same day accommodation. To achieve consistency with the Commonwealth *Private Health Insurance Act 2007,* the State sets these fees at a level equivalent to the Commonwealth Minimum Benefit.

Veterans

Hospital charges for eligible war service veterans are determined under a separate Commonwealth-State agreement with the Department of Veterans' Affairs (DVA). Under this agreement, the Department of Health does not charge medical treatment to eligible war service veteran patients. Instead, medical charges are fully recouped from the DVA.

The following fees and charges also apply:

- The Pharmaceutical Benefits Scheme regulates and sets the price of pharmaceuticals supplied to eligible outpatients, eligible patients on discharge and eligible day admitted chemotherapy patients. Inpatient medications are supplied free of charge to all eligible patients. Pharmaceuticals for Medicare ineligible patients are charged at the rates set by the WA Department of Health within the *WA Health Fees and Charges Manual.*
- The Dental Health Services charges to eligible patients for dental treatment are based on the Department of Veterans' Affairs Fee Schedule of dental services for dentists and dental specialists. Eligible patients are charged the following co-payment rates:
  - 50 per cent of the treatment fee if the patient holds a current Health Care Card or Pensioner Concession Card
  - 25 per cent of the treatment fee if the patient is the current holder of one of the above cards and receives a near full pension or an allowance from Centrelink or the Department of Veterans' Affairs.

There are other categories of fees specified under the terms of the *Health Services (Fees and Charges) Order 2016* such as the supply of surgically implanted prostheses, orthoses, magnetic resonance imaging services and pathology services. The pricing for these hospital services is determined according to their cost of service.

Other statutory information

CAPITAL WORKS

The capital works completed in 2021-22 is show in Table 39, and the works currently in progress are shown in Table 40.

Table 39: Capital works completed in 2021-22

Project Name	Actual Total Cost in 2021-22 ($ '000)	Estimated Total Costs reported in 2020-21 ($ '000)	Variance ($'000)	2020-21 and 2021-22 variation to cost explanation (>=10%)
Bunbury, Narrogin and Collie Hospitals-Pathology Laboratory Redevelopment	6646	6646	-	Not applicable
Carnarvon Health Campus Redevelopment	24,048	24,048	-	Not applicable
Country Staff Accomodation Stage 3	27,288	27,288	-	Not applicable
Eastern Wheatbelt District (including Merredin) Stage 1	7881	7881	-	Not applicable
Jurien Bay Helipad	668	668	-	Not applicable
Narrogin Helipad	800	800	-	Not applicable
Esperance Health Campus Redevelopment	31,555	31,555	-	Not applicable
Kalgoorlie Regional Resource Centre Stage 1	56,945	56,945	-	Not applicable
Strengthening Cancer Services: Regional Cancer Patient Accommodation	4093	4093	-	Not applicable
Strengthening Cancer Services: Regional Geraldton Cancer Centre	3733	3733	-	Not applicable
Broome Regional Resource Centre - Redevelopment Stage 1	41,707	41,707	-	Not applicable
Meet and Greet	114	114	-	Not applicable

Other statutory information

CAPITAL WORKS

Table 40: Capital works in progress in 2021-22

Project Name	Estimated Total Cost in 2021-22 ($ '000)	Reported in 2020-21 ($ '000)	Variance ($ '000)	2020-21 and 2021-22 variation to cost explanation (>=10%)
Election Commitment: Bunbury Hospital Redevelopment	200,100	200,100	-	
Albany Radiation Oncology	13,125	13,125	-	
Busselton Health Campus	114,808	114,858	50	
Country Staff Accommodation Stage 4	6446	6686	240	
District Hospital Investment Program	158,409	158,409	-	
Dongara Aged Care [1]	3300	1000	2300	See footnotes
East Kimberley Development Package	38,435	38,435	-	
Election Commitments: Collie Hospital Upgrade	12,200	12,200	-	
Election Commitments: Geraldton Health Campus Redevelopment	82,291	82,291	-	
Election Commitments: Kalgoorlie Health Campus Magnetic Resonance Imaging Suite	6276	6276	-	
Election Commitments: Country Ambulance Initiatives	1606	1606	-	
Election Commitments: Culturally Appropriate Housing Facility [4]	608	1158	550	See footnotes
Election Commitments: Meekatharra Hospital	48,487	Not Applicable	Not Applicable	
Election Commitments: Newman Renal Dialysis Service	1300	1300	-	
Harvey Health Campus Redevelopment	12,246	12,296	50	
Hedland Regional Resource Centre - Stage 2	136,157	136,237	80	
Karratha Health Campus Development	158,911	162,711	3800	

Other statutory information

CAPITAL WORKS

Table 40: Capital works in progress in 2021-22 (cont.)

Project Name	Estimated Total Cost in 2021-22 ($ '000)	Reported in 2020-21 ($ '000)	Variance ($ '000)	2020-21 and 2021-22 variation to cost explanation (>=10%)
Laverton Hospital [1, 2]	23,474	16779	6695	See footnotes
Newman Health Service Redevelopment Project	60,114	60,114	-	
Nickol Bay Hospital Demolition	7488	7488	-	
Onslow Hospital	32,391	34,217	1826	
Primary Health Centres Demonstration Program	31,504	31,504	-	
Remote Indigenous Health	23,775	23,775	-	
Renal Dialysis and Support Services	42,136	44,555	2419	
ICT Equipment and Infrastructure: Digital Innovation-Capital	5241	5241	-	
Urgent Mental Health Works at Regional Hospitals	1700	Not Applicable	Not Applicable	
WA Country Health Service Picture Archiving and Communication System Regional Resource Centre	6208	6258	50	
North West Health Initiative: Carnarvon Aged Care and Palliative Care Facility	19,953	18,149	1804	
North West Health Initiative: Derby Community Health Service	3672	3672	-	
North West Health Initiative: Tom Price Hospital Redevelopment [1, 3]	32,822	5222	27600	See footnotes
WA Country Health Service Expansion of Command Centre	10,191	10,291	100	

Notes:

(a) The above information is based upon the:
i 2021-22 published budget papers.
ii 2020-21 published budget papers.

b) The footnotes that apply to individual projects are:
1. Transfer of funding between projects.
2. Approved injection of additional capital funding - State Contribution.
3. Approved injection of additional capital funding - Industry Funds.
4. Transfer budget from AIP to BEC.

Other statutory information

INDUSTRIAL RELATIONS

Responsibility for industrial relations is delineated by an Industrial Relations Policy MP 0025/16 established under the Employment Policy Framework issued by the System Manager (the Chief Executive Officer of the Department of Health) pursuant to section 26 of the *Health Services Act 2016*.

The Department of Health as System Manager is responsible for WA Health system-wide industrial relations matters including negotiation and registration of industrial instruments. WA Country Health Service (WACHS) is responsible for the application of the WA Public Sector legislative and regulatory frameworks regulating employment and industrial relations, management of misconduct matters, representation and advocacy in industrial tribunals and courts, engagement with unions and other external stakeholders in industrial matters.

Negotiations have commenced for replacement industrial agreements for salaried officers, support workers, enrolled nurses and registered nurses. These negotiations will be conducted in line with the revised Public Sector Wages Policy. In principle agreement has been reached for a new industrial agreement for medical practitioners.

There was no significant industrial disputation in the year under review.

WACHS has implemented the *Health Worker (Restrictions of Access) Directions* and the *Booster Vaccination (Restrictions on Access) Directions,* which place access restrictions on health care and health support workers not vaccinated against COVID, from entering or remaining at health-care facilities.

Other statutory information

EMPLOYMENT PROFILE

Government agencies are required to report a summary of the number of employees by category compared with the preceding financial year. Table 41 shows the number of WA Country Health Service full-time equivalent (FTE) employees for 2019-20, 2020-21 and 2021-22.

Table 41: WA Country Health Service total full-time employees by category from 2019 to 2022

Category	Definition	2019-20	2020-21	2021-22
Administration and clerical	Includes all clerical-based occupations together with patient-facing (ward) clerical support staff.	1768	1875	2125
Agency	Includes full-time equivalent employees engaged via an external agency for the following occupational categories: administration and clerical, medical support, hotel services, site services, medical salaried.	205	208	261
Agency nursing	Includes workers engaged on a 'contract for service' basis. Does not include workers employed by NurseWest.	158	185	329
Assistants in nursing	Support registered nurses and enrolled nurses in delivery of general patient care.	80	85	92
Dental nursing	Includes registered dental nurses and dental clinic assistants.	0	0	0
Hotel services	Includes catering, cleaning, stores/supply, laundry and transport occupations.	1250	1281	1316
Medical salaried	Includes all salary-based medical occupations including interns, registrars and specialist medical practitioners. Includes medical sessional staff. Excludes Contract Medical Practitioners (i.e. Locums and Visiting Medical Practitioners on an MSA).*	473	528	587
Medical support	Includes all allied health and scientific/ technical related occupations.	924	933	989
Nursing	Includes all nursing occupations. Does not include agency nurses.	3177	3296	3406
Site services	Includes engineering, garden and security-based occupations.	159	157	163
Other categories	Includes Aboriginal and ethnic health worker related occupations.	144	146	143
TOTAL		**8338**	**8693**	**9411**

Notes:

- *FTE is calculated as the monthly average FTE and is the average hours worked during a period of time divided by the Award Full Time Hours for the same period. Hours include ordinary time, overtime, all leave categories, public holidays, Time Off in Lieu and Workers Compensation.*
- *FTE figures provided are based on Actual (Paid) month to date FTE.*
- ** Medical sessional staff are now coded under medical salaried as part of a WA Health wide system change.*

Other statutory information

STAFF DEVELOPMENT

WA Country Health Service (WACHS) provides a learning and development framework that ensures the delivery of safe, high quality and consumer-centred care services. This is achieved by supporting and facilitating learning programs that enables the development and maintenance of professional skills. Ongoing skills development and learning assists us to attract and retain a competent workforce that is aligned with service needs.

To assist the WACHS workforce in understanding their role specific mandatory training requirements, a Mandatory Training Catalogue is available for each employee in the Learning Management System (LMS). There are a range of Mandatory Training Catalogue's for different areas including, Nursing and Midwifery, Medical Services, Administration, Healthcare Support staff, Managers, Allied Health, and Emergency Management roles. The use of a consistent LMS enables WACHS to have a wide governance approach to the management, publication and reporting of mandatory training and development.

The WA Health Recruitment, Selection and Appointment Policy and Procedure is contained within the WA Health Employment Catalogue. This catalogue includes the requirements and standard processes for recruitment, selection and appointment, secondment, transfer and temporary deployment (acting), in WA Health in accordance with the relevant Western Australian public sector standards and legislative requirements. The Commissioner's Instruction No.1, Employment Standard and the Commissioner's Instruction No.2, Filling a Public Sector Vacancy establishes the minimum standards of merit, equity, and probity that must be applied when filling a vacancy. WACHS is committed to ensuring the timely recruitment of skilled candidates to vacancies in regional areas.

WACHS is committed to building a strong, skilled and growing Aboriginal health workforce across all levels in the organisation. A key strategy to increase the Aboriginal workforce in the WA Health system is through the application of Section 51 (s.51) of the *Equal Opportunity Act (1984)*.

Over the past few years, the COVID pandemic has had an impact on face to face training being conducted. WACHS has managed to maintain staff skills, development and host study days via Microsoft Teams and by using our LMS system. WACHS continues to expand its use of the innovative state-wide Command Centre services, by providing staff in regional and remote locations access to specialists delivering training to support clinical skills development.

Other statutory information

Nurse and Midwife learning opportunities have adapted through the COVID pandemic to ensure staff continue to have access to professional development.

The innovative Midwifery Education calendar was launched in 2022, ensuring equitable access to education and training for rural midwives. This online calendar has increased connectivity and collaboration to our Midwifery workforce through the establishment of a graduate Midwifery peer support network and Midwifery staff development forum. The BACKUP Nurse support service expanded beyond Newly Qualified Registered Nurses and is now available to all nurses. With the engagement of a Midwifery Educator who is a neonatal resus trainer, WACHS has successfully increased training compliance via virtual assessments for this module. The Care of the Ventilated Patient program was adapted to a contemporary online format, to support our nursing workforce with essential upskilling in care of the critically unwell patient. The 2022 COVID surge staffing initiatives were supported by the establishment of the nursing QuickStart Orientation Program. This program gives a sustainable education and training option to nurses redirected to a different speciality area to support in alternate models of care. In collaboration with Child and Adolescent Health, three Special Care Nursery's (SCN) Level 2 courses were run to increase the availability of non-midwives to work within the SCN, ensuring more midwives are available for maternity service delivery.

The Medical Education Unit adapted to the COVID environment by delivering a suite of programs via Teams, which were available to all medical staff in all regions. Programs included Advanced Life Support 2 (ALS2), Paediatric Life Support (PLS), Rural and Remote Emergency Medicine (RREM), Trauma Skills Refresher (TSR), Teaching on the Run (TOTR) and Foundations of Leadership for junior and senior doctors. WACHS-wide Grand Rounds, a Journal Club series, Beating Burnout workshops and career navigation sessions were also delivered via Microsoft Teams in 2021-22.

Allied Health Professionals are supported to attend learning and development opportunities. The WACHS Allied Health Transition to Practice Program for new and recent graduates was relaunched in 2022, with over 40 staff enrolled in the program.

WACHS continues to focus on building capacity internally to meet training needs, through strategies such as Communities of Practice and WACHS wide training programs.

Other statutory information

WORKERS COMPENSATION

Pursuant to the Workers' Compensation and Injury Management Act 1981, WA Country Health Service (WACHS) has a comprehensive injury management system in place, facilitated by our team of injury management coordinators and supplemented by local external rehabilitation providers. WACHS promotes a safe and sustainable return to work model for injured workers, to support them on their journey back to health and well-being.

The injury management coordinators and the wider Occupational Safety and Health team also supports employees, managers and local, People Capability and Culture teams in cases of non-work-related absences, illness and injury, according to the WACHS' Fitness for Work Policy. This year they have provided additional support with COVID related health matters, including vaccination exemptions, that have potential impact on employees' safety whilst at work.

In 2021-22, a total of 233 workers' compensation claims were lodged (see Table 42).

Table 42: Number of WACHS workers' compensation claims in 2021-22

Employee category	Number of claims in 2021-22
Nursing Services	86
Administration and Clerical	23
Medical Support	18
Hotel Services	86
Medical	5
Site Services	15
Total	**233**

Notes:
For the purposes of the Annual Report, employee categories are defined as:

- *Administration and Clerical includes executive, administration staff, ward clerks, receptionists and clerical staff.*
- *Medical Support includes physiotherapists, speech pathologists, medical imaging technologists, pharmacists, occupational therapists, dietitians and social workers.*
- *Hotel Services includes cleaners, caterers, and patient service assistants.*
- *Site Services includes handypersons, security officers, store people and electricians.*

Governance disclosures

CONTRACTS WITH SENIOR OFFICERS

At the date of reporting, no senior officer or Board member, or firms of which senior officers or Board members are members, or entities in which senior officers or Board members have substantial interest, held any shares as a nominee or beneficiary in WA Country Health Service or its subsidiary bodies.

INSURANCE PREMIUMS FOR DIRECTORS AND OFFICERS

For the reporting period, insurance premiums of $84,345 (GST exclusive) had been paid to indemnify any WA Country Health Service 'Directors', as defined in Part 3 of the *Statutory Corporations (Liability of Directors) Act 1996,* against a liability incurred under sections 13 or 14 of that Act.

Other legal requirements

COMPLIANCE WITH PUBLIC SECTOR STANDARDS AND ETHICAL CODES

WA Country Health Service (WACHS) is committed to complying with the Public Sector Standards in Human Resource Management (The Standards), the Western Australian Public Sector Commission's Code of Ethics and WA Health Code of Conduct. WACHS raises awareness of these Standards and Code of Conduct and Ethics by providing information to new employees as part of induction and orientation programs; by including a compliance statement in all job description forms; through mandatory training in Accountable and Ethical Decision Making; Aboriginal Cultural Awareness eLearning programs and the Management Development Program; through policies and procedures; and by publishing information in newsletters, on notice boards and on our intranet.

Human Resource officers provide a range of consultancy and advisory services to managers and employees to ensure they are aware of and manage their responsibilities in relation to the Standards. Centralised oversight of the recruitment and selection process, including notification of the outcome of recruitment processes to ensure that all applicants are provided information about their rights to claim a breach of the Standards where applicable.

Complaints alleging non-compliance with the Code of Ethics or Code of Conduct are reviewed, investigated and monitored by WACHS Industrial Relations in consultation with Human Resources.

Applications made for breach of Standards review, the outcome of claims, and number of complaints relating to non-compliance with the ethical codes is provided in Table 43 below.

Table 43: Summary of Breach of Standards Claims in 2021-22

	Recruitment selection and appointment	Transfers	Secondment	Performance management	Redeployment	Termination	Temporary deployment (acting)	Grievance resolution	Total
(i) Total claims (include all claims lodged whether resolved internally or referred to the Public Sector Commission)									
Claims lodged 2021-22	12	0	0	0	0	0	0	4	16
Claims carried over from previous financial year	0	0	0	0	1	0	0	1	2
Total claims handled in 2021-22	**12**	**0**	**0**	**0**	**1**	**0**	**0**	**5**	**18**
(ii) Outcome of claims handled									
Withdrawn in agency	9	0	0	0	0	0	0	1	10
Resolved in agency	0	0	0	0	0	0	0	0	0
Still pending in agency	0	0	0	0	0	0	0	0	0
Referred to Public Sector Commission	3	0	0	0	1	0	0	4	8
Total claims handled in 2021-22	**12**	**0**	**0**	**0**	**1**	**0**	**0**	**5**	**18**

Other legal requirements

SENIOR OFFICERS

Senior officers and their area of responsibility for the WA Country Health Service as at 30 June 2022 are listed in Table 44.

Table 44: WA Country Health Service senior officers in 2021-22

Area of responsibility	Title	Name	Basis of appointment
WA Country Health Service	Chief Executive	Mr Jeffrey Moffet	Term contract
Operations	Chief Operating Officer	Ms Margaret Denton	Term Contract
Operations Hub	Executive Director	Ms Melissa Vernon*	Term Contract
People Capability and Culture	Executive Director	Ms Colette Young**	Term Contract
Innovation and Development	Executive Director	Ms Robyn Sermon***	Term Contract
Nursing and Midwifery	Executive Director	Ms Kelly-Ann Hahn****	Acting
Clinical Excellence	Executive Director	Dr Helen Van Gessel	Term Contract
Medical Services	Executive Director	Dr Andrew Jamieson	Term Contract
Business Services	Executive Director	Mr Robert Pulsford	Acting
Finance	Director	Mr John Arkell	Substantive
Office of the Chief Executive	Director	Ms Tracy Rainford	Substantive
Major Projects	Executive Director	Mr Sean Conlan*****	Term Contract
Mental Health	Executive Director	Ms Paula Chatfield	Term Contract
Health Programs	Executive Director	Mr James Thomas	Term Contract
Aboriginal Health Strategy	Director	Mr Russell Simpson	Substantive
Infrastructure and Environment	Executive Director	Ms Sonia Ferla	Acting
Regional Operations	Regional Director Goldfields	Mr Peter Tredinnick	Term contract
Regional Operations	Regional Director Great Southern	Ms Geraldine Ennis	Substantive
Regional Operations	Regional Director Kimberley	Ms Bec Smith******	Term contract
Regional Operations	Regional Director Midwest	Ms Rachele Ferrari*******	Term contract
Regional Operations	Regional Director Pilbara	Ms Margi Faulkner	Term contract
Regional Operations	Regional Director Southwest	Ms Kerry Winsor	Substantive
Regional Operations	Regional Director Wheatbelt	Mr Russell Colyer-Cockburn	Acting

** Ms Melissa Vernon commenced in 09/11/2021.*
*** Ms Colette Young commenced on 09/11/2021.*
**** Ms Robyn Sermon ceased on 02/03/2022.*
***** Ms Kelly-Ann Hahn ceased on 05/02/2022.*
****** Mr Sean Conlan commenced on 31/01/2022.*
******* Ms Bec Smith ceased 25/02/2022.*
******** Ms Rachele Ferrari commenced on 18/10/2021.*

Other legal requirements

ACT OF GRACE PAYMENTS

No Act of Grace or Ex Gratia payments pursuant to authorisations given under Section 80(1) of the Financial Management Act were made in the 2021-22 financial year.

UNAUTHORISED USE OF CREDIT CARDS

WA Country Health Service (WACHS) uses purchasing cards for purchasing goods and services to achieve savings through improved administrative efficiency and more effective cash management. The purchasing card is a personalised credit card that provides a clear audit trail for management.

WACHS credit cards are provided to employees who require it as part of their role. Credit cards are not for personal use by the cardholder. Should a cardholder use a credit card for personal purposes, they are required to submit a Notice of Personal Expense (Form 625-2) to the accountable authority within five working days of becoming aware of the transaction and refund the total amount of expenditure.

There were 38 transactions in the period where credit cards were inadvertently used for personal purposes. All transactions were refunded before the end of the reporting period.

Table 45: Credit card personal use expenditure in 2021-22

Credit card personal use expenditure	1 July 2021 to 30 June 2022
Aggregate amount of personal use expenditure for the reporting period.	$2894.98
Aggregate amount of personal use expenditure settled by the due date (within five working days).	$2894.98
Aggregate amount of personal use expenditure settled after the period (after five working days).	$0.00
Aggregate amount of personal use expenditure outstanding at the end of the reporting period.	$0.00

Other legal requirements

ADVERTISING

In accordance with section 175Z of the *Electoral Act 1907,* WA Country Health Service incurred a total advertising expenditure of $423,983.80 in 2021-22 (see table 46). There was no expenditure in relation to polling organisations and market research organisations.

Table 46: Summary of advertising for 2021-22

Summary of advertising	Amount
Advertising agencies	$49,041.36
Market research organisations	$0
Polling organisations	$0
Direct mail organisations	$450.00
Media advertising organisations	$374,492.44
Total advertising expenditure	**$423,983.80**

Table 47: Summary of Organisations that provided advertising services in 2021-22

Person, agency or organisation name	Amount
Advertising agencies	
Feral Films Pty Ltd	$14,140.00
Health Communication Resources Inc	$7635.00
Jessica Louise Russel	$5000.00
Kate Elizabeth Ferguson	$13,636.36
Okeefe Media WA	$4500.00
Total Advertising agencies	**$49,041.36**
Total Market research organisations	**$0**
Total Polling organisations	**$0**
Total Direct mail organisations	**$450.00**

Table 47: Summary of Organisations that provided advertising services in 2021-22 *(cont.)*

Person, agency or organisation name	Amount
Media advertising organisations	
Australian and New Zealand College of Anaesthetists (ANZCA)	$8850.00
Australian College of Rural and Remote Medicine	$14,290.91
Bellagio Australia Pty Ltd	$3430.50
BMJ	$40,159.64
Carat Australia Media Services Pty Ltd	$3285.10
Government Education and Business Directories Pty Ltd	$3635.45
Health Sector Talent Limited	$37,288.14
Kate Elizabeth Ferguson	$6045.46
Linkedin Singapore Pte Ltd	$103,889.61
Livehire Ltd	$62,700.11
Medforum Pty Ltd	$9343.40
Royal Australian College of Medical Administrators (RACMA)	$3300.00
Royal Australasian College of Surgeons (RACS)	$3057.27
Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)	$3200.00
Rural Health West	$10,500.00
The Australasian College for Emergency Medicine	$8470.00
The Royal Australian and New Zealand College of Psychiatrists	$12,098.21
The Royal Australian College of General Practitioners	$11,700.00
The Trustee for the Commerce and Trade Index Discretionary Trust	$4540.91
Your Membership.com Inc	$10,495.79
Total Media advertising organisations	**$374,492.44**

Note: All costs with a value of less than $2500.00 are not listed, although the amount is included in the total.

Other legal requirements

DISABILITY ACCESS AND INCLUSION PLAN

WA Country Health Service (WACHS) is committed to enhancing the experiences of people with a disability through service delivery and workforce participation. We are here to improve country people's health and wellbeing, to care for the sick and to ensure that country communities can access high quality healthcare.

WACHS recognises the need for access and inclusion for people with a disability. This objective is fulfilled through the WACHS Disability Access and Inclusion Plan (DAIP).

The current DAIP was developed in consultation with our consumers, staff and key stakeholders to provide strategies for WACHS to enable access, support increased independence, opportunities and inclusion for people with disability. The plan outlined the key priorities over a five-year period and built upon our past achievements.

We have begun work on a new DAIP, which will ensure that our disability access and inclusion initiatives evolve with the dynamic healthcare environment and continue to provide people with a disability equal access to our services, employment and development opportunities. Amongst a range of inclusion activities, we will do this by:

- Ensuring that all capital works projects comply with the minimum access, egress and amenity levels set out in the Building Code of Australia. That all infrastructure improvements and redevelopments are undertaken with a view to universal access. In 2021-22, WACHS planned or delivered 19 capital projects compliant with the Building Code of Australia.
- The use of telehealth services, which enables patients to receive safe, high quality and cost-effective clinical services closer to home.
- Providing information to staff who are arranging events that will ensure events are accessible to people with disabilities.
- Providing disability awareness training as a recommended module of the WACHS induction program for all staff. As of June 2022, this training has been completed by 65 per cent of the WACHS workforce. A new Disability and Inclusion eLearning module developed as part of the WA Health Equity, Diversity and Inclusion eLearning package has also been launched this year. This package has been created as a collaborative effort between WA health service providers and the WA Department of Health. Released in March 2022, 54 staff have enrolled and 26 staff have passed the Disability and Inclusion eLearning module.
- Ensuring people can provide feedback in a range of ways, including by Care Opinion, which is an independent online consumer feedback platform with accessibility functions and the newly implemented MySay Healthcare Survey, which is a patient experience survey. MySay is sent automatically via text message to inpatients and day procedure patients (or their family/carers) approximately one week after discharge from a WACHS hospital or a health service. The survey results are being used to help the WACHS identify where we can improve and implement changes to the care and treatment we provide.
- Ensuring that information on patient rights and responsibilities and feedback options are displayed at WACHS sites and that this information, as well as patient health information, can be made available in alternative formats. WACHS launched its new SharePoint intranet page in 2021-22 which saw the transition to a new, more accessible staff intranet page that includes alternate text options for vision impaired employees, and access on mobile and tablet devices.
- Facilitating the use of interpreters and technology aids to improve access to information for people who speak limited English, have difficulty speaking, hearing, seeing and reading.

In accordance with the requirements of the *Disability Services Act 1993*, a progress report has been submitted to the Department of Communities Disability Services, outlining our progress against the priorities set out in the plan.

Other legal requirements

RECORDKEEPING PLANS

In compliance with the requirements of the *State Records Act 2000* WA Country Health Service (WACHS) has a Recordkeeping Plan (RKP) approved by the State Records Commission. The RKP addresses the areas of proper and adequate records, policies and procedures, language control, preservation, retention and disposal, compliance, and outsourced functions.

The RKP must be reviewed every five years to accurately reflect the organisation's functions, recordkeeping practices, storage arrangements, and implementation of updated disposal authorities.

In July 2023, WACHS will submit a reviewed RKP to the State Records Office in line with its legislative obligations. The RKP review, together with an upgrade to the WACHS recordkeeping system in late 2022 (involving changes to user interface and functionalities), will inform the next evaluation of the efficiency and effectiveness of WACHS recordkeeping systems and associated training programs. This evaluation is planned for the 2023 calendar year (a minimum of six months after upgrade works complete).

The WACHS Recordkeeping Awareness Training program forms part of the mandatory learning program for all staff and is usually completed upon induction. This program addresses the roles and responsibilities of individual employees complying with the RKP and relevant policies. To date, 1614 new staff completed this training in 2021-22. All new users of the WACHS approved recordkeeping system are also required to complete an online training program, of which 932 staff completed in 2021-22.

Other legal requirements

FREEDOM OF INFORMATION

The Western Australian *Freedom of Information Act 1992* gives all Western Australians a right of access to information held by the WA Country Health Service. The types of information held by the organisation include:

- reports on health programs and projects
- briefings for Minister for Health, Board and executive staff
- health circulars, policies, standards and guidelines
- health articles and discussion papers
- newsletters, magazines, bulletins and pamphlets
- health research and evaluation reports
- epidemiological, survey and statistical data/information
- publications relating to health planning and management
- committee meeting minutes
- administrative correspondence
- legislative reporting and compliance documents
- health infrastructure records
- financial and budget reports
- staff personnel records
- patient records created from episodes of care

Members of the public can access some of the above information from the WACHS website (www.wacountry.health.wa.gov.au). Members of the public who do not have internet access can obtain hard copy documents for free or a nominal fee outside of the Freedom of Information process.

Access to information under the *Freedom of Information Act 1992* must be made in writing and can be lodged via email, sent by post or delivered in person. The written request must provide sufficient detail to enable the application to be processed, including contact details and an Australian address for correspondence.

In the case of an application for amendment or annotation of personal information it is required that the request include:

- detail of the matters in relation to which the applicant believes the information is inaccurate, incomplete, out-of-date or misleading
- the applicant's reasons for holding that belief
- detail of the amendment that the applicant wishes to have made.

For applications seeking non-personal information there is a fee payable at the time of submission. WACHS has a Freedom of Information coordinator for each region. Contact details, including postal and email addresses can be sourced from this site (www.healthywa.health.wa.gov.au)

All requests for information can be granted, partially granted or may be refused in accordance with the Western Australian *Freedom of Information Act 1992.* The applicant can appeal if dissatisfied with the process, the reasons provided and in the event of an adverse access decision.

Other legal requirements

For the year ended 30 June 2022, WACHS dealt with 3489 applications for information. Of those 3319 applications were granted full or partial access and 111 were refused (Table 48).

Table 48: Applications for information under the *Freedom of Information Act 1992 (WA)* in 2021-22

Number of applications carried over from 2020-21	368
Number of applications received in 2021-22	3474
Total applications active in 2021-22	**3842**
Number of applications granted – full access	844
Number of applications granted – partial or edited access	2475
Number of applications withdrawn by applicant	59
Number of applications refused	111
Total applications dealt with for 2021-22	**3489**
Number of applications in progress	271
Other	82

Government policy requirements

COMMITMENT TO WORK HEALTH AND SAFETY MANAGEMENT

WA Country Health Service (WACHS) recognises the importance of promoting a culture that integrates safety as a core activity into all aspects of its work and, is committed to providing a safe workplace for its employees, contractors, visitors and patients. We do this by:

- Adopting an integrated risk management approach (identify, assess, control, evaluate) to managing work health and safety (WHS) issues in the workplace. This approach is underpinned and supported by WACHS policies and procedures created in accordance with the *Work Health and Safety Act 2020 (WA)* and the *Work Health and Safety (General) Regulations 2022 (WA)*,
- Ensuring all employees understand duty of care responsibilities for themselves and others, and in turn model and practise these behaviours in the workplace; and
- Promoting and providing suitable training, instruction and supervision for all staff in order to facilitate safe work behaviours and practices.

In 2022 WACHS commenced a WHS Legislation Project, in accordance with the transitional arrangements, to review and update WACHS WHS policies and procedures in accordance with the new legislative changes. WACHS WHS documents are available online to all WACHS staff through Health Point and health intranet pages.

In 2021-22, WACHS staff reported 1214 incidents which related to Occupational Violence and Aggression (OVA) in the workplace. OVA towards first responders is an issue that is increasing in prevalence and protecting our staff from OVA remains a key focus. In accordance with the WACHS Preventing and Managing Occupational Violence Strategy 2019–23, our aim is to continue in delivering a multifaceted approach to eliminate and reduce exposure of OVA to our staff. Key developments in this space in 2021-22 included:

- A WACHS-wide procurement of enhanced duress alarm technology aimed at improving lone worker duress notification and response capability. This will enable 250 additional mobile duress alarms to be used by healthcare staff who make home and community visits.
- A WACHS-wide review of staff accommodation commencing in conjunction with regional, WHS, Security and Infrastructure teams. This review has focussed on improving the security and safety of staff accommodation including the physical layout and additional control measures (fencing, CCTV, maintenance) that maintain safety in these facilities.

In 2021-22, supporting our staff and keeping them safe was our key priority, as we continue to manage with the evolving challenges presented by the COVID pandemic. WACHS understands that the health and wellbeing of our workforce is critical for delivering high quality care for country WA communities.

CONSULTATION

Given the unique geography of WACHS's network of health services and nursing posts located across rural and remote Western Australia, WACHS recognises that the risks and hazards associated with this geographical spread are multifaceted. In order to ensure adequate representation and consultation is considered across our sites, WACHS has an active network of WHS committees across all regional areas. These committees ensure all members are kept up to date with key trends, updates and focusses for work health safety matters at WACHS.

Health and safety representatives (HSRs) provide a valued conduit for work health and safety matters to assist in identifying and effectively managing safety risks. HSRs are trained and receive support and guidance from a network of WHS professionals at WACHS to enable them to perform in these roles at a high standard.

Government policy requirements

COMPLIANCE WITH INJURY MANAGEMENT

WACHS maintains a comprehensive Injury Management (IM) System and service for the rehabilitation of injured employees. This service is guided by the requirements of the *Workers' Compensation and Injury Management Act 1981.* WACHS has a dedicated Work Health and Safety and IM team that provides support and guidance for all stakeholders involved in the IM process. These services include claim lodgement assistance, fitness for work advice, return to work planning and liaison with the Government Insurance Division and treating practitioners.

This year there has been an increased focus on fitness for work management of COVID related exemptions (vaccination exemptions, mask exemptions and vulnerable employees).

The number of claims lodged and recorded WACHS wide for 2021-22 (231) represented a 30 per cent decrease over the prior year, and 13 per cent lower than 2019-20. The total cost of claims for 2021-22 ($1.88 million) is $500 thousand less than the prior year.

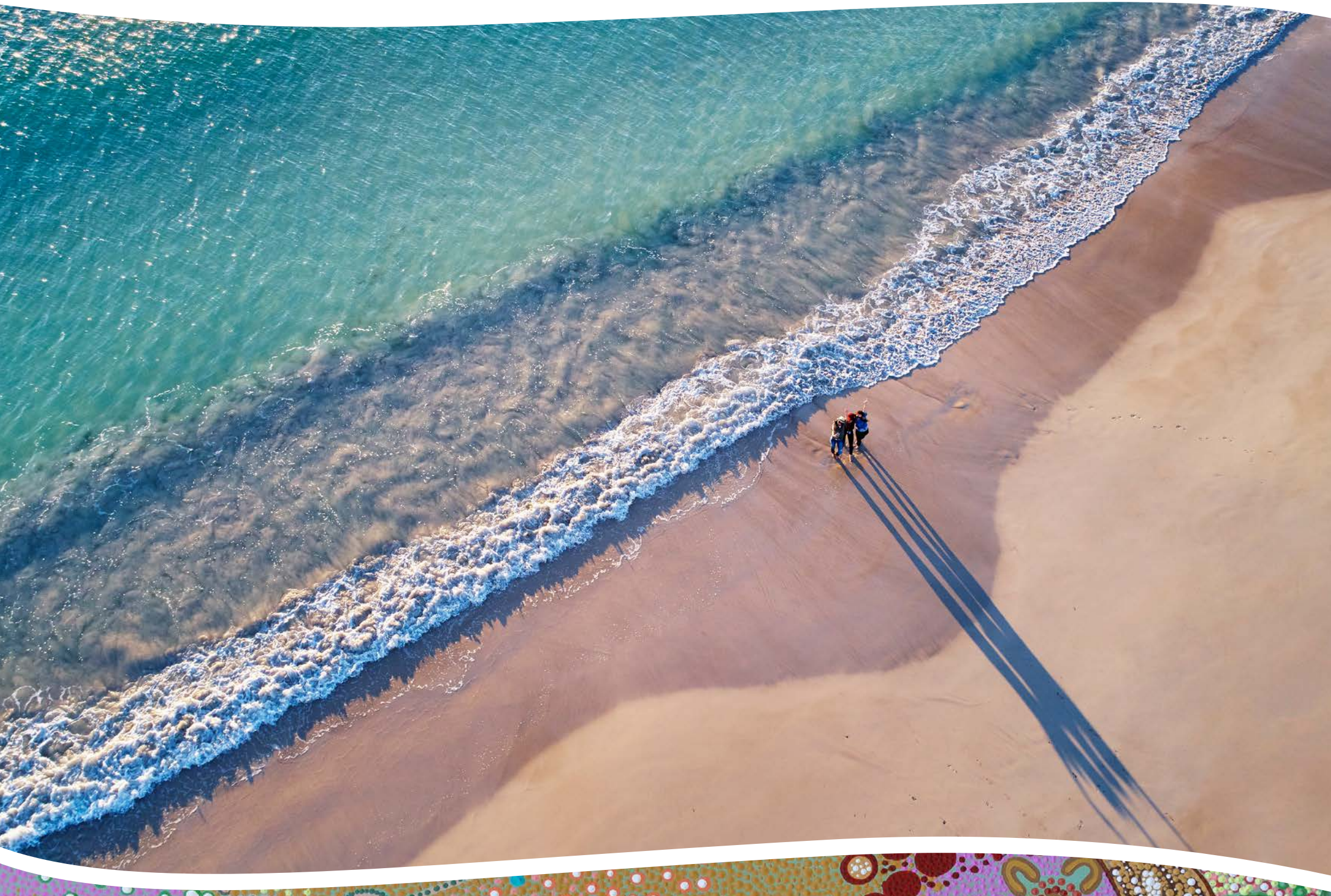
WORK HEALTH AND SAFETY PERFORMANCE INDICATORS

Table 49: Work health and safety performance reported in 2021-22

Measure	Actual results			Results against target	
	2019-20	2020-21	2021-22	Target	Comments
Number of fatalities	0	0	0*	0	**Target achieved**
Lost time injury and/or disease incidence rate	2.25	2.39	2.87	0 or 10% reduction on the previous three (3) years)	**Target not achieved**
Lost time injury and/or disease severity rate	37.0	42.0	45.0	0 or 10% reduction on the previous three (3) years)	**Target not achieved**
Percentage of injured workers returned to work:					
i) Within 13 weeks	38%	33%	34%	Greater than or equal to 80% return to	**Target not achieved**
ii) Within 26 weeks	43%	37%	47%	work within 26 weeks.	**Target not achieved**
Percentage of managers trained in occupational safety, health and injury management responsibilities	86%	85%	47%	Greater than or equal to 80%	**Target not achieved**

** Sadly in April, a NurseWest Registered Nurse was travelling by light aircraft from Broome to Halls Creek, when the aircraft crashed enroute, this resulted in a fatal injury to the nurse.*

Note: Performance is based on a three-year trend and as such the comparison base year is two years prior to the current reporting year (ie. current year is 2021/22 and comparison base year is 2019/20.



Government policy requirements

ASBESTOS AWARENESS AND MANAGEMENT

Historically, Australia was one of the highest users of asbestos as a building material in the world. Since asbestos was confirmed to be the cause of multiple asbestos-related diseases, the use of asbestos in residential buildings was phased out by 1990, and in 2003 the importation and use of all forms of asbestos was banned. To date, asbestos is still present in millions of homes and buildings across Australia, including in our WA regions.

WA Health are signatories to the National Strategic Plan for Asbestos Awareness and Management 2019–2023 (NSP), with the aim to eliminate asbestos-related diseases by preventing exposure to asbestos fibres.

The WA Country Health Service (WACHS) demonstrates its commitment to asbestos management by actively delivering on the NSP priorities for Health Service Providers by:

1. IMPROVE AWARENESS TO INFLUENCE BEHAVIOURAL CHANGE

WACHS is committed to increasing the awareness of asbestos to ensure staff and patient safety. Information regarding asbestos is available using Site Asbestos Registers, site induction information and signage. In collaboration with Department of Health, an Asbestos Awareness training video is in development for WA Health staff.

2. IDENTIFICATION AND EFFECTIVE LEGACY MANAGEMENT

The objective of the Asbestos Management Plan is to outline management responsibilities and processes to ensure staff and patient safety when asbestos is identified in line with Department of Water and Environmental Regulation guidelines. An update to the Asbestos Management Plan is in development, to ensure recent changes to the *Work Health and Safety Act 2020 (WA)* and the *Work Health and Safety (General) Regulations 2022 (WA)* are reflected in asbestos identification and management processes.

All known or suspected asbestos is recorded on the WACHS Asbestos Register, allowing for prioritisation of remediation and record keeping of all inspections and surrounding works.

3. SAFE PRIORITISED REMOVAL AND EFFECTIVE WASTE MANAGEMENT

WACHS is committed to keeping its patients and staff free from harm by reducing the risk of exposure to asbestos. Within the last 12 months, 26 instances of asbestos have been removed and mandatory inspections of asbestos have been completed across WACHS regions.

WACHS maintains asbestos management practices that are compliant with guidelines for the assessment, remediation and management of asbestos contaminated sites, including:

- Online Asbestos Register where Asbestos-Containing Material (ACM) is identified, risk assessed, managed and reported for owned sites.
- An organisation wide Asbestos Management Plan that documents asbestos management responsibilities, access to the Asbestos Register, notifications, planning for ACM removal and Safe Work Procedures.

Government policy requirements

SUMMARY OF BOARD AND COMMITTEES REMUNERATION

The total annual remuneration for each Board or committee is listed below. For details of individual Board or committee members, please refer to Appendix 2.

Table 50: Summary of State Government Boards and committees within the WA County Health Service in 2021-22

Board/committee name	Total remuneration
WA Country Health Service Board	$420,466.78
SUB TOTAL	**$420,466.78**
WA Country Health Service Human Research Ethics Committee	$14,753.00
SUB TOTAL	**$14,753.00**
Medical Advisory Committees	
Albany Hospital Medical Advisory Committee	$0
Blackwood Medical Advisory Committee	$4039.00
Bunbury Hospital Medical Advisory Committee	$0
Busselton Hospital Medical Advisory Committee	$1467.00
Carnarvon Medical Advisory Committee	$0
Central Great Southern Medical Advisory Committee	$4969.00
Collie Medical Advisory Council	$1529.00
Denmark Medical Advisory Committee	$4581.00
Donnybrook Hospital Medical Advisory Committee	$591.00
Medical Advisory Committees	
Eastern Wheatbelt Medical Advisory Committee	$0
Esperance Medical Advisory Committee	$0
Exmouth Medical Advisory Committee	$0
Geraldton Medical Advisory Committee	$0
Kalgoorlie Medical Advisory Committee	$0
Kimberley Regional Medical Advisory Committee	$0
Margaret River Medical Advisory Committee	$0
Plantagenet-Cranbrook Health Service Medical Advisory Committee	$194.00
Pilbara Medical Advisory Committee	$0
Ravensthorpe Health Service Medical Advisory Committee	$319.00
Southern Wheatbelt Medical Advisory Committee	$0
Warren Health Service District Medical Advisory Committee	$4717.00
Western District Medical Advisory Committee	$0
SUB TOTAL	**$22,406.00**

(cont.)

Government policy requirements

Table 50: Summary of State Government Boards and committees within the WA County Health Service in 2021-22 *(cont.)*

Board/committee name	Total remuneration
District Health Advisory Councils	
Blackwood District Health Advisory Council	$356.00
Broome District Health Advisory Council	$0
Bunbury District Health Advisory Council	$2758.00
Central Great Southern District Health Advisory Council	$6699.00
Derby District Health Advisory Council	$1595.00
East Kimberley District Health Advisory Council	$132.00
East Pilbara District Health Advisory Council	$1595.00
Eastern Wheatbelt District Health Advisory Council	$0
Gascoyne District Health Advisory Council	$140.00
Geraldton District Health Advisory Council	$770.00
Goldfields District Health Advisory Council	$4401.00
Leschenault Wellington District Health Advisory Council	$0
Lower Great Southern District Health Advisory Council	$70.00
Midwest District Health Advisory Council	$1190.00
Naturaliste District Health Advisory Council	$1391.00
Southern Wheatbelt District Health Advisory Council	$0
Warren District Health Advisory Council	$3227.00
Western District Health Advisory Council	$3752.00
SUB TOTAL	**$28,076.00**
TOTAL	**$485,701.78**

Government policy requirements

SUBSTANTIVE EQUALITY

The WA Country Health Service (WACHS) is committed to substantive equality for Western Australians living in the regions and, our employees through the implementation of the WA Health Policy Framework for Substantive Equality. Our commitment to recognising the diversity of our consumers, employees and other stakeholders is reflected in our organisational values, our strategies, and our policies and procedures.

WACHS is committed to addressing and preventing systemic discrimination by adjusting policies, procedures and practices to meet the specific needs of certain groups in the community. This includes, but is not limited to; people with a disability, Aboriginal and Torres Strait Islanders, those with a lived experience of mental health, people from culturally diverse backgrounds, people from the Lesbian, Gay, Bisexual, Transgender, Intersex, Queer/Questioning, Asexual (LGBTIQA+) communities and families and carers.

This includes:

- Providing strategies to increase independence, opportunities and inclusion for people with disability. The detailed strategies are currently being developed in the WACHS Disability Access and Inclusion Plan 2021–2025.
- Continuing to focus on improving the health outcomes of Aboriginal people through a coordinated approach to the planning, funding and delivery of Aboriginal health programs.
- Continuing to grow and support our Aboriginal workforce in all areas including professional streams, and by growing a non-Aboriginal workforce that understands and responds to the needs of Aboriginal people.

In 2021-22 WACHS continued to contribute to substantive equality in the following ways:

- Implementation of the *WACHS Aboriginal Health Strategy 2019-2024*, which outlines the organisation's approach to improving health outcomes for country Aboriginal people in WA by making 'Aboriginal health everybody's business.'
- Implementation of the key principals of the WACHS Cultural Governance Framework, which commits WACHS to providing;
  - a culturally and clinically competent workforce at all levels
  - a stronger focus on person and community-focussed practice
  - effective leadership, capable of working in culturally diverse settings, and
  - policies that are consistent, sustainable, and developed with a cultural lens across the organisation.
- Continued implementation of the Strengthening Aboriginal Health and Aboriginal Comprehensive Primary Health Care programs in partnership with key stakeholders, including Aboriginal Community Controlled Health Services, metropolitan health service providers, and a number of mainstream not-for-profit organisations.
- Review and updating of the Aboriginal Mental Health Model of Care to reflect the principles of the WACHS Cultural Governance Framework, describe the commitment towards substantive equality through the implementation of the key themes and principals, and the responsibility of the WACHS Mental Health workforce to ensure equitable access to and culturally appropriate care.
- Development of a Cultural Information Gathering Tool (MR23 form). With an e-learning program which provides the cultural understanding for the appropriate use of the MR23 form, and to inform the treatment and management of Aboriginal consumers within WACHS Mental Health Services.

Government policy requirements

- The Aboriginal Mental Health Consultation Guideline policy describes the role and responsibility of the Aboriginal Mental Health worker, and it informs Mental Health Clinicians to deliver a clinically safe and culturally responsive consultation process with Aboriginal consumers.
- As at June 2022, WACHS employed a total of 479 Aboriginal people, equating to 4.2 per cent of our total workforce. This is above the 3.7 per cent target set by the Public Sector Commission.
- As of April 2022, 8572 WACHS employees had completed the Department of Health's new mandatory Aboriginal Health and Wellbeing training, which was released on 14 April 2021. The Department of Health target is 100 per cent of employees completing the eLearning by 14 April 2023.
- Continued our longstanding participation and support of a range of State and National forums, including the Statewide Aboriginal Health Network and the WA Aboriginal Health Partnership Forum.
- Work is underway to improve culturally appropriate accommodation facilities for Aboriginal people travelling from remote and regional WA to Perth for specialist medical treatment. This includes renovations of the Elizabeth Hansen Autumn Centre and, joint investment with Aboriginal Hostels Limited to renovate Allawah Grove and Derbarl Bidjar Hostels.
- Continued our engagement with key stakeholders, agencies and partners, including the Aboriginal Health Council of WA, Commonwealth Department of Health, WA Primary Health Alliance, Rural Health West and Metropolitan Health Service Providers.

Government policy requirements

MULTICULTURAL PLAN

The WA Country Health Service (WACHS) Multicultural Plan is consistent with the Office of Multicultural Interest's Western Australian Multicultural Policy Framework. The WACHS Multicultural Plan provides a roadmap for the organisation to further extend its cultural responsiveness to meet the needs of those from Culturally and Linguistically Diverse (CaLD) backgrounds.

It will enable the provision of healthcare delivered with cultural sensitivity, ensuring all of our patients feel safe and welcomed.

The multicultural action plan sets out three priorities that WACHS will address over the coming years in order to further improve the provision of services, community engagement and employment opportunities for people from diverse backgrounds:

1. Harmonious and inclusive communities.
2. Culturally responsive policies, programs and services.
3. Economic, social, cultural, civic and political participation.

WACHS' actions against each strategy are outlined below.

Policy priority 1 - Harmonious and inclusive communities

Strategy: Address racism and discrimination at both an individual and institutional/systemic level, including implementing the Policy Framework for Substantive Equality, by preventing, monitoring and responding to racism, individual cases of racial discrimination, systemic racial discrimination and workplace racial harassment and discrimination.

WACHS Action	Proposed Timeframe	Status	Outcomes achieved to date
Review Induction Pathway INDP EL1 to ensure that it provides information for new staff about WACHS workplace culture.	June 2021 and ongoing	In development	Introduction of a new mandated induction learning program with compliance monitoring regularly report to WACHS Executive.
Review the recruitment, selection and appointment training module to include further information on unconscious bias.	June 2021 and ongoing	In development	Review of the online Recruitment, Selection and Appointment Modules in the Manager Development Program. With a planned release date of late 2022.
Develop face to face training including unconscious bias for Frontline Managers.	March 2021 and ongoing	In development	Development of face to face training for Frontline Managers. With a planned release date of late 2022.

Government policy requirements

Policy priority 1 - Harmonious and inclusive communities *(cont.)*

Strategy: Promote the benefits of cultural and linguistic diversity and celebrate the achievements of people from CaLD backgrounds, by promoting the benefits of cultural and linguistic diversity and celebrating the achievements of people from CaLD backgrounds.

WACHS Action	Proposed Timeframe	Status	Outcomes achieved to date
Promote the cultural diversity within WACHS by profiling three profiles per year of WACHS staff or working groups from cultural and linguistically diverse backgrounds. To celebrate their journey and successes in the corporate newsletter.	February 2022	Complete	The CE eNews profiled three staff from culturally and linguistically diverse backgrounds in 2021-22 and, will continue to promote the profiles of culturally and linguistically diverse staff via internal communications as part of business as usual operations.

Strategy: Initiate and support events and projects that build mutual understanding and respect between cultures by initiatives that have been delivered or supported to build intercultural understanding.

WACHS Action	Proposed Timeframe	Status	Outcomes achieved to date
Celebrate key multicultural events	February 2021 and ongoing	In development	Organisation of NAIDOC week celebrations across WACHS sites with support from site-based volunteers. All WACHS staff are encouraged to participate.
Promote events and training related to cultural and linguistic diversity.	April 2021	Complete	Development of the Diversity and Inclusion intranet page that promotes cultural events, diversity days, religious holidays, the WACHS Multicultural Plan, and the Workforce Diversity and Inclusion Plan with links to training.

Government policy requirements

Policy priority 1 - Harmonious and inclusive communities *(cont.)*

Strategy: Develop workplace cultures that are welcoming and inclusive of all Western Australians by creating welcoming and inclusive workplaces for staff, customers and clients.

WACHS Action	Proposed Timeframe	Status	Outcomes achieved to date
Explore strategies to raise workplace concerns to develop a positive workplace culture. Incorporated into the Frontline Managers training program.	March 2021 and ongoing	In development	Delivery of Above the Line and Below the Line behaviours training across a number of regions and directorates. Ongoing continuous improvement of Frontline Manager training will form business as usual operations from 2022-23 onwards.

Policy priority 2 - Culturally responsive policies, programs and services

Strategy: Collect and analyse cultural and linguistic data to contribute to the identification of client needs, the development of policies and programs, and evaluation of outcomes by, capturing cultural and linguistic data and then using the data to plan for policies, services and agency outcomes.

WACHS Action	Proposed Timeframe	Status	Outcomes achieved to date
Review of WACHS data, including the cultural and linguistic composition of communities to identify service access and outcomes.	December 2021	In development	Collation of current regional data plans and West Australian cultural and linguistic community data.
Leverage the information provided in the Diversity Dashboard developed by the Public Sector Commission to explore strategies to improve the collection of diversity data within WACHS.	February 2022	In development	Utilisation of the Diversity Dashboard developed by the Public Sector Commission by comparing local data to broader WA Public Sector agencies.

Government policy requirements

Policy priority 2 - Culturally responsive policies, programs and services *(cont.)*

Strategy: Integrate multicultural policy goals into strategic and corporate planning, procurement and review processes by developing culturally responsive policies and strategies for corporate planning and reviews, procurement processes and customer service and/or service delivery.

WACHS Action	Proposed Timeframe	Status	Outcomes achieved to date
In partnership with consumers from Non-English-Speaking Backgrounds (NESB) evaluate the accessibility of the complaints management process and the Care Opinion feedback platform.	October 2021	In development	Review of the accessibility for NESB consumers to lodge feedback through the Care Opinion platform, with the aim to improve the service that is offered.

Strategy: Provide language services to ensure language is not a barrier to equitable access to information and services, including complaints processes by addressing language service barriers to ensure equitable access to information, services and complaints processes. Training staff on effectively engaging interpreters and translators.

WACHS Action	Proposed Timeframe	Status	Outcomes achieved to date
Promote the WA Health System Language Services Policy e-Learning module.	September 2021	In development	Review of the new WACHS SharePoint intranet structure, to determine the best method in promoting the WA Health System Language Services Policy e-Learning module.
Incorporate the Diverse WA: Cultural Competency Training for working with people from culturally and linguistically diverse backgrounds into the WACHS Learning Management System.	January 2022	In development	In conjunction with other Health Service Providers, development and release of a WA Health system-wide Equity, Diversity and Inclusion training module.
Promote the Diverse WA: Cultural Competency Training Program to WACHS staff.	Ongoing	In development	Review of the WACHS SharePoint intranet structure to determine the best method in promoting the Diverse WA: Cultural Competency Training Program to WACHS staff.

Government policy requirements

Policy priority 2 - Culturally responsive policies, programs and services *(cont.)*

Strategy: Enable culturally diverse communities to have meaningful input into policies, programs and systems through co-design and planning, co-delivery and implementation, and evaluation processes by, creating opportunities for people from CaLD backgrounds to provide meaningful input into relevant policies, programs and services.

WACHS Action	Proposed Timeframe	Status	Outcomes achieved to date
District Health Advisory Council Members are involved in monitoring complaints and Care Opinion to ensure that WACHS strategies, policies and procedures relating to consumer input are inclusive and non-discriminatory.	June 2021	In development	Review of the WACHS policies and procedures associated with consumer feedback analysis, with the intent to promote inclusive behaviours among WACHS' employees.

Policy priority 3 - Economic, social, cultural, civic and political participation

Strategy: Implement recruitment and career development processes that support employment and progression of staff from CaLD backgrounds by, supporting career development for people from CaLD backgrounds in the workplace.

WACHS Action	Proposed Timeframe	Status	Outcomes achieved to date
Build on existing networks and expand current communication processes between WACHS and education service providers to promote employment opportunities at WACHS, with specific consideration for people from culturally and linguistically diverse backgrounds.	April 2021	In development	All advertised positions contain a standard diversity statement. WACHS continues to contribute to and expand its contribution to the WACHS-Curtin Alliance that focuses on supporting Aboriginal Health and Country and Regional Research.

Appendices

Appendix 1: WA Country Health Service contact details

WA COUNTRY HEALTH SERVICE (WACHS)

Street address: 189 Wellington Street, Perth WA 6000
Postal address: PO Box 6680, East Perth Business Centre WA 6892
Phone: (08) 9223 8500
Fax: (08) 9223 8599
Toll Free: 1800 629 028
Email: centralofficereception.WACHS@health.wa.gov.au
Web: www.wacountry.health.wa.gov.au

WACHS – GOLDFIELDS

Street address: The Palms, 68 Piccadilly Street, Kalgoorlie WA 6430
Postal address: PO Box 716, Kalgoorlie WA 6433
Phone: (08) 9080 5710
Fax: (08) 9080 5724
Email: WACHS-GoldfieldsExec@health.wa.gov.au

WACHS – GREAT SOUTHERN

Street address: 84 Collie Street, Albany WA 6330
Postal address: PO Box 252, Albany WA 6331
Phone: (08) 9892 2672
Fax: (08) 9842 2643
Email: gs.ces@health.wa.gov.au

WACHS – KIMBERLEY

Street address: U1 and 2, 29 Coghlan Street, Broome WA 6725
Postal address: Locked Bag 4011, Broome WA 6725
Phone: (08) 9195 2450
Fax: (08) 9192 5819
Email: KHS.ExecSecretary@health.wa.gov.au

WACHS – MIDWEST

Street address: Shenton Street, Geraldton WA 6531
Postal address: PO Box 22, Geraldton WA 6531
Phone: (08) 9956 2209
Fax: (08) 9956 2421
Email: CES.WACHS-Midwest@health.wa.gov.au

WACHS – PILBARA

Street address: Level 2, 34 Colebatch Way, South Hedland WA 6722
Postal address: PMB 12, South Hedland WA 6722
Phone: (08) 9174 1600
Fax: (08) 9173 3893
Email: Wachs-Pilbara.ExecutiveServices@health.wa.gov.au

WACHS – SOUTH WEST

Street address: Level 5, Bunbury Tower, 61 Victoria Street, Bunbury WA 6230
Postal address: PO Box 5301, Bunbury WA 6231
Phone: (08) 9781 2350
Fax: (08) 9781 2385
Email: execservices.wachssw@health.wa.gov.au

WACHS – WHEATBELT

Street address: Shop 4, 78 Wellington Street, Northam WA 6401
Postal address: PO Box 690, Northam WA 6401
Phone: (08) 9621 0700
Fax: (08) 9621 0701
Email: Wachs-WB.CES@health.wa.gov.au

Appendix 2: Boards and committees remuneration

WA COUNTRY HEALTH SERVICE BOARD

Table 51: Summary of all members that served on the WACHS Board committee for 2021-22

Position	Name	Type of remuneration	Period of membership	2021-22 Payments
Chair	Dr Neale Fong	Annual	12 months	$85,585.22
Deputy Chair	Wendy Newman	Annual	12 months	$45,971.07
Member	Alan Ferris *	Not Eligible	12 months	$0
Member	Paul Fitzpatrick	Annual	12 months	$45,971.07
Member	Dr Daniel Heredia	Annual	12 months	$45,971.07
Member	Kelly Howlett	Annual	12 months	$45,971.07
Member	Dr Kim Isaacs	Annual	12 months	$45,971.07
Member	Dr Diane Mohen	Annual	12 months	$45,971.07
Member	Mary Anne Stephens	Annual	12 months	$45,971.07
Member	Meredith Waters **	Annual	12 months	$13,084.07
Total				**$420,466.78**

Notes:
Includes superannuation
* As a local government employee, Board Member Alan Ferris is not eligible to receive remuneration for his role on the WACHS Board in accordance with Premier's Circular 2021/18.
** Ceased as a WACHS Board Member as at 30 September 2021.

Appendix 2: Boards and committees remuneration

WA COUNTRY HEALTH SERVICE HUMAN RESEARCH ETHICS COMMITTEE

Table 52: Summary of all members that served on the Human Research Ethics committee for 2021-22

Position	Name	Type of remuneration	Period of membership (months)	Gross/actual remuneration
Chairperson	Professor Alison Garton	Annual	4 months	$6101.00
Researcher	Dr Brennen Mills	Per Meeting	12 months	$618.00
Researcher	Associate Professor Anne Whitworth	Per Meeting	6 months	$618.00
Researcher	Dr Katrina Spilsbury	Per Meeting	12 months	$1236.00
Layperson	Tresslyn Maxine Smith	Per Meeting	12 months	$309.00
Layperson	Ruth Catherine Webb-Smith	Per Meeting	12 months	$927.00
Layperson	Dr Donald Barclay Reid	Per Meeting	12 months	$1236.00
Lawyer	Julia Barber	Per Meeting	12 months	$618.00
Lawyer	Eleanor Yates	Per Meeting	12 months	$618.00
Pastoral Care	Reverend Canon Geoffrey Paul Chadwick	Per Meeting	12 months	$1236.00
Professional Care	Natalie Rudling	Per Meeting	12 months	$618.00
Professional Care	Katrina Boldt	Per Meeting	12 months	$618.00
WACHS Aboriginal representative	Russell Grant Simpson	Not Eligible	12 months	$0
CEO Representative	Dr Peter Barratt	Not Eligible	12 months	$0
Total				**$14,753.00**

Appendix 2: Boards and committees remuneration

MEDICAL ADVISORY COMMITTEES

Table 53: Summary of all members that served on the Albany Hospital Medical Advisory Committee in 2021-22

Position	Name	Type of remuneration	Period of membership	Gross remuneration
Albany Hospital Medical Advisory Committee				
Chair	Dr Tom Bowles	Per Meeting	12 months	$0
Member	Dr Will MacDonald	Not Eligible	10 months	$0
Member	Dr Phillip Marmion	Not Eligible	12 months	$0
Member	Dr Kelly Ridley	Not Eligible	8 months	$0
Member	Dr Lynda Weir	Not Eligible	11 months	$0
Member	Dr Edward Yeboah	Not Eligible	12 months	$0
Member	Dr Josaphine Sadler	Not Eligible	5 months	$0
Ex-Officio Member	Jenny Thompson	Not Eligible	7 months	$0
Ex-Officio Member	Juan Clark	Not Eligible	5 months	$0
Ex-Officio Member	Paul Mark	Not Eligible	5 months	$0
Ex-Officio Member	Janine Watts	Not Eligible	6 months	$0
Ex-Officio Member	Barbara Marquand	Not Eligible	6 months	$0
Total				**$0**

Table 54: Summary of all members that served on the Blackwood Medical Advisory Committee in 2021-22

Position	Name	Type of remuneration	Period of membership	Gross remuneration
Blackwood Medical Advisory Council				
Chair	Dr Michael Hoar	Per Meeting	12 months	$1165.00
Member	Dr William Dewing	Per Meeting	12 months	$479.00
Member	Dr Gurpreet Singh	Per Meeting	12 months	$479.00
Member	Dr Jonathon Morling	Per Meeting	12 months	$958.00
Member	Dr Mildred Chiwara	Per Meeting	12 months	$0
Member	Dr Phillip De Ronchi	Per Meeting	12 months	$958.00
Member	CNM Boyup Brook	Not Eligible	12 months	$0
Member	CNM Nannup	Not Eligible	12 months	$0
Ex-Officio Member	Jeremy Higgins	Not Eligible	12 months	$0
Ex-Officio Member	Anne-Maree Martino	Not Eligible	12 months	$0
Ex-Officio Member	CNM Bridgetown	Not Eligible	12 months	$0
Total				**$4039.00**

Appendix 2: Boards and committees remuneration

Table 55: Summary of all members that served on the Bunbury Hospital Medical Advisory Committee in 2021-22

Position	Name	Type of remuneration	Period of membership	Gross remuneration
Bunbury Hospital Medical Advisory Committee				
Chair	Dr Stephen Hinton	Per Meeting	12 months	$0
Member	Dr Allen Chong	Not Eligible	12 months	$0
Member	Dr Jacinta Cover	Not Eligible	12 months	$0
Member	Dr Iain Gilmore	Not Eligible	12 months	$0
Member	Dr Nikhil Agrawal	Not Eligible	12 months	$0
Member	Dr Esther Knight-Terlouw	Not Eligible	12 months	$0
Member	Dr Parthasarathy Ramesh	Not Eligible	12 months	$0
Member	Dr Lila Stephens	Not Eligible	12 months	$0
Member	Dr Benjamin Cunningham	Not Eligible	12 months	$0
Member	Dr Stephen Hartwig	Not Eligible	12 months	$0
Member	Dr Bronwyn Bebee	Not Eligible	11 months	$0
Member (Proxy)	Dr Marten Howes	Not Eligible	6 months	$0
Member (Proxy)	Dr Geoff Hawking	Not Eligible	3 months	$0
Member (Proxy)	Dr Jason Pierce	Not Eligible	1 month	$0
Member	Dr Alison Newman	Not Eligible	4 months	$0
Member	Dr Stephanie Green	Not Eligible	7 months	$0
Member (Proxy)	Dr Anand Senthi	Not Eligible	1 month	$0
Member (Proxy)	Dr Mark Shea	Not Eligible	1 month	$0
Member	Dr Edid Ebrahim	Not Eligible	1 month	$0
Member	Dr Derek Wilson	Not Eligible	2 months	$0
Member (Proxy)	Dr Aine Tuohy	Not Eligible	1 month	$0
Member (Proxy)	Dr Koko Thaw	Not Eligible	1 month	$0
Ex-Officio Member and Member	Dr Altaf Khoja	Not Eligible	11 months	$0
Ex-Officio Invited Member	Lisa Smith	Not Eligible	5 months	$0
Ex-Officio Invited Member	Shane Bolton	Not Eligible	5 months	$0
Ex-Officio Member	Dr Elizabeth Tierney	Not Eligible	4 months	$0
Ex-Officio Invited Member	Rory Stemp	Not Eligible	1 month	$0
Ex-Officio Member	Dr Sergey Bibikov	Not Eligible	12 months	$0
Ex-Officio Member	Jeffery Calver	Not Eligible	12 months	$0
Ex-Officio Member	Dr Fiona Spencer	Not Eligible	8 months	$0
Total				**$0**

Appendix 2: Boards and committees remuneration

Table 56: Summary of all members that served on the Busselton Hospital Medical Advisory Committee in 2021-22

Position	Name	Type of remuneration	Period of membership	Gross remuneration
Busselton Hospital Medical Advisory Committee				
Chair	Dr Sarah Moore	Per Meeting	12 months	$1467
Member	Dr Stephen Arthur	Not Eligible	12 months	$0
Member	Dr Phil Chapman	Not Eligible	12 months	$0
Member	Dr Chandan Visweswar	Not Eligible	12 months	$0
Member	Dr Miles Earl	Not Eligible	12 months	$0
Member	Dr Mark Monaghan	Not Eligible	12 months	$0
Member	Dr Patrick Mulhern	Not Eligible	12 months	$0
Member	Dr Rachel Jackson	Not Eligible	12 months	$0
Member	Dr Werner Janse Van Rensburg	Not Eligible	12 months	$0
Ex-Officio	Jodie Omodei	Not Eligible	12 months	$0
Ex-Officio	Gaynor Taylor	Not Eligible	12 months	$0
Ex-Officio	Heather Thomson	Not Eligible	12 months	$0
Ex-Officio	Caroline Booker	Not Eligible	12 months	$0
Ex-Officio	Gemma Moyes	Not Eligible	12 months	$0
Ex-Officio	Dan Anderson	Not Eligible	12 months	$0
Ex-Officio	Karen Swallow	Not Eligible	12 months	$0
Ex-Officio	Jenny Hoskins	Not Eligible	12 months	$0
Ex-Officio	Peter Supanz	Not Eligible	12 months	$0
Ex-Officio	Clare Willix	Not Eligible	6 months	$0
Ex-Officio	Ursula Lavender	Not Eligible	12 months	$0
Ex-Officio	Brian Tucker	Not Eligible	12 months	$0
Ex-Officio	Chris Love	Not Eligible	12 months	$0
Ex-Officio	Darren Hawkes	Not Eligible	12 months	$0
Ex-Officio	Sarah De Klerk	Not Eligible	12 months	$0
Ex-Officio	Sarah Jovic	Not Eligible	12 months	$0
Total				**$1467.00**

Appendix 2: Boards and committees remuneration

Table 57: Summary of all members that served on the Carnarvon Hospital Medical Advisory Committee in 2021-22

Position	Name	Type of remuneration	Period of membership	Gross remuneration
Carnarvon Medical Advisory Committee				
Chair	Dr Geert Dijkwel	Not Eligible	12 months	$0
Member	Dr Batsi Chiureki	Not Eligible	11 months	$0
Member	Dr Etwell Mari	Not Eligible	6 months	$0
Member	Dr John Woodall	Not Eligible	12 months	$0
Member	Dr Allan Pelkowitz	Not Eligible	12 months	$0
Member	Grant Patrick	Not Eligible	9 months	$0
Member	Karen Horsley	Not Eligible	3 months	$0
Total				**$0**

Table 58: Summary of all members that served on the Central Great Southern Medical Advisory Committee in 2021-22

Position	Name	Type of remuneration	Period of membership	Gross remuneration
Central Great Southern Medical Advisory Committee				
Chair	Dr Nickie Du Preez	Per Meeting	12 months	$2640.00
Member	Dr Sam Patterson	Per Meeting	12 months	$1087.00
Member	Dr Emmon Mubbashir	Per Meeting	12 months	$0
Member	Dr Sam Weaver	Per Meeting	12 months	$0

Table 58: Summary of all members that served on the Central Great Southern Medical Advisory Committee in 2021-22 *(cont.)*

Position	Name	Type of remuneration	Period of membership	Gross remuneration
Central Great Southern Medical Advisory Committee				
Member	Dr Shapi Mukiapini	Per Meeting	12 months	$466.00
Member	Dr Wole Oluyede	Per Meeting	12 months	$0
Member	Dr Yuliya Novytska	Per Meeting	12 months	$310.00
Member	Dr Hayder Jumaah	Per Meeting	12 months	$466.00
Ex-Officio Member	Geraldine Ennis	Not Eligible	12 months	$0
Ex-Officio Member	Dr Paddy Glackin	Not Eligible	12 months	$0
Ex-Officio Member	Jenny Thompson	Not Eligible	5 months	$0
Ex-Officio Member	Trisha Power	Not Eligible	4 months	$0
Ex-Officio Member	Silvie Miczkova	Not Eligible	3 months	$0
Ex-Officio Member	Tina Jones	Not Eligible	5 months	$0
Ex-Officio member	Robyn Millar	Not Eligible	6 months	$0
Ex-Officio Member	Jean Daly	Not Eligible	12 months	$0
Ex-Officio Member	Claire Munch	Not Eligible	8 months	$0
Ex-Officio Member	Paul Totino	Not Eligible	12 months	$0
Ex-Officio member	Louise Hook	Not Eligible	12 months	$0
TOTAL				**$4969.00**

Appendix 2: Boards and committees remuneration

Table 59: Summary of all members that served on the Collie Medical Advisory Committee in 2021-22

Position	Name	Type of remuneration	Period of membership	Gross remuneration
Collie Medical Advisory Committee				
Chair	Dr Peter Wutchak	Per Meeting	12 months	$583.00
Member	Dr Adrian Lee	Per Meeting	12 months	$473.00
Member	Dr Jan Van Vollenstee	Per Meeting	12 months	$0
Member	Dr Shankar Paramaswaran	Per Meeting	12 months	$473.00
Member	Dr Alan Bosco	Per Meeting	12 months	$0
Member	Dr Marlene Oelofse	Per Meeting	12 months	$0
Member	Dr Emma Jones	Per Meeting	12 months	$0
Member	Dr Jeff Kallawk	Per Meeting	12 months	$0
Member	Dr Basudeb Saharay	Per Meeting	10 months	$0
Ex-Officio Member	Jeremy Higgins	Not Eligible	12 months	$0
Ex-Officio Member	Barry Moroney	Not Eligible	12 months	$0
Ex-Officio Member	Dan Mahony	Not Eligible	1 month	$0
Ex-Officio Member	Kate Kelly	Not Eligible	9 months	$0
Ex-Officio Member	Elaine Woodman	Not Eligible	12 months	$0
Total				**$1529.00**

Table 60: Summary of all members that served on the Denmark Medical Advisory Committee in 2021-22

Position	Name	Type of remuneration	Period of membership	Gross remuneration
Denmark Medical Advisory Committee				
Chair	Dr Brett Lamb	Per Meeting	12 months	$990.00
Member	Dr Virginia Longley	Per Meeting	12 months	$799.00
Member	Dr Christine Archer	Per Meeting	12 months	$799.00
Member	Dr Hector Faulkner	Per Meeting	12 months	$875.00
Member	Dr Oliver Angliss	Per Meeting	12 months	$160.00
Member	Dr Rob Money	Per Meeting	12 months	$160.00
Member	Dr Alex Sleeman	Per Meeting	12 months	$798.00
Ex-Officio Member	Dr Paddy Glackin	Not Eligible	12 months	$0
Ex-Officio Member	Jenny Thompson	Not Eligible	5 months	$0
Ex-Officio Member	Trisha Power	Not Eligible	4 months	$0
Ex-Officio Member	Silvie Miczkova	Not Eligible	3 months	$0
Ex-Officio Member	Julie Hollingworth	Not Eligible	12 months	$0
Ex-Officio Member	Kylie Spencer	Not Eligible	12 months	$0
Ex-Officio Member	Kym Cawthray	Not Eligible	12 months	$0
Total				**$4581.00**

Appendix 2: Boards and committees remuneration

Table 61: Summary of all members that served on the Donnybrook Hospital Medical Advisory Committee in 2021-22

Position	Name	Type of remuneration	Period of membership	Gross remuneration
Donnybrook Hospital Medical Advisory Committee				
Chair	Dr Wietske van der Velden Schuijling	Per Meeting	12 months	$591.00
Member	Dr Prathap Kaliaraj	Per Meeting	12 months	$0
Member	Dr Emily Hill	Per Meeting	12 months	$0
Ex-Officio Member	Barry Moroney	Not Eligible	12 months	$0
Ex-Officio Member	Daniel Mahony	Not Eligible	12 months	$0
Ex-Officio Member	CNM Donnybrook Hospital	Not Eligible	12 months	$0
Total				**$591.00**

Table 62: Summary of all members that served on the Eastern Wheatbelt Hospital Medical Advisory Committee in 2021-22

Position	Name	Type of remuneration	Period of membership	Gross remuneration
Eastern Wheatbelt Medical Advisory Committee				
Chair	Dr Peter Barratt	Not Eligible	12 months	$0
Member	Dr Jonathan Ruiz	Not Eligible	12 months	$0
Member	Dr Olumuyiwa Jegede	Not Eligible	12 months	$0
Member	Dr Ifeanyi-Chukwu Nwoko	Not Eligible	12 months	$0
Member	Dr Mirielsa Ruiz	Not Eligible	12 months	$0
Member	Zoe Ashby-Deering	Not Eligible	12 months	$0
Member	Dr Andrew Van Ballegooyen	Not Eligible	12 months	$0
Member	Dr Akeem Lawal	Not Eligible	12 months	$0
Member	Dr Jonathan Ruiz	Not Eligible	12 months	$0
Member	Diane Dixon	Not Eligible	3 months	$0
Member	Subin Daniel	Not Eligible	3 months	$0
Total				**$0**

Appendix 2: Boards and committees remuneration

Table 63: Summary of all members that served on the Esperance Medical Advisory Committee in 2021-22

Position	Name	Type of remuneration	Period of membership	Gross remuneration
Esperance Medical Advisory Committee				
Chair	Dr Jono Mbangani	Per Meeting	12 months	$0
Member	Dr John Spencer	Not Eligible	12 months	$0
Member	Dr Annette Hackett	Not Eligible	6 months	$0
Member	Dr Jeff Power	Not Eligible	6 months	$0
Member	Dr Karl Staer	Not Eligible	12 months	$0
Member	Dr Dale Bosenberg	Not Eligible	8 months	$0
Member	Dr Mark Mottershead	Not Eligible	12 months	$0
Member	Dr Richard Clingen	Not Eligible	12 months	$0
Member	Dr Toby Pearn	Not Eligible	12 months	$0
Member	Dr Andrew Marangou	Not Eligible	12 months	$0
Member	Dr Andrew DeGroot	Not Eligible	4 months	$0
Member	Dr Paul Ricciardo	Not Eligible	12 months	$0
Member	Dr Louise Pearn	Not Eligible	12 months	$0
Member	Dr Graham Jacobs	Not Eligible	12 months	$0
Member	Dr Mike Mears	Not Eligible	12 months	$0
Member	Dr Genevieve McPherson	Not Eligible	12 months	$0
Ex-Officio Member	Peter Tredinnick	Not Eligible	12 months	$0
Ex-Officio Member	Dr James Harris	Not Eligible	8 months	$0
Ex-Officio Member	Dr Sankha Mitra	Not Eligible	4 months	$0
Ex-Officio Member	Margaret Smillie	Not Eligible	12 months	$0
Ex-Officio Member	Donna Hindmarsh	Not Eligible	12 months	$0
Ex-Officio Member	Carla Jones	Not Eligible	12 months	$0
Total				**$0**

Table 64: Summary of all members that served on the Exmouth Medical Advisory Committee in 2021-22

Position	Name	Type of remuneration	Period of membership	Gross remuneration
Exmouth Medical Advisory Council				
Chair	Dr John Woodall	Not Eligible	12 months	$0
Chair	Dr Dawn Reeler	Not Eligible	10 months	$0
Member	Dr Hans Grobbelaar	Not Eligible	12 months	$0
Member	Dr Ayman Arnaouty	Not Eligible	12 months	$0
Total				**$0**

Appendix 2: Boards and committees remuneration

Table 65: Summary of all members that served on the Geraldton Medical Advisory Committee in 2021-22

Position	Name	Type of remuneration	Period of membership	Gross remuneration
Geraldton Medical Advisory Council				
Chair	Dr Angela Glen	Not Eligible	12 months	$0
Member	Dr Anita Banks	Not Eligible	12 months	$0
Member	Dr Caroline Haeusler	Not Eligible	12 months	$0
Member	Dr Ruth Highman	Not Eligible	12 months	$0
Member	Dr Nalini Rao	Not Eligible	12 months	$0
Member	Dr Damien Zilm	Not Eligible	9 months	$0
Member	Dr Duy Tran	Not Eligible	12 months	$0
Member	Dr Mat Coleman	Not Eligible	12 months	$0
Ex Officio Member	Dr Allan Pelkowitz	Not Eligible	12 months	$0
Ex Officio Member	Dr Katherine Templeman	Not Eligible	12 months	$0
Ex Officio Member	Dr Ranjit Paul	Not Eligible	12 months	$0
Ex Officio Member	Derek Fraser	Not Eligible	12 months	$0
Ex Officio Member	Dr Divine Verbe Njolah	Not Eligible	12 months	$0
Ex Officio Member	Di Franklin	Not Eligible	6 months	$0
Total				**$0**

Table 66: Summary of all members that served on the Kalgoorlie Medical Advisory Committee in 2021-22

Position	Name	Type of remuneration	Period of membership	Gross remuneration
Kalgoorlie Medical Advisory Committee				
Chair	Dr Sabu Thomas	Per Meeting	12 months	$0
Member	Dr Jonathan Tembo	Not Eligible	8 months	$0
Member	Dr Sean George	Not Eligible	12 months	$0
Member	Dr Colin McIver	Not Eligible	12 months	$0
Member	Dr Ljiljana Ilic-Jeftic	Not Eligible	6 months	$0
Member	Dr Tilo Amussen	Not Eligible	6 months	$0
Member	Dr Pushpika Gunaratne	Not Eligible	12 months	$0
Member	Dr Charles Douglas	Not Eligible	12 months	$0
Member	Dr David Chapman	Not Eligible	6 months	$0
Member	Dr Rosanna Ramos	Not Eligible	12 months	$0
Member	Dr Jo Keen	Not Eligible	12 months	$0
Ex-Officio Member	Peter Tredinnick	Not Eligible	12 months	$0
Ex-Officio Member	Dr James Harris	Not Eligible	8 months	$0
Ex-Officio Member	Dr Neill Kling	Not Eligible	6 months	$0
Ex-Officio Member	Dr Sankha Mitra	Not Eligible	4 months	$0
Ex-Officio Member	Scott Jones	Not Eligible	10 months	$0
Ex-Officio Member	Alicia Michalanney	Not Eligible	2 months	$0
Ex-Officio Member	Donna Hindmarsh	Not Eligible	12 months	$0
Ex-Officio Member	Donnie Martin	Not Eligible	12 months	$0
Total				**$0**

Appendix 2: Boards and committees remuneration

Table 67: Summary of all members that served on the Kimberley Regional Medical Advisory Committee in 2021-22

Position	Name	Type of remuneration	Period of membership	Gross remuneration
Kimberley Regional Medical Advisory Committee				
Member	Lydia Scott	Not Eligible	12 months	$0
Member	Kai Hellberg	Not Eligible	12 months	$0
Member	Jared Watts	Not Eligible	12 months	$0
Member	Vernon Powell	Not Eligible	12 months	$0
Member	Melanie Thompson	Not Eligible	12 months	$0
Member	Roland Main	Not Eligible	12 months	$0
Member	David Hailes	Not Eligible	12 months	$0
Member	Melanie Little	Not Eligible	12 months	$0
Member	Sebastian Rubinsztein-Dunlop	Not Eligible	12 months	$0
Member	Catherine Engelke	Not Eligible	12 months	$0
Member	Pippa May	Not Eligible	12 months	$0
Member	Sarah Straw	Not Eligible	12 months	$0
Member	Sascha Saharov	Not Eligible	12 months	$0
Member	Sheilnin Pisani	Not Eligible	12 months	$0
Member	David Woodward	Not Eligible	12 months	$0
Member	Christian Wium	Not Eligible	12 months	$0
Member	Davina Oates	Not Eligible	12 months	$0
Member	Brittney Wicksteed	Not Eligible	12 months	$0
Member	Yehuda Levy	Not Eligible	12 months	$0
Member	Bec Smith	Not Eligible	8 months	$0
Ex Officio	Suzanne Phillips	Not Eligible	12 months	$0
Ex Officio	Ruth Crawford	Not Eligible	3 months	$0
Ex Officio	Deirdre Murphy	Not Eligible	9 months	$0
Ex Officio	Manu John	Not Eligible	2 months	$0
Ex Officio	James Sherriff	Not Eligible	10 months	$0
Ex Officio	Nick Mildenhall	Not Eligible	12 months	$0
Ex Officio	Keda Bond	Not Eligible	9 months	$0
Ex Officio	Robyn Timms	Not Eligible	3 months	$0
Total				**$0**

Appendix 2: Boards and committees remuneration

Table 68: Summary of all members that served on the Margaret River Medical Advisory Committee in 2021-22

Position	Name	Type of remuneration	Period of membership	Gross remuneration
Margaret River Medical Advisory Committee				
Chair	Dr Cameron-Crothers Stomps	Per Meeting	3 months	$0
Chair	Dr Jaimie Drysdale	Per Meeting	9 months	$0
Senior Medical Officer	Dr Adam Bancroft	Not Eligible	2 months	$0
Senior Medical Officer	Dr Liam Walsh	Not Eligible	10 months	$0
Member	Dr Verelle Roocke	Not Eligible	12 months	$0
Member	Dr Ray Clarke	Not Eligible	12 months	$0
Member	Dr Cathy Milligan	Not Eligible	12 months	$0
Member	Dr Bob Bucat	Not Eligible	12 months	$0
Member	Dr Kirsty MacGregor	Not Eligible	12 months	$0
Member	Dr Shaun O'Rourke	Not Eligible	12 months	$0
Member	Dr Sharyn Bennier	Not Eligible	12 months	$0
Member	Dr Martin Ibach	Not Eligible	12 months	$0
Member	Dr Nathalie Maron	Not Eligible	12 months	$0
Member	Dr Louise Marsh	Not Eligible	12 months	$0
Member	Dr Gareth Mann	Not Eligible	12 months	$0
Member	Dr Richard Roddy	Not Eligible	12 months	$0
Member	Dr Rebecca Vernon	Not Eligible	12 months	$0
Member	Dr Fintan Andrews	Not Eligible	12 months	$0
Member	Dr Chris Thexton	Not Eligible	12 months	$0
Member	Dr Jaimie Drysdale	Not Eligible	4 months	$0
Member	Dr Kelsey Sweeney	Not Eligible	12 months	$0
Member	Dr Mike Frood	Not Eligible	12 months	$0
Member	Dr Callum Peet	Not Eligible	12 months	$0
Member	Dr Rachel Cryer	Not Eligible	5 months	$0
Member	Dr Liam Walsh	Not Eligible	10 months	$0
Member	Dr Heidi Tudehope	Not Eligible	12 months	$0
Member	Dr Ian McKellow	Not Eligible	12 months	$0
Member	Dr Simon Clough	Not Eligible	11 months	$0
Member	Dr Jonika Mosedale	Not Eligible	6 months	$0
Member	Dr Rebecca Pike	Not Eligible	4 months	$0
Ex-Officio Member	Jodie Omodei	Not Eligible	12 months	$0
Ex-Officio Member	Dr Stephen Arthur	Not Eligible	12 months	$0
Ex-Officio Member	Marie Tweedie	Not Eligible	12 months	$0
Ex-Officio Member	Sandy Znidarsich	Not Eligible	12 months	$0
Ex-Officio Member	Colin Bristow	Not Eligible	12 months	$0
Ex-Officio Member	Chris Love	Not Eligible	12 months	$0
Ex-Officio Member	Luke Fowles	Not Eligible	5 months	$0
Ex-Officio Member	Dane Hendry	Not Eligible	12 months	$0
Ex-Officio Member	Peter Supanz	Not Eligible	12 months	$0
Total				**$0**

Appendix 2: Boards and committees remuneration

Table 69: Summary of all members that served on the Plantagenet Cranbrook Health Service Medical Advisory Committee in 2021-22

Position	Name	Type of remuneration	Period of membership	Gross remuneration
Plantagenet Cranbrook Health Service Medical Advisory Committee				
Chair	Dr Victor Seah	Per Meeting	12 months	$194.00
Member	Dr Carol Fitzpatrick	Per Meeting	12 months	$0
Member	Dr Ligia Galvez	Per Meeting	12 months	$0
Member	Dr Laura Carija	Per Meeting	12 months	$0
Member	Dr Amanda Villis	Per Meeting	12 months	$0
Member	Dr Caitlen Growden	Per Meeting	12 months	$0
Ex-Officio Member	Dr Paddy Glackin	Not Eligible	12 months	$0
Ex-Officio Member	Jenny Thompson	Not Eligible	5 months	$0
Ex-Officio Member	Trisha Power	Not Eligible	4 months	$0
Ex-Officio Member	Silvie Miczkova	Not Eligible	3 months	$0
Ex-Officio Member	Julie Hollingworth	Not Eligible	12 months	$0
Ex-Officio Member	Kym Cawthray	Not Eligible	12 months	$0
Ex-Officio Member	Paul Entwistle	Not Eligible	12 months	$0
Ex-Officio Member	Sarah Willis	Not Eligible	12 months	$0
TOTAL				**$194.00**

Table 70: Summary of all members that served on the Pilbara Medical Advisory Committee in 2021-22

Position	Name	Type of remuneration	Period of membership	Gross remuneration
Pilbara Medical Advisory Committee				
Chair	Dr John Van Bockxmeer	Not Eligible	10 months	$0
Member	Dr Ganesan Sakarapani	Not Eligible	10 months	$0
Member	Dr Michael Birch	Not Eligible	10 months	$0
Member	Dr Rhoanna McNeil	Not Eligible	10 months	$0
Member	Dr Andrew Savery	Not Eligible	10 months	$0
Member	Dr Justin Withnall	Not Eligible	10 months	$0
Member	Dr Rolla (Bruce) Campbell	Not Eligible	8 months	$0
Member	Dr Crystal Claite	Not Eligible	10 months	$0
Member	Dr Brent Joubert	Not Eligible	10 months	$0
Member	Dr Yen Koh	Not Eligible	10 months	$0
Member	Dr Annie Lang	Not Eligible	10 months	$0
Member	Dr Sarah McEwan	Not Eligible	10 months	$0
Member	Dr Cynthia Leeuwin	Not Eligible	10 months	$0
Member	Dr Niran Bose	Not Eligible	10 months	$0
Member	Dr Sing Lok	Not Eligible	10 months	$0
Member	Dr Tadzoka Mangwana	Not Eligible	10 months	$0
Member	Dr Vafa Naderi	Not Eligible	10 months	$0
Member	Dr Daniel Saplontai	Not Eligible	10 months	$0

(cont.)

Appendix 2: Boards and committees remuneration

Table 70: Summary of all members that served on the Pilbara Medical Advisory Committee in 2021-22 *(cont.)*

Position	Name	Type of remuneration	Period of membership	Gross remuneration
Pilbara Medical Advisory Committee				
Member	Dr Wendy Sexton	Not Eligible	10 months	$0
Member	Dr Kate Poland	Not Eligible	10 months	$0
Member	Dr Shin Ng	Not Eligible	6 months	$0
Member	Dr Sathiaseelan (Peggie) Nair	Not Eligible	6 months	$0
Member	Dr Nikee Msuo	Not Eligible	8 months	$0
Member	Dr Chris Peyton	Not Eligible	9 months	$0
Member	Dr William Smith	Not Eligible	6 months	$0
Member	Dr Adriane Houghton	Not Eligible	3 months	$0
Member	Dr Prema Siva	Not Eligible	4 months	$0
Member	Dr Heather Lyttle	Not Eligible	10 months	$0
Member	Dr Danielle Scoones	Not Eligible	3 months	$0
Member	Dr Imran Qaisrani	Not Eligible	2 months	$0
Member	Dr Cherelle Fitzclarence	Not Eligible	10 months	$0
Member	Dr Graeme Fitzclarence	Not Eligible	10 months	$0
Member	Dr Lucas Speed	Not Eligible	2 months	$0
Member	Dr Tony Kierath	Not Eligible	6 months	$0
Member	Dr Sarah Gane	Not Eligible	2 months	$0
Member	Dr Paula Straatsma	Not Eligible	4 months	$0
Member	Dr Francois-Regis De Salve-Villedieu	Not Eligible	10 months	$0
Member	Dr Stephanie Krajniak	Not Eligible	10 months	$0
Member	Dr Gabrielle Fairfield-Boshuis	Not Eligible	3 months	$0
Member	Dr Nigel Hendrickson	Not Eligible	8 months	$0
Member	Dr Christopher Woods	Not Eligible	10 months	$0
Member	Dr Coert Kruger	Not Eligible	10 months	$0
Member	Dr Michael Langford	Not Eligible	10 months	$0
Member	Dr Igor Bezuglov	Not Eligible	3 months	$0
Member	Dr Min Min Moe	Not Eligible	10 months	$0
Member	Dr Edward Sibahi	Not Eligible	10 months	$0
Member	Dr Dong Wang	Not Eligible	10 months	$0
Member	Dr Debra Langford	Not Eligible	10 months	$0
Member	Dr Jessica Chee	Not Eligible	4 months	$0
Member	Dr Keng Koay	Not Eligible	8 months	$0
Ex-Officio Member	Margi Faulkner	Not Eligible	10 months	$0
Ex-Officio Member	Dr Nicolaas van Zyl	Not Eligible	10 months	$0
Ex-Officio Member	Yvonne Bagwell	Not Eligible	10 months	$0
Ex-Officio Member	Louise Steedman	Not Eligible	10 months	$0
Ex-Officio Member	Liam Avery	Not Eligible	10 months	$0
Ex-Officio Member	Alistair Pinto	Not Eligible	10 months	$0
Ex-Officio Member	Angus Burnett	Not Eligible	6 months	$0
Total				**$0**

Appendix 2: Boards and committees remuneration

Table 71: Summary of all members that served on the Ravensthorpe Health Service Medical Advisory Committee in 2021-22

Position	Name	Type of remuneration	Period of membership	Gross remuneration
Ravensthorpe Health Service Medical Advisory Committee				
Chair	Dr Paddy Glackin	Not Eligible	12 months	$0
Member	Dr Michael Livingston	Per Meeting	12 months	$319.00
Member	Dr Hermanus Lochner	Per Meeting	12 months	$0
Ex-Officio Member	Debra Eggleston	Not Eligible	6 months	$0
Ex-Officio Member	Leanne Laurie	Not Eligible	6 months	$0
Ex-Officio Member	Jenny Thompson	Not Eligible	5 months	$0
Ex-Officio Member	Trisha Power	Not Eligible	4 months	$0
Ex-Officio Member	Silvie Miczkova	Not Eligible	3 months	$0
Ex-Officio Member	Marnie Gilvray	Not Eligible	3 months	$0
Ex-Officio Member	Rachel Pages	Not Eligible	12 months	$0
Ex-Officio Member	Anne Gerick	Not Eligible	12 months	$0
Ex-Officio Member	Fleur Gilroy	Not Eligible	3 months	$0
Consumer representative	Ann Dunlop	Not Eligible	12 months	$0
TOTAL				**$319.00**

Table 72: Summary of all members that served on the Southern Wheatbelt Medical Advisory Committee in 2021-22

Position	Name	Type of remuneration	Period of membership	Gross remuneration
Southern Wheatbelt Medical Advisory Committee				
Chair	Dr Peter Smith	Not Eligible	12 months	$0
Member	Dr Brendon Parmar	Not Eligible	12 months	$0
Member	Dr Peter Maguire	Not Eligible	12 months	$0
Member	Dr Peter Barratt	Not Eligible	12 months	$0
Member	Dr Alan Kerrigan	Not Eligible	12 months	$0
Member	Dr Nicole Liesis	Not Eligible	12 months	$0
Member	Dr Clare Willix	Not Eligible	12 months	$0
Member	Catherine Milliner	Not Eligible	12 months	$0
Member	Dr Megan Hardie	Not Eligible	12 months	$0
Member	Dr Adenola Adeleye	Not Eligible	12 months	$0
Member	Dr Nnaemeka Exeorakwe	Not Eligible	12 months	$0
Member	Dr Peter Van Maarseveen	Not Eligible	12 months	$0
Member	Dr Coert Erasmus	Not Eligible	12 months	$0
Member	Dr Wynand Breytenbach	Not Eligible	12 months	$0
Member	Dr Olay Omoniyi	Not Eligible	12 months	$0
Member	Dr Ralph Chapman	Not Eligible	12 months	$0
Member	Dr Rhona Marques	Not Eligible	12 months	$0
Member	Dr Fauzan Rosli	Not Eligible	12 months	$0
Member	Dr Ilario Da Silva	Not Eligible	12 months	$0
Member	Dr Clare Hardie	Not Eligible	12 months	$0
Ex-Officio Member	Jenny Menasse	Not Eligible	12 months	$0
Ex-Officio Member	Kerry Fisher	Not Eligible	6 months	$0
Ex-Officio Member	Sara Pellant	Not Eligible	6 months	$0
Total				**$0**

Appendix 2: Boards and committees remuneration

Table 73: Summary of all members that served on the Warren Health Services Medical Advisory Committee in 2021-22

Position	Name	Type of remuneration	Period of membership	Gross remuneration
Warren Health Services Medical Advisory Council				
Chair	Dr John Davies	Per Meeting	12 months	$4078.00
Member	Dr Alison Turner	Not Eligible	12 months	$0
Member	Dr Mark Monaghan	Not Eligible	12 months	$0
Member	Dr Lillian Daniels	Not Eligible	12 months	$0
Member	Dr Casper Murove	Not Eligible	12 months	$0
Member	Dr Paul Griffiths	Per Meeting	12 months	$399.00
Member	Dr Peter Wutchak	Per Meeting	12 months	$240.00
Member	Dr Lynette Reid	Not Eligible	12 months	$0
Ex-Officio Member	Justine Kelly	Not Eligible	12 months	$0
Ex-Officio Member	Daniel Mahony	Not Eligible	12 months	$0
Ex-Officio Member	Clinical Nurse Manager Warren	Not Eligible	12 months	$0
Ex-Officio Member	Clinical Nurse Manager Pemberton	Not Eligible	12 months	$0
Total				**$4717.00**

Table 74: Summary of all members that served on the Western District Medical Advisory Committee in 2021-22

Position	Name	Type of remuneration	Period of membership	Gross remuneration
Western District Medical Advisory Council				
Co-Chair	Dr Anna Varone	Not Eligible	12 months	$0
Co-Chair	Dr Tony Mylius	Not Eligible	12 months	$0
Member	Dr Samer Al Mur	Not Eligible	12 months	$0
Member	Dr Gavin Osgarby	Not Eligible	12 months	$0
Member	Dr Damien Zilm	Not Eligible	12 months	$0
Member	Dr Marion Rae	Not Eligible	12 months	$0
Member	Dr Katherine Saunders	Not Eligible	12 months	$0
Member	Dr Peter Barratt	Not Eligible	12 months	$0
Member	Dr Azim Khan	Not Eligible	12 months	$0
Member	Dr Stephanie Spencer	Not Eligible	12 months	$0
Member	Dr Ajit Chaurasia	Not Eligible	12 months	$0
Member	Dr Femi Onikola	Not Eligible	12 months	$0
Ex-Officio Member	Trenton Greive	Not Eligible	12 months	$0
Ex-Officio Member	Jennifer Lee	Not Eligible	12 months	$0
Total				**$0**

Appendix 2: Boards and committees remuneration

DISTRICT HEALTH ADVISORY COUNCILS

Table 75: Summary of all members that served on the Blackwood District Health Advisory Council in 2021-22

Position	Name	Type of remuneration	Period of membership	Gross remuneration
Blackwood District Health Advisory Council				
Chair	Philippe Kaltenreider	Per Meeting	12 months	$0
Member	John Nicolas	Per Meeting	12 months	$0
Member	Liz Parker	Per Meeting	12 months	$0
Member	Cate Stevenson	Per Meeting	12 months	$356.00
Member	Kathryn Westphal	Per Meeting	12 months	$0
Member	Leonie Robinson	Per Meeting	12 months	$0
Ex-Officio	Jeremy Higgins	Not Eligible	12 months	$0
Ex-Officio	Anne-Maree Martino	Not Eligible	12 months	$0
Ex-Officio	Helen Stuart	Not Eligible	12 months	$0
Total				**$356.00**

Table 76: Summary of all members that served on the Broome District Health Advisory Council in 2021-22

Position	Name	Type of remuneration	Period of membership	Gross remuneration
Broome District Health Advisory Council				
Chair	Tracey-lee Chamberlain	Not Eligible	12 months	$0
Deputy Chair	Chris Mitchell	Not Eligible	12 months	$0
Member	Kaz Fitzpatrick	Not Eligible	12 months	$0
Member	Kuzi Sakupwanya	Not Eligible	12 months	$0
Member	Cheryl Ozies	Not Eligible	3 months	$0
Member	James Sherriff	Not Eligible	11 months	$0
Member	Millie Stewart	Not Eligible	12 months	$0
Member	Adam Vincent	Not Eligible	12 months	$0
Member	Hayley Moore	Not Eligible	3 months	$0
Total				**$0**

Appendix 2: Boards and committees remuneration

Table 77: Summary of all members that served on the Bunbury District Health Advisory Council in 2021-22

Position	Name	Type of remuneration	Period of membership	Gross remuneration
Bunbury District Health Advisory Council				
Chair	John Gardyne	Per Meeting	12 months	$1078.00
Member	Robert Blakeman	Per Meeting	12 months	$140.00
Member	Mary Dunlop	Per Meeting	12 months	$770.00
Member	Margaret Smith	Per Meeting	12 months	$770.00
Member	Newton Moore Students	Not Eligible	12 months	$0
Member	Nicole Campbell	Not Eligible	7 months	$0
Member	Wendy Botha	Not Eligible	12 months	$0
Member	Terri Hann	Not Eligible	12 months	$0
Member	Salena Linforth-Milham	Not Eligible	12 months	$0
Total				**$2758.00**

Table 78: Summary of all members that served on the Central Great Southern District Health Advisory Council in 2021-22

Position	Name	Type of remuneration	Period of membership	Gross remuneration
Central Great Southern District Health Advisory Council				
Co-Chair	Hilary Harris	Per Meeting	12 months	$1044.00
Co-Chair	Gladys Wells	Per Meeting	12 months	$750.00
Deputy Chair	Irene Farrow	Per Meeting	12 months	$595.00
Member	Norma Hersey	Per Meeting	12 months	$1566.00
Member	Pauline Roosendaal	Per Meeting	12 months	$1060.00
Member	Jill Mathwin	Per Meeting	12 months	$914.00
Member	Lesley Black	Per Meeting	12 months	$682.00
Member	Hafidah Eradat	Per Meeting	12 months	$88.00
Member	Lesley Pearson	Not Eligible	12 months	$0
Member	Jo Crooks	Not Eligible	12 months	$0
Member	Barbara Groves	Not Eligible	12 months	$0
Member	Chris Conning	Not Eligible	12 months	$0
Member	Robin Holstead	Not Eligible	12 months	$0
Ex-Officio Member	Geraldine Ennis	Not Eligible	12 months	$0
Ex-Officio Member	Jenny Thompson	Not Eligible	5 months	$0
Ex-Officio Member	Trisha Power	Not Eligible	4 months	$0
Ex-Officio Member	Silvie Miczkova	Not Eligible	3 months	$0
Ex-Officio Member	Tina Jones	Not Eligible	5 months	$0
Ex-Officio Member	Robyn Millar	Not Eligible	6 months	$0
Ex-Officio Member	Jean Daly	Not Eligible	12 months	$0
Ex-Officio Member	Claire Munch	Not Eligible	6 months	$0
Ex-Officio Member	Louise Hook	Not Eligible	12 months	$0
Ex-Officio Member	Pauline O'Connor	Not Eligible	12 months	$0
Ex-Officio Member	Jane Hung	Not Eligible	12 months	$0
Ex-Officio Member	Michelle Carrington	Not Eligible	12 months	$0
Ex-Officio Member	Amber Giblett	Not Eligible	12 months	$0
Total				**$6699.00**

Appendix 2: Boards and committees remuneration

Table 79: Summary of all members that served on the Derby District Health Advisory Council in 2021-22

Position	Name	Type of remuneration	Period of membership	Gross remuneration
Derby District Health Advisory Council				
Chair	Robyn Bowcock	Per Meeting	12 months	$825.00
Deputy Chair	Elsia Archer	Per Meeting	12 months	$385.00
Community Member	Vivienne Welch	Per Meeting	12 months	$385.00
Ex-Officio Member	Laura Webster	Not Eligible	12 months	$0
Ex-Officio Member	Haley Moore	Not Eligible	1 month	$0
Ex-Officio Member	Elliot Money	Not Eligible	8 months	$0
Ex-Officio Member	Sonia Tait	Not Eligible	8 months	$0
Ex-Officio Member	Marissa Randal	Not Eligible	12 months	$0
Ex-Officio Member	Shelly Kneebone	Not Eligible	12 months	$0
Ex-Officio Member	Peter McCumstie	Not Eligible	12 months	$0
Ex-Officio Member	Ruth Southern	Not Eligible	12 months	$0
Ex-Officio Member	Nick Mildenhall	Not Eligible	12 months	$0
Ex-Officio Member	Tracey Hepi	Not Eligible	12 months	$0
Ex-Officio Member	WK Quality Coordinator	Not Eligible	12 months	$0
Ex-Officio Member	Chris Wium	Not Eligible	12 months	$0
Total				**$1595.00**

Table 80: Summary of all members that served on the East Kimberley District Health Advisory Council in 2021-22

Position	Name	Type of remuneration	Period of membership	Gross remuneration
East Kimberley District Health Advisory Council				
Chair	Maxine Reid	Per Meeting	12 months	$132.00
Member	Lesley James	Not Eligible	12 months	$0
Member	Beverley Walley	Not Eligible	12 months	$0
Member	Denise Gallo	Not Eligible	12 months	$0
Member	Jean O'Reeri	Not Eligible	12 months	$0
Member	Tony Chafer	Not Eligible	12 months	$0
Member	Virginia O'Neil	Not Eligible	12 months	$0
Member	Terry Howe	Not Eligible	12 months	$0
Total				**$132.00**

Appendix 2: Boards and committees remuneration

Table 81: Summary of all members that served on the East Pilbara District Health Advisory Council in 2021-22

Position	Name	Type of remuneration	Period of membership	Gross remuneration
East Pilbara District Health Advisory Council				
Chair	Gloria Jacbo	Per Meeting	12 months	$1595.00
Member	Katie Norwell	Per Meeting	12 months	$0
Member	Natalie Middleton	Per Meeting	12 months	$0
Member	George Pitt	Per Meeting	12 months	$0
Member	Zabia Chmielewiski	Per Meeting	12 months	$0
Ex-Officio Member	Margi Faulkner	Not Eligible	12 months	$0
Ex-Officio Member	Louise Steedman	Not Eligible	12 months	$0
Ex-Officio Member	Simone McKinlay	Not Eligible	12 months	$0
Ex-Officio Member	Gan Sakarapani	Not Eligible	12 months	$0
Ex-Officio Member	Liz Starling	Not Eligible	12 months	$0
Ex-Officio Member	Jodie Morton	Not Eligible	12 months	$0
Ex-Officio Member	Anne Porter	Not Eligible	12 months	$0
Ex-Officio Member	Ha Pham	Not Eligible	12 months	$0
Total				**$1595.00**

Table 82: Summary of all members that served on the Eastern Wheatbelt District Health Advisory Council in 2021-22

Position	Name	Type of remuneration	Period of membership	Gross remuneration
Eastern Wheatbelt District Health Advisory Council				
Chair	Sandra Waters	Per Meeting	12 months	$0
Member	Subin Daniel	Per Meeting	3 months	$0
Member	Zoe Ashby-Deering	Per Meeting	12 months	$0
Member	Dianne Kelly	Per Meeting	12 months	$0
Member	Diane Dixon	Per Meeting	12 months	$0
Member	Janine Gliddon	Per Meeting	12 months	$0
Member	Jannah Stratford	Per Meeting	12 months	$0
Member	Jo Haythornthwaite	Per Meeting	3 months	$0
Member	Lyn White	Per Meeting	12 months	$0
Total				**$0**

Appendix 2: Boards and committees remuneration

Table 83: Summary of all members that served on the Gascoyne District Health Advisory Council in 2021-22

Position	Name	Type of remuneration	Period of membership	Gross remuneration
Gascoyne District Health Advisory Council				
Chair	Karen Horsley	Not Eligible	3 months	$0
Member	Merle Dann	Per Meeting	12 months	$140.00
Member	Jackie Cameron	Not Eligible	12 months	$0
Member	Joan Sedgwick	Not Eligible	12 months	$0
Member	John McCleary	Not Eligible	12 months	$0
Member	Sharon Jones	Not Eligible	12 months	$0
Member	Ashton Ryder	Not Eligible	6 months	$0
Member	Ainsley Hardie	Not Eligible	12 months	$0
Member	Mark Smith	Not Eligible	12 months	$0
Ex-Officio Member	Renee Gilbert	Not Eligible	12 months	$0
Ex-Officio Member	Dani Mladinov	Not Eligible	6 months	$0
Ex-Officio Member	Helen Webb	Not Eligible	12 months	$0
Total				**$140.00**

Table 84: Summary of all members that served on the Geraldton District Health Advisory Council in 2021-22

Position	Name	Type of remuneration	Period of membership	Gross remuneration
Geraldton District Health Advisory Council				
Chairperson	Donald Rolston	Per Meeting	12 months	$490.00
Member	Margaret Pike	Per Meeting	12 months	$280.00
Member	Merrilyn Agnew	Per Meeting	12 months	$0
Member	Desda Buckle	Per Meeting	4 months	$0
Member	Lee-Anne Taylor	Per Meeting	4 months	$0
Member	Glenn Jones	Per Meeting	12 months	$0
Total				**$770.00**

Appendix 2: Boards and committees remuneration

Table 85: Summary of all members that served on the Goldfields District Health Advisory Council in 2021-22

Position	Name	Type of remuneration	Period of membership	Gross remuneration
Goldfields District Health Advisory Council				
Chair	Keith Cowan	Per Meeting	12 months	$586.00
Deputy Chair	Haylie Dowson	Per Meeting	12 months	$1146.00
Member	Kirsty McCluskey	Per Meeting	12 months	$464.00
Member	Diane Paddon	Per Meeting	12 months	$429.00
Member	Margaret Christie	Per Meeting	12 months	$0
Member	Debbie Van Luxemborg	Per Meeting	12 months	$219.00
Member	Greg Baxter	Per Meeting	12 months	$586.00
Member	Natasha Edgecombe	Per Meeting	12 months	$350.00
Member	Frank Andinach	Per Meeting	12 months	$621.00
Member	Cheryl Cotterill	Per Meeting	7 months	$0
Total				**$ 4401.00**

Table 86: Summary of all members that served on the Leschenault Wellington District Health Advisory Council in 2021-22

Position	Name	Type of remuneration	Period of membership	Gross remuneration
Leschenault Wellington District Health Advisory Council				
Chair	Colin Beauchamp	Per Meeting	12 months	$0
Deputy Chair	Geoff Wilks	Per Meeting	12 months	$0
Deputy Chair	Ann Clifford	Per Meeting	12 months	$0
Member	Ann Briggs	Per Meeting	12 months	$0
Member	Thomas Reardon	Per Meeting	8 months	$0
Member	Michelle Smith	Per Meeting	12 months	$0
Member	Robyn Coleman	Per Meeting	12 months	$0
Member	Fresina Pierina	Per Meeting	12 months	$0
Member	Johanna Jasper	Per Meeting	12 months	$0
Member	Ian Miffling	Per Meeting	6 months	$0
Total				**$0**

Appendix 2: Boards and committees remuneration

Table 87: Summary of all members that served on the Lower Great Southern District Health Advisory Council in 2021-22

Position	Name	Type of remuneration	Period of membership	Gross remuneration
Lower Great Southern District Health Advisory Council				
Chair	Sue Etherington	Per Meeting	12 months	$0
Member	Denise Kay	Per Meeting	12 months	$0
Member	Ruth Ainscough	Per Meeting	6 months	$0
Member	Beverly Brooks	Per Meeting	12 months	$0
Member	Diane Gray	Per Meeting	11 months	$0
Member	Libby Foster	Per Meeting	9 months	$0
Member	Edward Szydlowski	Per Meeting	8 months	$70.00
Member	Russell Nelson	Per Meeting	7 months	$0
Member	Jo Crook	Per Meeting	12 months	$0
Ex-Officio Member	Jenny Thompson	Not Eligible	7 months	$0
Ex-Officio Member	Juan Clark	Not Eligible	5 months	$0
Ex-Officio Member	Fleur Gilroy	Not Eligible	6 months	$0
Ex-Officio Member	Amber Giblett	Not Eligible	12 months	$0
Total				**$70.00**

Table 88: Summary of all members that served on the Midwest District Health Advisory Council in 2021-22

Position	Name	Type of remuneration	Period of membership	Gross remuneration
Midwest District Health Advisory Council				
Chairperson	Graeme Bedford	Per Meeting	12 months	$0
Vice Chairperson	Noel Fallen	Per Meeting	12 months	$280.00
Member	Merle Isbister	Per Meeting	12 months	$280.00
Member	Iris Annear	Per Meeting	12 months	$210.00
Member	Joanne Hirsch	Per Meeting	12 months	$140.00
Member	Steph Bligh-Lee	Per Meeting	12 months	$280.00
Total				**$1190.00**

Appendix 2: Boards and committees remuneration

Table 89: Summary of all members that served on the Naturaliste District Health Advisory Council in 2021-22

Position	Name	Type of remuneration	Period of membership	Gross remuneration
Naturaliste District Health Advisory Council				
Chair	Elizabeth Jones	Per Meeting	12 months	$0
Member	Tanya Gillett	Per Meeting	12 months	$0
Member	Yen Hawkes	Per Meeting	12 months	$0
Member	Max Kewish	Per Meeting	12 months	$0
Member	Kenneth May	Per Meeting	12 months	$447.00
Member	Lorrae Loud	Per Meeting	12 months	$281.00
Member	Jennifer Richards	Per Meeting	12 months	$663.00
Member	Amanda Bell	Per Meeting	12 months	$0
Member	Dr Claire Langdon	Per Meeting	6 months	$0
Total				**$1391.00**

Table 90: Summary of all members that served on the Southern Wheatbelt District Health Advisory Council in 2021-22

Position	Name	Type of remuneration	Period of membership	Gross remuneration
Southern Wheatbelt District Health Advisory Council				
Chairperson	Lindsay Smoker	Per Meeting	12 months	$0
Member	Geoff Hodgson	Per Meeting	12 months	$0
Member	Debrah Clarke	Per Meeting	9 months	$0
Member	Raylene Storey	Per Meeting	12 months	$0
Member	Frank Heffernan	Per Meeting	12 months	$0
Member	Amanda Milton	Per Meeting	10 months	$0
Member	Dorothy Trefort	Per Meeting	12 months	$0
Member	Rose Ballard	Per Meeting	12 months	$0
Member	Cr Murray Fisher	Per Meeting	4 months	$0
Member	Cr Brian Seale	Per Meeting	7 months	$0
Member	Cr Tamara Alexander	Per Meeting	8 months	$0
Member	Stan Sherry	Per Meeting	12 months	$0
Total				**$0**

Appendix 2: Boards and committees remuneration

Table 91: Summary of all members that served on the Warren District Health Advisory Council in 2021-22

Position	Name	Type of remuneration	Period of membership	Gross remuneration
Warren District Health Advisory Council				
Chair	Gordon Smith	Per Meeting	12 months	$2737.00
Member	Kathy Yovkoff	Per Meeting	12 months	$490.00
Member	Jodi Johnston	Per Meeting	12 months	$0
Member	Wayne Herdigan	Per Meeting	12 months	$0
Vice Chair	Susan Priddis	Per Meeting	12 months	$0
Member	Susan Griffiths	Per Meeting	12 months	$0
Total				**$3227.00**

Table 92: Summary of all members that served on the Western District Health Advisory Council in 2021-22

Position	Name	Type of remuneration	Period of membership	Gross remuneration
Western District Health Advisory Council				
Chairperson	Irene Mills	Per Meeting	12 months	$567.00
Member	Julie Chester	Per Meeting	6 months	$105.00
Member	Michelle Cockman	Per Meeting	12 months	$175.00
Member	Julian Krieg	Per Meeting	12 months	$455.00
Member	Georgina MacIntosh	Per Meeting	6 months	$210.00
Member	Cynthia McMorran	Per Meeting	12 months	$350.00
Member	Keith Murray	Per Meeting	12 months	$385.00
Member	Sandra Randall	Per Meeting	12 months	$175.00
Member	Michelle Thompson	Per Meeting	12 months	$455.00
Member	Patricia Walters	Per Meeting	12 months	$315.00
Member	Dianne Kelly	Per Meeting	12 months	$210.00
Member	Rob Fraser	Per Meeting	12 months	$350.00
Total				**$3752.00**

Appendix 3: References and data sources

Table 93: Summary all references and data sources

Page	Source
12-15	**Executive Summary** Australian Bureau of Statistics Estimated Residential Population Data (2021 – Catalogue No. 3235.0 – Regional Population by Age and Sex, Population Estimates by Age and Sex, Local Government Areas (ASGS 2021), 2022. Note: 2020 Aboriginal population figures based on proportions reported in 2016 ABS Estimated Residential Population Data as data by regions is not yet available for 2021. Emergency Department Attendances – Emergency Department Data Collection, Purchasing and System Performance Division, Department of Health WA, extracted on 25 August 2022. Admissions and Discharges – Hospital Morbidity Data Collections (HMDC) and Wait List Data Collection, extracted on 25 August 2022. Births in Country Hospitals – HMDC and Wait List Data Collection, extracted on 25 August 2022. Elective Surgery Waitlist patients seen – HMDC and Wait List Data Collection, extracted on 25 August 2022, (Elective Surgery Wait List reportable (surgical) cases as per the reference document ESWLDC Commonwealth Non-reportable Procedures). Outpatient appointments – Non-admitted Patient Activity and Wait List Data Collection (NAPAAWL DC) extracted on 12 August 2022.
60-61	**Consumer Feedback** www.careopinion.org.au extracted on 15 August 2022.
64-67	**Our COVID Response** VaccinateWA, Vaccines Administered, and PCR tests administered extracted on 26 August 2022.

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