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

Metropolitan Health Service
Annual Report 2015–16

better health • better care • better value

Metropolitan Health Service

Annual Report 2015–16

North Metropolitan Health Service
South Metropolitan Health Service
Child and Adolescent Health Service
Dental Health Service
PathWest Laboratory Medicine

Statement of compliance

HON MR JOHN DAY BSc BDSc MLA
MINISTER FOR HEALTH

In accordance with section 63 of the *Financial Management Act 2006*, I hereby submit for your information and presentation to Parliament, the final Annual Report of the Metropolitan Health Service for the financial year ended 30 June 2016.

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

As on 1 July 2016, the Metropolitan Health Service as it was previously constituted under the *Hospital and Health Services Act 1927* section 15 was abolished and the Minister for Health ceased to have management and control of any hospital in the Metropolitan Health Service. This report is submitted, signed by the Reporting Officer, Dr David Russell-Weisz, Director General of the Department of Health, as appointed by the Treasurer under section 68(1) of the *Financial Management Act 2006*.

Dr D J Russell-Weisz
DIRECTOR GENERAL
DEPARTMENT OF HEALTH
REPORTING OFFICER

15 September 2016

Contents

Overview of agency

Vision statement

Vision

To deliver a safe, high quality, sustainable health system for all Western Australians.

Values

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

Our values are:

Priorities

Our strategic priorities are focused on a continuum of care to support and guide health care through integrated service delivery from prevention and health promotion, early intervention, primary care through to diagnosis, treatment, rehabilitation and palliation.

Ensuring people in Western Australia receive safe, high quality and accessible health services underpins our strategic priorities. This includes delivering health services that are patient centred, based on evidence and within a culture of continuous improvement.

WA Health's strategic priorities are:

1. Prevention and Community Care Services
2. Health Services
3. Chronic Disease Services
4. Aboriginal Health Services.

Executive summary

The 2015–16 financial year marked the end of an era for WA Health, as the health system made preparations to move away from a centralised governance structure and embrace a devolved structure as of 1 July 2016.

Guided by the *WA Health Reform Program 2015–2020*, WA Health spent 2015–16 planning for the transition to the new governance arrangements, which will support the ongoing sustainability and performance of the health system, and make it more responsive to local communities.

Central to the new structure was the passing of the *Health Services Act 2016*, which received Royal Assent on 26 May 2016.

The new legislation allowed for the creation of five Health Service Providers as separate statutory authorities, governed by Boards, which are legally responsible and accountable for the oversight of hospital and health service delivery in their area. This included the creation of the new East Metropolitan Health Service.

The Health Information Network, Health Corporate Network and Health Supply Network were also amalgamated as Health Support Services which from 1 July 2016 was created as a non-Board governed Health Service Provider.

The legislation also established the Department of Health as the 'System Manager', responsible for the overall management, performance and strategic direction of WA Health.

Also in 2015–16, the *Mental Health Act 2014* was enacted and the long-awaited *Public Health Bill 2014* passed through Parliament, replacing 100-year-old legislation and introducing a contemporary approach to managing public health.

In addition, the State's $7 billion infrastructure program continued its success, with the opening of the 307-bed St John of God Midland Public Hospital, which replaced the outdated Swan District Hospital.

Significant headway was also made in preparation for the opening of the new Perth Children's Hospital in the coming months.

Information and Communications Technology (ICT) service delivery was also improved with the upgrade of more than 90 per cent of WA Health's computer fleet and the establishment of an Incident Management Triage team to provide a 24-hour a day, seven-day-a-week, on-call facility for hospital staff requiring assistance with an ICT issue.

Roll-out of core clinical applications continued and the Psychiatric Online Information System was upgraded to support the implementation of changes to the *Mental Health Act 2014*. A contract was also awarded for the implementation of a new Laboratory Information System to support the delivery of pathology services.

The most notable achievement of 2015–16, however, was the way in which WA Health's professional, 42,000-strong workforce continued to excel at its core business of delivering world-class health care to the people of Western Australia, while also meeting increasing demand on the system.

In 2015–16 WA Health managed:

- more than 562,000 inpatient separations, an increase of 25,000 on the previous year
- more than one million emergency department attendances, an increase of 20,000 on the previous year
- more than 2.4 million outpatient occasions of service – an increase of 145,000 on the previous year.

WA Health also performed well for the community against the four strategic priorities outlined in the *WA Health Strategic Intent 2015–2020*: Prevention and Community Care Services; Health Services; Chronic Disease Services; and Aboriginal Health Services.

Prevention and Community Care Services

The Metropolitan Health Service delivers a number of prevention programs, focusing on the health and wellbeing of whole populations. These programs include comprehensive health education, disease control, public health and mental health services to people living in the metropolitan region.

In 2015–16, Child Health Services continued to offer a universal schedule of child health and developmental assessments to every child in the metropolitan area at the key developmental ages of 0–10 days, 6–8 weeks, 3–4 months, 8 months, 18 months and three years. In addition, School Health Services promoted improved health outcomes for school aged children and young people using a population-based approach to universal and targeted prevention, health promotion, and early identification and intervention for children and adolescents in schools.

The Child and Adolescent Community Health Service also ran a range of programs targeting vulnerable families including: the Best Beginnings Program – a voluntary, structured, home-visiting service for families with additional risk factors; and the Refugee Health Team, which assists transitioning families to access local health services, and helps young children enter the community health Universal Contract Schedule.

The Perth metropolitan Child Development Service provided community-based allied health and developmental paediatric services to children (0–16 years of age) with, or at risk of, developmental delays such as speech or motor delays. Services included:

- Parent workshops
- Home and school programs
- Individual or group intervention sessions.

Also in 2015–16, two new dental clinics opened in the metropolitan area to address the increase in children eligible for treatment via the School Dental Service.

The South Metropolitan Health Service sites providing mental health services introduced Mental Health Assessment Treatment Teams and Community Treatment Teams to enable timely community access to, and supported discharge from, mental health facilities. These teams improve the quality of mental health services provided to patients accessing mental health services. In addition, the Individual Placement and Support program implemented at Fremantle Hospital and Health Service, Armadale Health Service and Bentley Health Service continued to help mental health clients find employment according to their strengths and abilities.

Other mental health initiatives across the metropolitan region included:

- The one-year anniversary of Touchstone, the metropolitan area's integrated, multi-disciplinary specialist mental health service for 12 to 16-year-olds
- The establishment of the Child and Adolescent Mental Health Specialist Aboriginal Mental Health Service
- Co-location of Ward 4H at Princess Margaret Hospital (PMH) to Bentley Adolescent Unit, ahead of the move to Perth Children's Hospital.
- Full implementation of 69 out of 83 recommendations for the Child and Adolescent Health Service in the 'Stokes Report'.

PathWest worked with Health Care Infection Council of WA to reduce hospital acquired infections, and contributed to implementing the Models of Care for HIV, Hepatitis C and sexually transmitted infections.

Also, in 2015-16, North Metropolitan Health Service (NMHS) Public Health and Ambulatory Care achieved 'Gold workplace recognition' from Healthier Workplace WA for its wellness at work program. The program, designed to create healthier, happier and more supportive workplace environments, increased awareness of the benefits of implementing health lifestyle behaviours.

NMHS also collaborated with the City of Bayswater to identify priority areas for a new Public Health Plan in its geographic area.

Health Services

The new 307-public bed St John of God Midland Public Hospital opened its doors on 24 November 2015. The new hospital, operated by St John of God Health Care, is Western Australia's third public-private hospital partnership. It provides a comprehensive range of services, enabling higher acuity and more complex clinical care to be delivered locally. Swan District Hospital closed after serving the community for more than 61 years to make way for the new hospital.

Also in 2015–16, the $15 million Telethon Children's Ward at Joondalup Health Campus opened. The ward, which is double the size of its predecessor, offers the latest in technology and design to benefit children and their families.

Fiona Stanley Hospital (FSH) celebrated its first year of operation in February 2016, with some impressive statistics regarding the amount of service it provided to the community. For example, more than 100,000 patients were treated in the FSH emergency department, an average of 275 a day; 40,000 people were admitted as inpatients; and 22,600 surgeries were performed – 12,600 of which were elective.

FSH also:

- became the first hospital in Western Australia to implement the Pharmacy Automation solution, resulting in improved patient safety, increased efficiencies and enhanced medication governance
- became the first Intensive Care Unit in Western Australia to provide an integrated, paperless and automated charting system called the Intensive Care Unit Clinical Information System
- installed a fourth linear accelerator at the FSH Cancer Centre, enabling more patients to receive radiation treatment.

Rockingham General Hospital celebrated 40 years of service – and joined Armadale Health Service in further developing services and treating patients requiring more complex care.

In 2015–2016, significant planning continued in preparation for the opening of the Perth Children's Hospital (PCH). More than 1,400 Princess Margaret Hospital staff, volunteers and representatives of non-government organisations participated in a seven-week site tour program. Reform programs were undertaken to support the upcoming move to the new hospital, such as the reconfiguration of wards at PMH to facilitate the introduction of a short-stay surgical model and alignment with the ward configuration at PCH.

A number of new ICT systems were implemented across Child and Adolescent Health Service (CAHS) to streamline communications and prepare for the move to PCH, such as the 'iLearn' Learning Management System; the Notification and Clinical Summary System (NaCS); and eDiet/CBORD – an electronic dietary requirements package that also addresses the safety requirements of documenting and tracking allergy alert information.

Progress was also made in planning for the State Quadriplegic Centre, as well as the divestment of Graylands Hospital by 2025.

Also in 2015–16:

- PMH launched a database for the Child Protection Unit to enable more efficient and timely reporting to health and other professionals
- Fremantle Hospital began to provide an additional 881 endoscopy procedures for over-boundary patients across the metropolitan area
- PathWest rolled out 2D identification patient bands at Sir Charles Gairdner and King Edward Memorial Hospitals in preparation for the roll-out of eOrder. Together these increase positive patient identification when collecting pathology samples.
- A Gender Diversity Service was established within CAHS.

PathWest realigned referred pathology work from the South Metropolitan Health Service (SMHS) hospitals to the Fiona Stanley Hospital hub laboratory. Providing more timely reporting of referred pathology from SMHS general/secondary hospitals.

In addition, the NMHS prepared for the transfer of Kalamunda Hospital and some of its community-based services to the South and East Metropolitan Health Services. It also undertook necessary preparations for the continuation of contract management for the St John of God Midland Public Hospital, up until its transfer to the East Metropolitan Health Service on 1 July 2016.

Chronic Disease Services

Chronic diseases are the main cause of death and illness in the metropolitan area, and are strongly associated with lifestyle risk factors, such as smoking, physical inactivity, poor diet, and being overweight and obese.

Metropolitan Health Services target chronic disease through prevention programs in areas such as such as tobacco control, health literacy, physical activity and healthy eating.

BreastScreen WA opened a new clinic in Wanneroo, providing easier access to screening mammograms for local women through an additional screening unit, enhanced parking, and public transport and disability access.

This year also saw the launch of the *WA Rare Diseases Strategic Framework and Implementation Plan 2015–2018*. The first of its kind in Australia, this Framework is a comprehensive plan for improving the health and wellbeing of people living with a rare disease, enabling more timely diagnosis and better integrated care.

PathWest developed and implemented new genetic testing using Next Generation Sequencing to provide early detection of auto-inflammatory disease. It also developed a better diagnostic service for patients with possible immunodeficiency.

The Dental Health Service played an important role in preventing major chronic disease and maintaining the health of vulnerable populations across WA. Some of its initiatives in 2015–16 included:

- partnerships with Aboriginal Community Controlled Health Organisations and the Royal Flying Doctor Service to provide dental services in rural and remote areas.
- subsidised treatment for health care card and pensioner concession card holders
- partnerships with mental health services to develop a model for delivering oral health to mental health consumers, with a pilot program underway to examine the oral health of mental health patients as part of their physical health check.
- emergency dental treatment provided to Corrective Services patients.

In addition, the first phase of the Institute for Social Inclusion opened at Royal Perth Hospital in June 2016 to address the health care needs of homeless people and to ensure that upon discharge the patients have the greatest chance of being housed with the required support mechanism in place.

Aboriginal Health Services

The Metropolitan Health Service continues to support and invest in the delivery of services and programs that seek to close the gaps in the health and wellbeing of Aboriginal people. In 2015–16, the South Metropolitan Health Service delivered a number of programs aimed at addressing the key issues and improving health outcomes for Aboriginal people, such as:

- Moorditj Djena – a mobile community outreach service providing chronic disease assessment, diabetes education and podiatry services
- Journey of Living with Diabetes – an Aboriginal diabetes health education program delivered through residential workshops and 10-weekly programs across SMHS
- Nidjalla Waangan Mia (Aboriginal Health and Wellbeing Centre Mandurah) – primary health care services and health promotion programs for Aboriginal people living in the Peel area.
- Aboriginal Maternity Group Practice Program – a community-based maternity service that provides an Aboriginal Health Officer and Grandmother.

The NMHS partnered with Nyoongar Wellbeing and Sports Association to increase participation of Aboriginal people in physical activity and healthy eating, resulting in 55 Aboriginal people participating in the 2015 City to Surf event through the initiative.

PathWest introduced a training scholarship program for Aboriginal applicants to study Certificate III in Pathology in order to diversify its frontline workforce and strengthen and improve services to the Aboriginal people of WA.

Sir Charles Gairdner Hospital, in conjunction with the WA Chamber of Commerce and Industry, ran a pilot initiative which employed 26 Aboriginal people on six-month contracts in patient support roles, giving them experience to better position them for future employment opportunities.

Dental Health Service had a six per cent increase in Aboriginal patient attendance at clinics compared to last financial year.

Also, in 2015–16, a comprehensive evaluation of the statewide Specialised Aboriginal Mental Health Service began to give consideration to extending funding beyond June 2017. The Service helps to address the mental health needs of Aboriginal people throughout Western Australia.

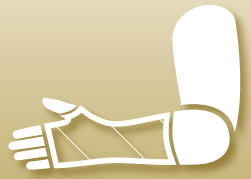
The Child and Adolescent Community Health Service Aboriginal Health Team (AHT) provided culturally appropriate and secure services to the Aboriginal community across the Perth metropolitan area. The AHT provided additional support to families through targeted and intensive services, specifically designed for vulnerable families. Services focused on children, adolescents, young people and their families who are socially or economically disadvantaged. These groups include migrants, refugees, culturally and linguistically diverse groups and Aboriginal people.

The North, South and Child and Adolescent Health Services – along with the newly established East Metropolitan Health Service – enter the new year keen to consolidate and build upon the reforms and achievements of 2015–16.

Metropolitan WA at a glance

In metropolitan WA a male is expected to live to **81.5** years of age and female to **86.2** years of age

428,771
discharges from a metropolitan public hospital in 2015



1,737
people on any day will present to a metropolitan emergency department

1,342
deaths in metropolitan WA are caused by coronary heart disease

9,661
people in metropolitan WA were diagnosed with cancer in 2014

43,386
people were treated by a WA metropolitan specialised public mental health service in 2015

44.1%
of all potentially preventable hospitalisations in metropolitan WA were due to chronic conditions

60.3%
of WA children living in the metropolitan area do not undertake sufficient physical activity

25.6%
of adults living in the metropolitan area are obese

92.1%
of adults living in the metropolitan area do not eat 2 serves of fruit and 5 serves of vegetables daily

317,789
WA school children were enrolled in the school dental service in 2015

120,000
WA women have a mammogram each year to screen for breast cancer

Operational structure

Enabling legislation

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

Administered legislation

Please refer to the *Department of Health's Annual Report 2015–16* for administered legislation.

Accountable authority

The Director General of Health, Dr David Russell-Weisz, was the reporting officer for the Metropolitan Health Service in 2015–16.

Responsible Minister

The Metropolitan Health Service is responsible to the Minister for Health, the Hon. John Day.

WA Health structure

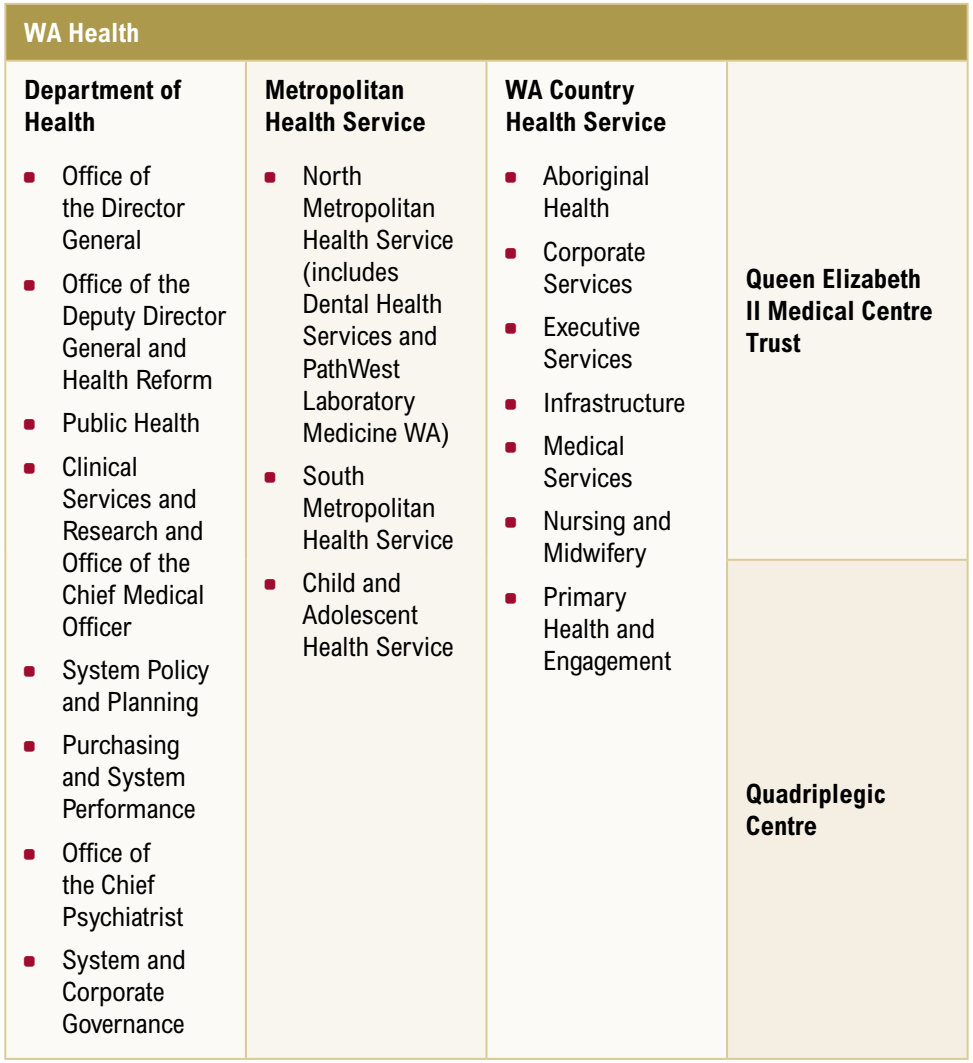
WA Health encompasses five health service areas:

1. Department of Health
2. Metropolitan Health Service
3. WA Country Health Service
4. Quadriplegic Centre
5. Queen Elizabeth II Medical Centre Trust (see Figure 1).

Each service area is composed of health service providers and/or support service providers. The Quadriplegic Centre and the Queen Elizabeth II Medical Centre Trust are responsible for submitting their own annual reports.

The WA Health structure is displayed in Figure 1.

Figure 1: **WA Health structure**



Metropolitan Health Service management structures

In 2015–16 the Metropolitan Health Service consisted of three separate entities, the North Metropolitan Health Service, South Metropolitan Health Service, Child and Adolescent Health Service. The management structure for each respective entity is provided in Figures 2 to 4.

The Metropolitan Health Service Chief Executives are also on the State Health Executive Forum that advises the Director General. For information and the management structure of the State Health Executive Forum, please refer to the *Department of Health Annual Report 2015–16*.

Figure 2: **North Metropolitan Health Service management structure**

Minister for Health

Director General

Chief Executive

Executive Director Sir Charles Gairdner Osborne Park Group	**Executive Director** Swan Kalamunda Health Service and Contract Management and Procurement	**Executive Director** Clinical Planning and Redevelopment
Executive Director Mental Health	**Executive Director** Medical Services (0.5 FTE)	**Executive Director** Safety, Quality and Performance
Executive Director Nursing Services (0.2 FTE)	**Executive Director** Women and Newborn Health Service	**Executive Director** Facilities Management
Executive Director Workforce	**Executive Director** Finance	**Executive Director** Public Health and Ambulatory Care
Executive Director PathWest Laboratory Medicine WA	**Director** Aboriginal Health	**Chief Pathologist** PathWest Laboratory Medicine WA
Executive Director Health Reform	**Project Director**	**Executive Director** Corporate Services Reform (commenced 4/04/16)

Figure 3: **South Metropolitan Health Service management structure**

Minister for Health

Director General

Chief Executive

Deputy Chief Executive South Metropolitan Health Service	**Executive Director** Contract Management	**Executive Director** Finance and Performance
Executive Director Fiona Stanley Fremantle Hospitals Group	**Executive Director** Royal Perth Group	**Executive Director** Armadale Health Service
Executive Director Rockingham Peel Group	**Executive Director** Population Health	**Group General Manager** Strategy and Workforce
Director Strategic Issues		

Figure 4: **Child and Adolescent Health Service management structure**

Senior officers

Senior officers and their area of responsibility for the Metropolitan Health Service as at 30 June 2016 are listed in Tables 1 to 3.

Table 1: **North Metropolitan Health Service senior officers**

Area of responsibility	Title	Name	Basis of appointment
North Metropolitan Health Service	Chief Executive	Wayne Salvage	Term Contract
Aboriginal Health	Director	Cheryl Smith	Substantive
Clinical Planning and Redevelopment	Executive Director	Caroline Langston	Secondment
Facilities Management	Executive Director	John Fullerton	Term Contract
Finance	Executive Director	Alain St Flour	Term Contract
Medical Services	Executive Director	Dr Timothy Williams	Term Contract
Mental Health	Executive Director	Patrick Marwick	Acting
Nursing Services	Executive Director	Anthony Dolan	Term Contract
PathWest	Executive Director	Silvano Palladino	Term Contract
PathWest	Chief Pathologist	Dr Dominic Mallon	Term Contract
Public Health and Ambulatory Care (including Dental Services)	Executive Director	Roslyn Elmes	Substantive
Safety, Quality and Performance	Executive Director	Olly Campbell	Acting

Area of responsibility	Title	Name	Basis of appointment
Sir Charles Gairdner Osborne Park Health Care Group	Executive Director	Dr Victor Cheng	Term Contract
Women and Newborn Health Service	Executive Director	Dr Peter Wynn Owen	Term Contract
Workforce	Executive Director	Cynthia Seenikatty	Term Contract
Perth Children's Hospital Integration	Executive Director	David Mulligan	Term Contract
Contract Management and Procurement	Executive Director	Philip Alyward	Secondment
Reform	Executive Director	Sandra Miller	Acting
Projects	Project Director	Sylvia Meier	Secondment
Office of Chief Executive	Director	Dawnia Chiu	Substantive

Table 2: **South Metropolitan Health Service senior officers**

Area of responsibility	Title	Name	Basis of appointment
South Metropolitan Health Service	Chief Executive	Dr Robyn Lawrence	Term Contract
South Metropolitan Health Service	Deputy Chief Executive	Jodie South	Acting
Finance	Executive Director	Brad Sebbes	Acting
Population Health	Executive Director	Kate Gatti	Substantive
Strategy, Workforce and Organisational Development	Group General Manger	Jane Saligari	Acting
Strategic Issues	Director	Joel Gurr	Acting
Contract Management	Executive Director	Leon McIvor	Substantive
Royal Perth Bentley Group	Executive Director	Dr Aresh Anwar	Acting
Fiona Stanley Hospital	Executive Director	Dr Paul Mark	Acting
Rockingham Peel Group	Executive Director	Geraldine Carlton	Substantive
Armadale Health Service	Executive Director	Shae Seymour	Acting

Table 3: **Child and Adolescent Health Service senior officers**

Area of responsibility	Title	Name	Basis of appointment
Child and Adolescent Health Service	Chief Executive	Prof Frank Daly	Term Contract
Aboriginal Health	Director	Leah Bonson	Substantive
Child and Adolescent Community Health	Executive Director	Trulie Pinnegar	Term Contract
Child and Adolescent Mental Health Service	Executive Director	Wade Emmeluth	Term Contract
Child and Adolescent Mental Health Service	Clinical Director	Dr Caroline Goossens	Term Contract
Finance and Contract Management	Executive Director	Wayne Millen	Term Contract
Medical Services	Executive Director	Dr Mark Salmon	Term Contract
Nursing	Director	Sue Peter	Term Contract
Perth Children's Hospital Commissioning	Executive Director	Tina Chinery	Term Contract
Princess Margaret Hospital	Executive Director	Dr Gervase Chaney	Term Contract
Organisational Development	Executive Director	Michelle Dillon	Term Contract
Strategic Issues	Director	Erin Gauntlett	Term Contract

Metropolitan Health Service 2015–16

North Metropolitan Health Service

The North Metropolitan Health Service provides public hospital, and community and mental health services to a population of approximately one million people living in Perth's north and north-eastern suburbs. The North Metropolitan Health Service consists of:

- Sir Charles Gairdner Hospital
- King Edward Memorial Hospital
- Kalamunda Hospital
- Swan District Hospital (closed November 2015)
- Graylands Hospital
- Osborne Park Hospital
- Joondalup Health Campus
- St John of God Midland Public Hospital.

A range of statewide, highly specialised multi-disciplinary services are also offered from several hospital and clinic sites such as:

- emergency services
- intensive and high-dependency care
- coronary care
- medical services
- mental health
- maternity and newborn services
- surgical services
- cancer services
- rehabilitation and aged care
- mental health services
- ambulatory care
- community-based services
- clinical support services
- public health.

South Metropolitan Health Service

The South Metropolitan Health Service provides a comprehensive range of medical, surgical, emergency, mental health, rehabilitation, ambulatory and primary health services. This includes specialised statewide services to patients from across Western Australia, as well as tertiary, secondary and community-based services to people living in Perth's southern suburbs.

South Metropolitan Health Service includes the following hospitals and health services:

- Armadale Health Service
- Fiona Stanley Hospital (including Rottnest Island Nursing Post)
- Fremantle Hospital and Health Service
- Peel Health Campus (South Metropolitan Health Service oversees the provision of contracted public health care from this privately operated facility)
- Rockingham Peel Group (including Murray District Hospital)
- Royal Perth Group (including Bentley Hospital).

Other services provided include communicable disease control, health promotion and Aboriginal health.

The South Metropolitan Health Service has continued to make changes to its delivery of services during 2015–16 to meet the hospital and health needs of the south metropolitan area and the broader WA community within its allocated budget/funding. These changes include the governance for Fremantle Hospital and Fiona Stanley Hospital, which realigned under a new Fiona Stanley Fremantle Hospitals Group on 1 February 2016 to have with a single and unified management structure.

Child and Adolescent Health Service

The Child and Adolescent Health Service comprises:

- Princess Margaret Hospital for Children
- Child and Adolescent Community Health Service
- Child and Adolescent Mental Health Service
- Perth Children's Hospital Commissioning.

Princess Margaret Hospital is a paediatric tertiary teaching hospital. It is Western Australia's only dedicated paediatric hospital for treating children and adolescents.

Child and Adolescent Community Health Service provides a comprehensive range of health promotion and early identification and intervention community based services to children and families in the Perth Metropolitan area. Services are provided in a variety of settings including homes, local community health centres, child and parent centres, and schools. Child and Adolescent Community Health Service provides services across the Perth metropolitan area, which covers 7,250 square kilometres. This area includes 174 Statistical Areas 2 (SA2) and 34 Local Government Areas. Child and Adolescent Community Health Service facilities extend from Two Rocks in the north to Waroona in the south and out to Chidlow in the east.

The Child and Adolescent Mental Health Service provides mental health services to infants, children, young people and their families across the Perth metropolitan area. Services include inpatient care at the Child and Adolescent Mental Health Service Inpatient Unit, which is currently on the Bentley Hospital site but will be relocating to the Perth Children's Hospital.

Perth Children's Hospital, located at the QEII Medical Centre in Nedlands, will replace Princess Margaret Hospital. It will include an integrated paediatric research and education facility, and will provide inpatient, ambulatory and outpatient services. It will also house WA's only paediatric trauma centre.

Performance management framework

To comply with its legislative obligation as a WA government agency, WA Health operates under the Outcome Based Management performance management framework. This framework describes how outcomes, services and key performance indicators are used to measure agency performance towards achieving the relevant overarching whole-of-government goal. WA Health's key performance indicators measure the effectiveness and efficiency of the health services provided by WA Health in achieving the stated desired health outcomes.

All WA Health reporting entities contribute to the achievement of the outcomes through health services delivered either directly by the entities or indirectly through contracts with non-government organisations.

WA Health's outcomes and key performance indicators for 2015–16 are aligned to the State Government goal of *"greater focus on achieving results in key service delivery areas for the benefit of all Western Australians"* (see Figures 5 and 6).

The WA Health outcomes for achievement in 2015–16 are as follows:

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

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

The health service activities that are aligned to Outcome 1 and 2 are cited below (Figures 5 and 6).

Activities related to Outcome 1 aim to:

1. Provide quality diagnostic and treatment services that ensure the maximum restoration to health after an acute illness or injury.
2. Provide appropriate after-care and rehabilitation to ensure that people's physical and social functioning is restored as far as possible.
3. Provide appropriate obstetric care during pregnancy and the birth episode to both mother and child.
4. Provide appropriate care and support for patients and their families during terminal illness.

Activities related to Outcome 2 aim to:

1. Increase the likelihood of optimal health and wellbeing by:
   - providing programs which support the optimal physical, social and emotional development of infants and children
   - encouraging healthy lifestyles (e.g. diet and exercise).
2. Reduce the likelihood of onset of disease or injury through:
   - immunisation programs
   - safety programs
3. Reduce the risk of long-term disability or premature death from injury or illness through prevention, early identification and intervention, such as:
   - programs for early detection of developmental issues in children and appropriate referral for intervention
   - early identification and intervention of disease and disabling conditions (e.g. breast and cervical cancer screening; screening of newborns) with appropriate referrals
   - programs that support self-management by people with diagnosed conditions and disease (e.g. diabetic education)
   - monitor the incidence of disease in the population to determine the effectiveness of primary health measures.
4. Provide continuing care services and programs that improve and enhance the wellbeing and environment for people with chronic illness or disability, enabling people with chronic illness or disability to maintain as much independence in their everyday life as their illness or disability permits, supporting people in their homes for as long as possible and providing extra care when long-term residential care is required. Services and programs are delivered to:
   - ensure that people experience the minimum of pain and discomfort from their chronic illness or disability
   - maintain the optimal level of physical and social functioning
   - prevent or slow down the progression of the illness or disability
   - enable people to live, as long as possible, in the place of their choice supported by, for example, home care services or home delivery of meals
   - support families and carers in their roles
   - provide access to recreation, education and employment opportunities.

Performance against these activities and outcomes are summarised in the Agency Performance section and described in detail under Key Performance Indicators in the Disclosure and Compliance section of this report.

Figure 5: **Outcomes and key effectiveness indicators aligned to the State Government goal for the Metropolitan Health Service**

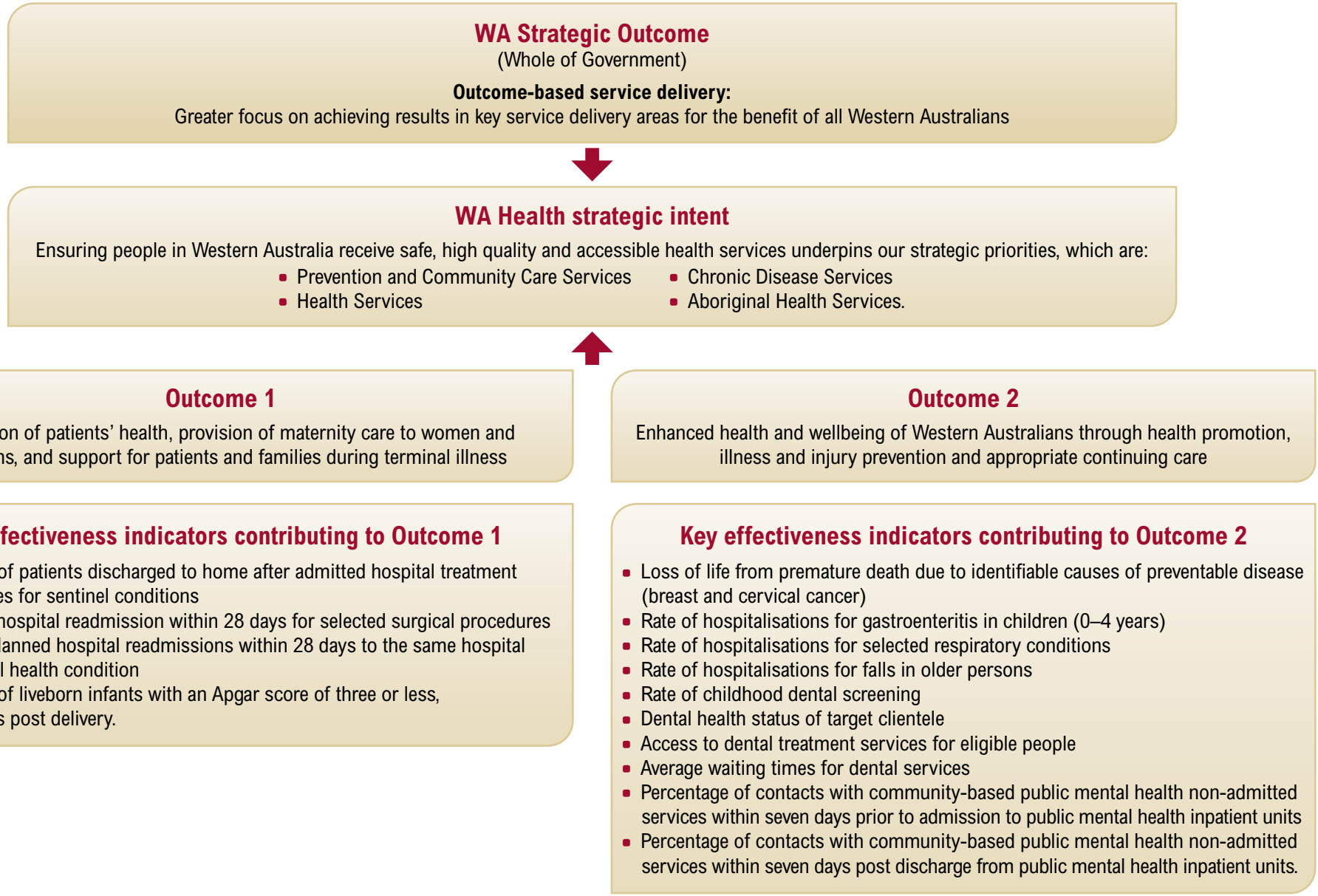


Figure 6: **Services delivered to achieve WA Health outcomes and key efficiency indicators for the Metropolitan Health Service**

Outcome 1

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

Outcome 2

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

Services delivered to achieve Outcome 1

1. Public hospital admitted patients
2. Home-based hospital programs
3. Palliative care
4. Emergency department
5. Public hospital non-admitted patients
6. Patient transport.

Services delivered to achieve Outcome 2

7. Prevention, promotion and protection
8. Dental health
9. Continuing care
10. Contracted mental health.

Key efficiency indicators for services within Outcome 1

- Average cost per casemix adjusted separation for tertiary hospitals
- Average cost per casemix adjusted separation for non-tertiary hospitals
- Average cost of public admitted patient treatment episodes in private hospitals
- Average cost per bed-day for admitted patients (small hospitals)
- Average cost per home-based hospital patient day
- Average cost per client receiving contracted palliative care services
- Average cost per emergency department attendance
- Average cost per public patient non-admitted activity
- Average cost per trip of Patient Assisted Travel Scheme.

Key efficiency indicators for services within Outcome 2

- Average cost per capita of Population Health Units
- Average cost per breast screening
- Average cost of service for school dental service
- Average cost of completed courses of adult dental care
- Average cost per bed-day in specialised mental health inpatient units
- Average cost per three-month period of care for community mental care.

This page is left blank intentionally.

Agency performance

Financial

The total cost of providing health services to WA in 2015–16 was $8.4 billion. Results for 2015–16 against agreed financial targets (based on Budget statements) are presented in Table 4.

Full details of the Department of Health's financial performance during 2015–16 are provided in the Financial statements.

Table 4: **Actual results versus budget targets for WA Health**

Financial	2015–16 Target $'000	2015–16 Actual $'000	Variation $ +/–
Total cost of service	8,149,524	8,420,946	271,422
Net cost of service	4,799,867	4,933,295	133,428
Total equity	10,119,720	9,576,838	-542,882
Net increase/decrease in cash held	(107,948)	(325,300)	(217,352)
Approved full time equivalent staff level (salary associated with FTE)	4,686,045	4,703,263	17,218

Note: 2015–16 targets are specified in the 2015–16 Budget statements.

Data sources: Budget Strategy Branch, Health Corporate Network.

Summary of key performance indicators

Key performance indicators assist the Metropolitan Health Service to assess and monitor the extent to which Government outcomes are being achieved. Effectiveness indicators provide information that aid with 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 produce the service. Key performance indicators also provide a means to communicate to the community how the Metropolitan Health Service is performing.

A summary of the Metropolitan Health Service key performance indicators and variation from the 2015–16 targets is given in Table 5.

Note: Table 5 should be read in conjunction with detailed information on each key performance indicator found in the Disclosure and Compliance section of this report.

Table 5: **Actual Results versus KPI Targets**

Key performance indicators	2015–16 Target	2015–16 Actual	Variation
Outcome 1: Restoration of patients' health, provision of maternity care to women and newborns, and support for patients and families during terminal illness.			
Key effectiveness indicators:			
Percentage of patients discharged to home after admitted hospital treatment	≥98.1%	98.1%	0.0%
Survival rates for Stroke, by age group:			
0–49 years	≥95.3%	94.8%	-0.5%
50–59 years	≥94.1%	92.8%	-1.3%
60–69 years	≥93.3%	92.9%	-0.4%
70–79 years	≥90.8%	89.8%	-1.0%
80+ years	≥83.3%	83.3%	0.0%

Key performance indicators	2015–16 Target	2015–16 Actual	Variation
Survival rates for Acute Myocardial Infarction (AMI), by age group:			
0–49 years	≥99.5%	99.2%	-0.3%
50–59 years	≥99.2%	98.7%	-0.5%
60–69 years	≥98.4%	97.9%	-0.5%
70–79 years	≥96.7%	96.3%	-0.4%
80+ years	≥92.7%	92.3%	-0.4%
Survival rates for Fractured Neck of Femur (FNOF), by age group:			
70–79 years	≥98.8%	99.0%	0.2%
80+ years	≥96.4%	96.1%	-0.3%
Percentage of unplanned readmissions within 28 days for selected surgical procedures:			
Knee replacement	N/A	2.2%	
Hip replacement	N/A	2.1%	
Tonsillectomy and Adenoidectomy	N/A	7.1%	
Hysterectomy	N/A	4.7%	N/A
Prostatectomy	N/A	3.4%	
Cataract surgery	N/A	0.1%	
Appendicectomy	N/A	3.9%	
Rate of unplanned hospital readmissions within 28 days to the same hospital for a mental health condition	≤5.6%	7.9%	2.3%
Percentage of live births with an Apgar score of three or less five minutes post delivery, by birth weight:			
0–1499 grams	≤3.7%	3.8%	0.1%
1500–1999 grams	≤0.3%	0.3%	0.0%
2000–2499 grams	≤0.2%	0.4%	0.2%
2500+ grams	≤0.1%	0.2%	0.1%

Key performance indicators	2015–16 Target	2015–16 Actual	Variation
Key efficiency indicators:			
Average cost per casemix adjusted separation for tertiary hospitals	$7,380	$8,082	$702
Average cost per casemix adjusted separation for non-tertiary hospitals	$5,487	$7,448	$1,961
Average cost of public admitted patient treatment episodes in private hospitals	$3,494	$3,933	$439
Average cost per day-bed for admitted patients (small hospitals)	$699	$1,055	$356
Average cost per home based hospital patient day	$328	$378	$50
Average cost per client receiving contracted palliative care services	$3,767	$2,084	-$1,683
Average cost per emergency department attendance	$679	$765	$86
Average cost per public patient non-admitted activity	N/A*	$357	N/A
Average cost per trip of Patient Assisted Travel Scheme	$44	$31	-$13
Outcome 2: Enhanced health and wellbeing of Western Australians thorugh health promotion, illness and injury prevention and appropriate continuing care.			
Key effectiveness indicators:			
Loss of life from premature death due to identifiable causes of preventable disease (person years of life lost):			
Breast cancer	≤2.2	1.7	-0.5
Cervical cancer	≤0.3	0.3	0.0
Rate of hospitalisations for gastroenteritis in children (0-4 years) (per 1,000)	≤3.7	4.3	0.6

Key performance indicators	2015–16 Target	2015–16 Actual	Variation
Rate of hospitalisation for selected respiratory conditions Asthma, by age group (per 1,000):			
0–4 years	≤1.2	2.7	1.5
5–12 years	≤1.8	2.2	0.4
13–18 years	≤0.2	0.6	0.4
19–34 years	≤0.4	0.4	0.0
35+ years	≤0.6	0.7	0.1
Acute Bronchitis (0-4 years of age) (per 1,000)	≤0.1	0.1	0.0
Bronchiolitis (0-4 years of age) (per 1,000)	≤7.7	9.5	1.8
Croup (0-4 years of age) (per 1,000)	≤2.1	2.2	0.1
Rate of hospitalisation for falls in older persons (per 1,000)	0.5% reduction per annum	29.4	-0.2
Rate of childhood dental screening			
(a) Percentage of eligible school children who are enrolled in the School Dental Service program			
• Pre-primary program	≥69%	69.0%	0.0%
• Primary program	≥69%	84.0%	15.0%
• Secondary program	≥69%	76.0%	7.0%
(b) Percentage of school children who are free of dental caries	≥65%	69.0%	4.0%
Dental health status of target clientele			
(a) Average number of DMFT for school children (age 12 years)	0.60–1.7	0.60	N/A
(b) Average number of DMFT for adults	N/A	8.4	N/A

Key performance indicators	2015–16 Target	2015–16 Actual	Variation
Access to dental treatment services for eligible people			
(a) People who accessed Dental Health Services	≥15%	15%	0%
(b) People who completed dental treatment			
• Emergency	≤50%	41%	9%
• Non-Emergency	≥50%	59%	9%
Average waiting times for dental services	≤24 months	4 months	20 months
Percent of contacts with community-based public mental health non-admitted services within seven days prior to admission to a public mental health inpatient unit	70%	56.4%	-13.6%
Percent of contacts with community-based public mental health non-admitted services within seven days post discharge from public mental health inpatient units	75%	58.9%	-16.1%
Key efficiency indicators:			
Average cost per capita of Population Health Units	$96	$89	-$7
Average cost per breast screening	$165	$187	$22
Average cost of service for school dental service	$133	$118	-$15
Average cost of completed courses of adult dental care	$349	$395	$46
Average cost per day-bed in specialised mental health inpatient units	$1,217	$1,716	$499
Average cost per three-month period of care for community mental health	$1,704	$2,148	$444

Performance towards the National Partnership Agreement targets

WA signed the National Partnership Agreement on Improving Public Hospital Services in 2011. The objective of the agreement was to drive major improvements in public hospital service delivery and better health outcomes for Australians. It included the National Elective Surgery Target (NEST) and the National Emergency Access Target (NEAT).

Following the expiry of the National Partnership Agreement during 2015, WA Health introduced a new WA Elective Services Target (WEST) and WA Emergency Access Target (WEAT). As these were not implemented until 2016, for the purposes of this report, NEST and NEAT are reported up to the end of the 2015 calendar year.

National Elective Surgery Target (NEST)

Elective surgery is a term used to describe surgery that is medically necessary, but can be delayed for at least 24 hours. The NEST commenced on 1 January 2012 and focused on two areas. Under NEST Part 1 of the national agreement, WA had a target to increase the percentage of elective surgery cases admitted within the clinically recommended time for all urgency categories. Under NEST Part 2 of the national agreement, WA had a target to reduce the average overdue days waited beyond the clinically desirable times for each urgency category.

The urgency categories and clinically desirable times were:

- category 1 – admitted within 30 days
- category 2 – admitted within 90 days
- category 3 – admitted within 365 days.

Part 1: Treating patients within the clinically recommended time

WA Health was required to progressively increase the number of elective surgeries performed within the clinically recommended time by 2016.

From 2010 to 2015, the number of patients treated within clinically recommended times improved from the baseline by approximately 6.2 per cent for category 1, by approximately 11.5 per cent for category 2 and approximately 0.8 per cent for category 3 (see Table 6).

From 1 January to 31 December 2015, 92.8 per cent of urgency category 1 patients were admitted within 30 days, lower than the set target of 100 per cent. For urgency category 2 patients, 88.3 per cent were admitted within the recommended 90 days, which is below the set target of 100 per cent and 98.0 per cent of urgency category 3 patients were admitted within the recommended 365 days, which is marginally below the set target of 100 per cent.

Table 6: **Percentage of WA patients admitted within the clinically recommended time, by category, 2010–2015**

		2010 Baseline (%)	2011 (%)	2012 (%)	2013 (%)	2014 (%)	2015 (%)
Category 1	Performance	87.4	86.6	86.3	95.9	98.1	**92.8**
	Target	-	87.4	94.0	100.0	100.0	**100.0**
Category 2	Performance	79.2	83.5	82.0	89.4	91.6	**88.3**
	Target	-	79.2	84.0	88.0	95.0	**100.0**
Category 3	Performance	97.2	96.3	96.4	97.7	98.5	**98.0**
	Target	-	97.2	98.0	98.0	98.5	**100.0**

Data sources: Wait List Data Collection, Inpatient Data Collections.

Part 2: Reducing the average waiting time for overdue patients

Performance against the elective surgery targets from 1 January to 31 December 2015 shows that WA did not meet the 2015 targets for each urgency category (see Table 7); however, the average overdue waiting time for Category 1 and 2 patients had improved significantly compared to the 2010 baseline.

Table 7: **Average overdue wait time (in days) for WA patients who have waited beyond clinically recommended times, by category, 2010–2015**

		31 Dec 2010 (baseline)	31 Dec 2011	31 Dec 2012	31 Dec 2013	31 Dec 2014	31 Dec 2015
Category 1	Performance	27.0	27.3	12.1	12.9	36.3	**14.7**
	Target	-	27	0	0	0	**0**
Category 2	Performance	90.0	77.4	54.2	55.0	48.7	**71.3**
	Target	-	90	68	45	23	**0**
Category 3	Performance	87.0	69.3	66.9	75.8	62.9	**89.4**
	Target	-	87	65	44	22	**0**

Notes: As part of the National agreement, this measure is assessed at 31 December as a point in time measure.

Data sources: Wait List Data Collection, Inpatient Data Collections

National Emergency Access Target (NEAT)

The National Emergency Access Target (NEAT) aim was to drive improvements in access to emergency care for patients.

Between 2012 and 2015 all States and Territories have been striving to meet progressive annual interim targets with the aim of ensuring that where clinically appropriate patients presenting to a public hospital emergency department would be admitted, transferred or discharged within four hours. By 2015, WA Health's aim was to ensure that 90 per cent of patients presenting to a public hospital emergency department would be admitted, transferred or discharged within four hours, where clinically appropriate.

NEAT performance is calculated as an average of all participating hospitals over the calendar year. In the Metropolitan Health Service, the participating hospitals included all tertiary hospitals (Fiona Stanley Hospital, Fremantle Hospital, King Edward Memorial Hospital, Princess Margaret Hospital, Royal Perth Hospital and Sir Charles Gairdner Hospital) as well as general hospitals (Armadale Health Service, Rockingham General Hospital, St John of God Midland Hospital, Swan District Hospital (closed November 2015), Joondalup Health Campus and Peel Health Campus).

Results for Metropolitan Health Service compared to the State result and National targets are presented in Table 8. In 2015, 76.0 per cent of patients presenting to a Metropolitan Health Service emergency department were admitted, transferred or discharged within four hours. This is below the 2015 State average of 80.3 per cent and the National target of 90.0 per cent.

Table 8: **Percentage of emergency department presentations at Metropolitan Health Service hospitals with a length of stay of 4 hours or less, 2014–2015**

Year	MHS (%)	State (%)	Target (%)
2011	76.9	79.3	71.3 (baseline)
2012	75.7	78.3	76.0
2013	75.1	77.6	81.0
2014	77.8	79.7	85.0
2015	**76.0**	**80.3**	**90.0**

Data source: Emergency Department Data Collection.

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 the increasing demand on emergency departments and health services, it is imperative that health service provision is continually monitored to ensure the effective and efficient delivery of safe high-quality care.

Percentage of emergency department patients seen within recommended times

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

The triage process and scores are recognised by the Australasian College for Emergency Medicine and is recommended for prioritising those who present to an emergency department. A patient is allocated a triage category 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**

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

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

In 2015–16, 91.8 per cent of all triage 5 patients were seen within the clinically recommended time, above the target of 70 per cent. (see Table 10).

In 2015–16 the Australasian College for Emergency Medicine targets for patients categorised as triage 1, 2, 3 and 4 were not met (see Table 10). While the targets have not been met, the 2015–16 results remain consistent with previous years.

Table 10: **Percentage of metropolitan emergency department patients seen within recommended times, by triage category, 2011–12 to 2015–16**

Triage Category	2011–12 (%)	2012–13 (%)	2013–14 (%)	2014–15 (%)	2015–16 (%)	Target
1	97.3	99.5	99.6	99.7	**98.8**	**100%**
2	73.6	78.1	85.0	82.4	**78.7**	**≥80%**
3	44.1	42.4	52.4	49.9	**46.9**	**≥75%**
4	61.5	58.8	66.9	63.8	**62.5**	**≥70%**
5	92.1	89.7	93.0	92.2	**91.8**	**≥70%**

Note: Peel Health Campus data is not included due to data quality issues.

Data source: Emergency Department Data Collection.

Percentage of admitted patients transferred to an inpatient ward within 8 hours of emergency department arrival

Timely movement of patients from the emergency department is important because it potentially reduces adverse incidents that may result from overcrowding or access block (patients waiting for eight hours or more for admission). Most patients who require a hospital bed will benefit from early transfer to the inpatient unit that can best treat their condition.

The monitoring of emergency department patients transferred to an inpatient ward within eight hours can aid in supporting further improvements in the clinical service redesign, bed management and health reform. This, in turn, can help drive improvements in the timeliness of care for patients presenting to the emergency department without any detriment to clinical care.

Over a number of years, the health services have implemented operational improvements that have resulted in an increase in the percentage of patients who were transferred to an inpatient ward within eight hours. Thus the target has been revised over a number of years to reflect these improvements.

In 2015–16, 86.8 per cent of metropolitan patients were transferred to an inpatient ward within 8 hours of arrival to an emergency department, above the target of 85 per cent (see Table 11).

Table 11: **Percentage of metropolitan admitted patients transferred to an inpatient ward within 8 hours of emergency department arrival, 2011–12 to 2015–16**

	2011–12 (%)	2012–13 (%)	2013–14 (%)	2014–15 (%)	2015–16 (%)
Percentage of patients transferred within 8 hours	86.9	84.5	86.4	88.0	**86.8**
Target	75.0	80.0	85.0	85.0	**85.0**

Data source: Emergency Department Data Collection.

Rate of emergency attendances for falls in older persons

Falls are common in older people and increase in prevalence with advancing old age. A significant proportion of falls can lead to severe injuries that impact quality of life and frequently result in attendance to an emergency department. With the growth of the ageing population, fall-related injuries threaten to significantly increase demand on the public hospital system.

Interventions and prevention programs, such as the *Falls Prevention Model of Care 2014*, can reduce the number and severity of falls in older persons, thus enhancing their overall health and wellbeing and enabling them to remain independent and productive members of their community. By measuring the rate of emergency department attendances for falls in older persons, processes that aid timely treatment within the emergency department, and effective intervention and prevention programs, can be delivered.

In 2015, the rate of persons aged 80 years and older who attended a metropolitan emergency department for falls was 98.3 per 1,000 persons (see Table 12). The rate of emergency department attendances for falls for persons aged 55 to 79 years was slightly higher than prior years.

Table 12: **Rate of metropolitan emergency attendances for falls per 1,000 by age group, 2011-2015**

Age Group (Years)	2011	2012	2013	2014	2015
55–64	14.3	13.8	14.0	13.9	**15.3**
65–79	26.7	26.1	26.0	25.1	**26.9**
80+	99.3	96.5	92.4	94.7	**98.3**

Notes: While the results for this performance indicator are based on patient's residential code, it does not mean that the patient presented to an emergency department close to where they reside.

Refer to the Key Performance Indicator section of this report is information on the 'Rate of hospitalisations for falls per 1,000 by age group, 2011 to 2015'.

Data source: Emergency Department Data Collection.

Significant issues

The *WA Health Strategic Intent 2015–2020* underpins the requirement for people in Western Australia to receive safe, high quality and accessible health services. The Strategic Intent outlines the key direction that the health system will undertake. It aims to support operational planning that will take into account necessary health service demand management, sustainability and improvement, with a key focus on:

1. Prevention and Community Care Services
2. Health Services
3. Chronic Disease Services
4. Aboriginal Health Services

The *WA Health Reform Program 2015–2020* is an integrated program of work aligned to the Strategic Intent. It comprises a series of projects across four key areas of reform:

1. Governance
2. Performance
3. Support services
4. Procurement.

The reform will enable decision-making and health service delivery that supports local community needs. It will also allow policy and standards to be aligned to national and international best practice. This will ensure the quality and safety of health services is maintained.

North Metropolitan Health Service

Demand and activity

North Metropolitan Health Service's population is growing and ageing, which has led to increased demand for services in 2015–16. Despite this challenge, the focus remains on maintaining safety and high quality care.

To manage additional demand, Sir Charles Gairdner Osborne Park Health Care Group commenced ongoing work to reduce inpatient length of stay. This has resulted in the lowest length of stay in its peer hospital group in Australia. A review of theatre processes at Sir Charles Gairdner Hospital has instigated a bid to increase performance. Movement of appropriate elective surgery activity from Sir Charles Gairdner Hospital to Osborne Park Hospital has also improved elective surgery access.

To address the increase in children eligible for treatment via the School Dental Program, two new clinics opened in the metropolitan area and another in Carnarvon. The number of eligable adults who hold health care and pensioner concession cards has also increased. The Dental Health Service has treated an extra 12,000 inpatients 2015–16 as a result of the *Commonwealth National Partnership Agreement on Treating More Public Dental Patients*. Efficiency at clinics has also improved by centralising administrative tasks.

Changes in Medicare payments include the loss of bulk billing incentive payments for pathology services. This has increased demand on public pathology services as patients move from private services that ceased bulk billing. Faced with rising demand, the challenge is to increase efficiency to maintain clinically appropriate turnaround times. PathWest has realigned the majority of South Metropolitan Health Service referred work to the Fiona Stanley Hospital laboratory. This has provided capacity for PathWest at the Queen Elizabeth II Medical Centre to meet increased demand. New pathology facilities are under construction at Bunbury, and new facilities are planned for Manjimup, Narrogin and Karratha hospitals.

The *Mental Health, Alcohol and Other Drug Services Plan 2015–2025* provides for the replacement of the aged infrastructure at Graylands Health Campus and the Selby Older Adult Mental Health Unit with contemporary models of care. A Master Plan is being developed to identify the current and future population needs, and models of care for adults, older adults and forensic patients with severe mental disorders. Further development of the State Forensic Mental Health Service is planned to respond to increased demand from the prison population. Increased demand for mental health services is also being addressed by provision for an additional six Mental Health in the Home beds operating from the Sir Charles Gairdner Hospital Mental Health Unit.

Workforce challenges

The North Metropolitan Health Service is managing changes to its workforce in a way that maximises the quality and safety of patient care and the quality of the patient experience. For example, Sir Charles Gairdner Hospital is one of only three Magnet accredited hospitals in Australia. The Magnet Recognition Program is operated by the American Nurses Credentialing Centre. In addition to improving clinical outcomes and patient satisfaction, the program leads to higher satisfaction and lower turnover among nurses.

The Dental Health Service experiences difficulties in attracting and retaining suitably qualified and experienced clinicians in rural and remote areas. This includes attracting dental therapists to the School Dental Service in country locations. Employees based in the metropolitan area provide relief work in rural and remote areas, and rotational rosters are used to make these postings more appealing. A mentoring program supports new Dental Health Service employees in regional and remote areas. An Aboriginal workforce strategy has also been developed to overcome limited permanent employment opportunities for Aboriginal people.

PathWest faces the challenge of increasing complexity and specialisation of pathology work and an ageing workforce. A review into how to best rationalise its services is underway.

There is a relative shortage of Consultant Forensic Psychiatrists at a local, national and international level. Clinical services have been maintained and a joint working group convened to address possible issues. The statewide graduate program run by North Metropolitan Health Service Mental Health continues to provide on-the-job training for nurses seeking work in mental health settings. The program reduces the burden on individual sites by providing work-ready junior nursing staff. A dedicated Allied Health Coordinator position was established during 2015–16 to ensure professional standards in mental health care are maintained and developed.

Managing funding reform and cost efficiencies

A key challenge for the North Metropolitan Health Service is delivering financially sustainable services. Financial sustainability and recovery programs are in place at a number of North Metropolitan Health Service service sites. Executive oversight of these programs is key to managing services and cost efficiently. An example is the Triple S program being implemented at the Women and Newborn Health Service. This program aims to make Women and Newborn Health Service Safe, Smart and Sustainable through organisational, financial, and clinical review and reform.

Graylands Hospital has responded very proactively to the challenges of operating in a financially sustainable manner after Activity Based Funding of acute care was introduced in 2015–16. Mental Health Finance and Business staff responded by developing and implementing training sessions for cost centre managers and senior clinical staff on the effective management of resources.

Health inequalities

The World Health Organization has stated that there is clear evidence of the relationship between oral health and general health, as follows:

- Poor oral health is significantly associated with major chronic diseases
- Poor oral health causes disability
- Oral health issues and major diseases share common risk factors
- General health problems may cause or worsen oral health conditions.

The Dental Health Service therefore plays an important role in maintaining the health of vulnerable populations across WA. This includes rural and remote communities, people of low economic status, people with mental illness or cognitive impairment, and Corrective Services patients. The Dental Health Service addresses the needs of these groups in several ways:

- Partnerships have been formed with Aboriginal Community Controlled Health Organisations and the Royal Flying Doctor Service to provide dental services in rural and remote areas. An outreach program operating from regional centres offers free emergency dental treatment in a culturally safe environment.
- Health care card and pensioner concession card holders receive subsidised treatment.
- Mental health services are partnering with Dental Health Services to develop a model for delivering oral health care to mental health consumers. A pilot program is underway to examine the oral health of mental health patients as part of their physical health check.
- Emergency dental treatment is provided to Corrective Services patients.

North Metropolitan Health Service Mental Health is undertaking a variety of initiatives to meet the mental health needs of the community:

- A two-year trial of a mental health co-response team commenced in January 2016. Senior mental health clinicians are working alongside frontline police in specially trained teams, tasked with responding to the growing number of calls to police relating to mental health incidents. The aim is to improve health outcomes by diverting people with mental illness away from the criminal justice system to the health and support networks they need.
- An audit is being undertaken of the needs of long stay patients at Graylands Hospital and the Selby and Osborne Park Older Adult Mental Health Units. It will be used to inform the models of care, service plans and business cases required to replace these facilities.

- Participation in a national study of the physical health care needs of people with disabling psychotic disorders. The information this study is generating has already proven valuable in local system improvement initiatives.
- Youth Mental Health Services, governed by North Metropolitan Health Service Mental Health, is collaborating with the Office of Mental Health to develop options to increase the number of mental health beds dedicated to 16 and 17 year olds.

South Metropolitan Health Service

Demand and activity

The population of the South Metropolitan Health Service continues to grow each year, but is doing so unevenly across the health service. The population is also ageing, with the Peel region having a particularly high proportion of residents aged 65 years and over. Both of these factors are likely to impact significantly on future service demand.

The volume of work undertaken at Fiona Stanley Hospital during the first year of operation provides insight into the level of demand for services at the South Metropolitan Health Service:

- more than 100,000 patients treated in the emergency department; an average of 275 a day
- 30,000 patients were admitted from the emergency department
- 40,000 people were admitted as inpatients
- more than 2,500 babies were born
- more than 2,000 children were cared for in the paediatric ward
- 22,600 surgeries were performed
- 30 heart and lung transplants were performed
- 750,000 plated meals were served to patients.

To meet growing demand, the South Metropolitan Health Service continues to undergo reconfiguration. To facilitate better patient flow and transfer processes between Fiona Stanley Hospital and Fremantle Hospital, governance changes came into effect in February 2016 to develop a seamless connection between the two hospitals. The intention is to achieve better patient flow and transfer processes between the sites, and a flexible workforce with enhanced clinical rotations and improved workforce opportunities.

To ensure patients receive more timely care, Royal Perth Hospital undertook a review of its waitlists to transfer activity to the most appropriate hospital site. This includes those hospitals with shorter lists. Hospital sites continue to identify alternative options for patients to access care outside of tertiary facilities, and to develop robust winter bed strategies.

All South Metropolitan Health Service sites providing mental health services now include Mental Health Assessment Treatment Teams and Community Treatment Teams to enable timely community access and supported discharge from a mental health facility.

The ageing population presents many challenges, including managing demand associated with chronic disease and preventable admissions. The South Metropolitan Health Service delivers a number of prevention programs focusing on the health and wellbeing of whole populations. This includes comprehensive health education, disease control and public health services

Chronic diseases, including cardiovascular disease, cancer, diabetes mellitus and related complications, chronic obstructive pulmonary disease and cerebrovascular disease, are the main causes of death and illness within the South Metropolitan Health Service. Many diseases are strongly associated with lifestyle risk factors, such as smoking, physical inactivity, poor diet, and being overweight and obese. These are responsive to effective and inexpensive prevention programs run by the South Metropolitan Health Service in areas such as such as tobacco control, health literacy, physical activity and healthy eating.

Annual health costs continue to outpace the consumer price index, reflecting new technologies, treatments and ever increasing community expectations of healthcare. The South Metropolitan Health Service Financial Recovery Management Program aims to deliver financial savings and ensure that patients continue to receive high quality and sustainable clinical services in the right location.

Workforce challenges

The South Metropolitan Health Service continues to ensure its workforce profile is sustainable within the National Activity Based Funding/Activity Based Management model while continuing to deliver safe, high quality care. Following the introduction of the East Metropolitan Health Service on 1 July 2016, the South Metropolitan Health Service will engage with and support staff as it builds new work teams and culture. New organisational structures, leadership and governance models, systems and processes will result from further reconfiguration of Health Services.

Reconfiguration of staffing profiles entails matching staff to positions in line with the clinical services being delivered. Developing workforce requirements within affordable workforce projections and the reconfigured state required a high level of engagement from hospital teams. Specialist information technology systems supported workforce provisioning. Implementation of a Voluntary Severance Scheme assisted with this by reducing the number of staff requiring case management. Building flexibility into the existing workforce is important in meeting organisational requirements associated with new service delivery models, while balancing staff expectations and needs. Organisational development will continue to align culture and work practice, performance, innovation and accountability.

The South Metropolitan Health Service received exemptions from the State Government's recruitment freeze in areas of clinical shortage. There is a continuing focus on recruiting for high priority, difficult to fill clinical roles in nursing and midwifery, medical, allied health, perioperative and critical care nursing.

Education and upskilling will enhance staff skills to support service transformation. There is a strong emphasis on clinical training and upskilling of the nursing and allied health workforce. Providing managers and staff with comprehensive education, resources and support is necessary to assist managing staff allocation, particularly in areas of oversupply.

The South Metropolitan Health Service continues to employ a culturally diverse workforce that aims to reflect the cultural diversity of its consumers. It is committed to increasing its Aboriginal workforce through the establishment of targeted employment strategies, such as traineeships and cadetships. Increasing the Aboriginal workforce representation will improve access to health services that better meet the needs of Aboriginal patients and their families.

Managing funding reform and cost efficiencies

A number of funding reform issues are impacting on service delivery within the South Metropolitan Health Service. Of most significance are the challenges posed by the reconfiguration and transitioning of services through the Financial Recovery Management Program, and planning for the full rollout of Activity Based Funding in WA Health.

In an Activity Based Funding/Activity Based Management environment, there is a need for greater ground level, devolved accountability for managing demand, funding reform and costs efficiently across all service streams. Comprehensive and accurate capture of data and identification of gaps within the activity data is a priority given its importance in aiding decision making.

Improvement in efficiency is crucial, particularly because the National Efficient Price is determined by the Independent Hospital Pricing Authority, which does not fully consider the unique circumstances relevant to WA Health.

In line with restructuring service models and continuing to meet Activity Based Funding/Activity Based Management in 2016–17, a number of strategies were implemented throughout 2015–16 to address these challenges:

- education and real time access to budget and activity information assisted decision making and managing activity within an efficient cost
- the Business Intelligence Unit continued to develop and provide budget dashboard tools to assist front line managers and the Area Executive Group in monitoring costs
- devolving responsibility for budget and spending to those managing the delivery of care helped increase understanding and transparency of spending decisions
- development of workforce profiles in hospitals' reconfigured state was undertaken, costed and managed to assist in delivering a safe quality service within the an ABF/M environment.

The introduction of enhanced financial reporting tools and training has allowed hospital management teams to better understand their financial position. This included timely implementation of strategies to target and address areas of financial concern or risk.

Health inequalities

In addition to activities aimed at prevention and improving health outcomes in the general population, the South Metropolitan Health Service has programs that focus on the most vulnerable and at risk. After the Pilbara region, the South Metropolitan Health Service has the largest Aboriginal population in the State. There are persistent health inequalities among Aboriginal people, including shorter life expectancy, higher rates of communicable and chronic diseases, and poorer neonatal outcomes.

Programs and services aimed at improving the health outcomes of Aboriginal people include:

- Moorditj Djena – a mobile community outreach service providing chronic disease assessment, diabetes education and podiatry services
- Journey of Living with Diabetes – a health education program delivered through residential workshops and 10 weekly programs
- Nidjalla Waangan Mia (Aboriginal Health & Wellbeing Centre Mandurah) – primary health care services and health promotion programs for Aboriginal people living in the Peel area
- Aboriginal Maternity Group Practice Program – a community based maternity service that provides an Aboriginal Health Officer and Grandmother
- continual liaison with Child and Adolescent Community Health and Medicare Locals to improve Aboriginal childhood immunisation rates
- the Aboriginal Health Liaison Officer program, which improves the quality of care for Aboriginal patients and raises the cultural competency of health care workers at hospitals.

Improving the quality of service provided to patients accessing mental health services has also been a priority, including:

- implementation of Assessment and Treatment Teams and Clinical Treatment Teams in a standardised way across all South Metropolitan Health Service mental health sites.
- the Individual Placement and Support program implemented at the Fremantle Hospital and Health Service, Armadale Health Service and Bentley Health Service. The program helps mental health clients find employment, which plays an active part in their recovery.

The first phase of the Institute for Social Inclusion opened at Royal Perth Hospital in June 2016. The service aims to address the high number of homeless people who attend with multiple comorbidities on a frequent basis. The service utilises external general practitioners and registered nurses who support Royal Perth Hospital staff with ward rounds in reviewing and seeing referred patients identified as homeless or at risk of being homeless. The service then utilises case workers and links with community service providers to ensure that upon discharge patients have the greatest chance of being housed with required support mechanisms in place. This is to ensure they maintain long-term accommodation.

Child and Adolescent Health Service

Demand and activity

The population of 0–17 year olds in WA is currently growing at over 13,500 each year, which places a strain on existing services at Princess Margaret Hospital. As there has been no ability to expand services to meet additional demand, strategies employed to manage demand include:

- telehealth initiatives, including emergency trauma management, remote patient diagnostic and follow up consultation, simulation, observation and feedback
- revision of clinic profiles
- trialling measures to decrease non-attendance rates
- engaging clinicians to re-triage identified referrals to determine ongoing need
- improved access to and quality of waitlist data
- formation of the Outpatient Management Committee to prioritise outpatient management and improvement strategies
- allocating resources to areas where most benefit can be derived.

The opening of the Perth Children's Hospital will also address the increase in demand resulting from population growth.

The Child Development Service has seen a 28 per cent increase in referrals over the past five years. This is attributed to a combination of population growth, increased community awareness of the service, and recognition of the importance of early intervention. The Child and Adolescent Community Health Service is implementing a number of strategies to manage this increase in demand. More than 60 additional nurses were employed to the end of 2015–2016, and over 100 school health nurses and eight speech pathologists will be employed in the metropolitan area by the end of 2016–17. Over the last two school years, there has been a 10.7 per cent increase in the number of Kindergarten children receiving a Universal School Entry Health Assessment, with nearly 96 per cent of them being assessed in 2015.

Reforms to improve accessibility and the quality of services have been implemented or are planned, including:

- adopting recommendations from the review into child health services completed by Professor Karen Edmond
- commencing a pilot program to evaluate the delivery of child health checks in the child care setting
- reviewing the range and number of services provided to each client cohort in order to ensure equitable and timely access
- developing a business case for capital works to improve community health service facilities in the metropolitan area.

The implementation of clinical reform initiatives in 2015–16 has already seen a considerable decrease in the waiting time for Child Development Service speech pathology and occupational therapy services.

As part of *The Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025*, acute activity for young people aged under 16 will transfer to a 20-bed authorised unit at Perth Children's Hospital. Eight Fiona Stanley Hospital youth beds are currently open to patients aged 16 to 24 years; however, 16 and 17 year olds receive preferential admission. The Community Child and Adolescent Mental Health Service has undertaken a system wide reform process aimed at maximising efficient use of existing resources. The full implementation of the Choice and Partnership Approach model from 1 July 2015 has resulted in:

- a no wait-list service across all community sites
- a reduction in referral to first appointment times from an average of 50 to 20 days, with elimination of extremes in variation
- 2,864 children being seen in the first 10 months of 2015–16, which is 1,225 more than the same period the previous year
- 1,310 more clinical assessments being undertaken in the first 10 months of 2015–16.

Although more children and young people are being seen, demand continues to rise. If children and young people are not seen in a timely way within the community, then hospital admission often follows, which can adversely affect their development.

Workforce challenges

Planning and commissioning of the Perth Children's Hospital has continued, which has resulted in some expertise shift from clinical to planning areas. A high proportion of temporary vacancies has resulted, and these are more difficult to attract staff to. Health service reconfiguration and new facilities have also made the employment market competitive.

Early adoption of some of the planned changes for Perth Children's Hospital has occurred at Princess Margaret Hospital in the areas of medical typing, ward configurations, and play and leisure services. The Perth Children's Hospital Project has created new workforce opportunities. This includes Assistants in Nursing and Nurse Practitioners expanding the scope of their practice in the outpatient area, and the rotation of ward and outpatient staff to mirror the patient's journey.

Recruitment efforts in the Child and Adolescent Community Health Service continued throughout 2015–2016. Strategies implemented to bolster recruitment across the school health nursing workforce included:

- promoting Child and Adolescent Community Health Service nursing to other Health Services
- use of nursing recruitment pools
- alignment of Child and Adolescent Community Health Service recruitment needs with strategies being undertaken by the Office of the Chief Nurse.

There were some delays to the recruitment of school heath staff due to a shortage of suitably qualified nurses and the recruitment freeze; however, all positions funded for the year were filled. Recruitment was further challenged by the tendency for 70 per cent of metropolitan community health nurses to work part-time. The extent is such that for every 10 full-time equivalent positions, Child and Adolescent Community Health Service must recruit approximately 16 nurses. The release of key staff to undertake reform initiatives was complicated by the difficulty of backfilling positions.

Managing funding reform and cost efficiencies

Access to timely and accurate data remains challenging for some departments at Princess Margaret Hospital. This is particularly so for outpatients, where there is an Activity Based Funding/Management coding project to ensure capture and correct coding of attendances, and alignment of purchasing plans. The development of an overarching integrated governance structure for outpatient facilities will improve the flow and efficiencies within outpatient clinics and create additional clinic services. This in turn will improve flexibility for nursing staff and training.

The outpatient Tier 2 clinic review continues to categorise clinics that are not covered under Activity Based Funding to ensure the correct funding model is applied. This is imperative for the ongoing requirements for services, such as the program for patients requiring home ventilation.

The commissioning of the Perth Children's Hospital posed challenges, as planning and affordability projects required tight Full Time Employee controls. Limitations on the flexibility for clinic allocation to achieve efficiencies has been compounded by the delay in moving to the Perth Children's Hospital.

The Independent Hospital Pricing Authority altered the Specialist Psychiatric Age Adjustment for a subset of admitted patients in the setting of the 2015–16 National Efficient Price. This had a significant impact on Mental Health services delivered by the Child and Adolescent Mental Health Service. The adjustment reduced the number of Weighted Activity Units to be delivered by 20 per cent.

Health inequalities

The Child and Adolescent Community Health Service is increasing its focus on vulnerable families in line with the recommendations of the review conducted by Professor Karen Edmond. Throughout 2015–16, work continued on a reform program for child and school health service delivery. Services include:

- The Enhanced Aboriginal Child Health Schedule, which provides support at critical periods in a child's life to minimise the harmful effects of disadvantage
- the Aboriginal Health team, whereby Aboriginal health workers and nurses work in partnership to deliver culturally appropriate health checks, support and information to the children of the Aboriginal communities
- the Refugee Health Team, which assists transitioning families to access local health services independently and young children to enter the Community Health Universal Contact Schedule
- The Best Beginnings program, a voluntary, structured home visiting service for families with additional risk factors
- the Enhanced Home Visiting team, which offers an evidence-based service response in the home that minimises risk and maximises protective factors for infants and their families
- implementation of the Neglect Protocol, which strengthens and standardises child health nursing practice around infants and children where there are concerns of neglect.

The Child and Adolescent Community Mental Health Service has focused on developing links and consulting regularly with Child Development Services to share information and improve care for children with intellectual disabilities and autism. Child and Adolescent Community Mental Health Service is also a key participant in the Young People with Exceptionally Complex Needs initiative. The program aims to provide a better coordinated service delivery response to improve the wellbeing and quality of life of young people with exceptionally complex needs.

Disclosure and compliance

Audit Opinion

Auditor General

INDEPENDENT AUDITOR'S REPORT

To the Parliament of Western Australia

THE MINISTER FOR HEALTH IN HIS CAPACITY AS THE DEEMED BOARD OF THE METROPOLITAN PUBLIC HOSPITALS

Report on the Financial Statements

I have audited the accounts and financial statements of The Minister for Health in his Capacity as the Deemed Board of the Metropolitan Public Hospitals.

The financial statements comprise the Statement of Financial Position as at 30 June 2016, the Statement of Comprehensive Income, Statement of Changes in Equity and Statement of Cash Flows for the year then ended, and Notes comprising a summary of significant accounting policies and other explanatory information.

Opinion
In my opinion, the financial statements are based on proper accounts and present fairly, in all material respects, the financial position of The Minister for Health in his Capacity as the Deemed Board of the Metropolitan Public Hospitals at 30 June 2016 and its financial performance and cash flows for the year then ended. They are in accordance with Australian Accounting Standards and the Treasurer's Instructions.

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

Auditor's Responsibility 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 based on my audit. The audit was conducted in accordance with Australian Auditing Standards. Those Standards require compliance with relevant ethical requirements relating to audit engagements and that the audit be planned and performed to obtain reasonable assurance about whether the financial statements are free from material misstatement.

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

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

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

Report on Controls

I have audited the controls exercised by The Minister for Health in his Capacity as the Deemed Board of the Metropolitan Public Hospitals during the year ended 30 June 2016.

Controls exercised by The Minister for Health in his Capacity as the Deemed Board of the Metropolitan Public Hospitals are those policies and procedures established by the Director General to ensure that the receipt, expenditure and investment of money, the acquisition and disposal of property, and the incurring of liabilities have been in accordance with legislative provisions.

Basis for Qualified Opinion
Controls over medical practitioners' treatment charges were deficient as there were inadequate procedures in place to ensure that all revenue associated with the medical practitioners' treatment of private and overseas patients has been brought to account. As a result, I was unable to determine whether all patient charges that should have been billed were billed.

Qualified Opinion
In my opinion, except for the possible effects of the matter described in the Basis for Qualified Opinion paragraph, the controls exercised by The Minister for Health in his Capacity as the Deemed Board of the Metropolitan Public Hospitals 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 2016.

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

Auditor's Responsibility for the Audit of Controls
As required by the Auditor General Act 2006, my responsibility is to express an opinion on the controls exercised by The Minister for Health in his Capacity as the Deemed Board of the Metropolitan Public Hospitals based on my audit conducted in accordance with Australian Auditing and Assurance Standards.

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

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

Report on the Key Performance Indicators

I have audited the key performance indicators of The Minister for Health in his Capacity as the Deemed Board of the Metropolitan Public Hospitals for the year ended 30 June 2016.

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

Opinion
In my opinion, in all material respects, the key performance indicators of The Minister for Health in his Capacity as the Deemed Board of the Metropolitan Public Hospitals are relevant and appropriate to assist users to assess the Metropolitan Public Hospitals' performance and fairly represent indicated performance for the year ended 30 June 2016.

Matters of Significance
Emergency Department Waiting Times
The Minister for Health in his capacity as the Deemed Board of the Metropolitan Public Hospitals received approval from the Acting Under Treasurer to remove the following indicators as the audited key performance indicators (KPIs) from 1 July 2013:

- Percentage of Emergency Department patients seen within recommended times (by triage category)
- Percentage of admitted patients transferred to an inpatient ward within 8 hours of Emergency Department arrival
- Rate of hospitalisation for falls in older persons – 'Rate of emergency attendances per 1,000 persons aged 55-80+' – component only

The approval was conditional on their inclusion as unaudited performance indicators in the agency's 2013-14 Annual Report and that they be reinstated as audited KPIs following the implementation of a new Emergency Department data collection system. A new system had not been developed at 30 June 2016. Consequently, the three KPIs have not been included in the audited KPIs for the year ended 30 June 2016. My opinion is not modified in respect of this matter.

Elective Surgery Waiting Times
The Minister for Health in his capacity as the Deemed Board of the Metropolitan Public Hospitals received approval from the Under Treasurer to remove the 'Elective Surgery Waiting Times' Key Performance Indicator (KPI) from the audited KPIs for the year ended 30 June 2012. The approval was conditional on the inclusion of unaudited performance indicators measuring elective surgery waiting times in the agency's 2011-12 Annual Report and that elective surgery waiting times be reinstated as an audited KPI following the successful definition of national elective surgery waiting time indicators. The definition of national elective surgery waiting times has been developed. Implementation is planned from 1 July 2016 in line with the national implementation date. Consequently, the 'Elective Surgery Waiting Times' KPI has not been included in the audited KPIs for the year ended 30 June 2016. My opinion is not modified in respect of this matter.

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

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

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

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

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

Matters Relating to the Electronic Publication of the Audited Financial Statements and Key Performance Indicators
This auditor's report relates to the financial statements and key performance indicators of The Minister for Health in his Capacity as the Deemed Board of the Metropolitan Public Hospitals for the year ended 30 June 2016 included on the Metropolitan Public Hospitals' website. The Metropolitan Public Hospitals' management is responsible for the integrity of the Metropolitan Public Hospitals' website. This audit does not provide assurance on the integrity of the Metropolitan Public Hospitals' website. The auditor's report refers only to the financial statements and key performance indicators described above. It does not provide an opinion on any other information which may have been hyperlinked to/from these financial statements or key performance indicators. If users of the financial statements and key performance indicators are concerned with the inherent risks arising from publication on a website, they are advised to refer to the hard copy of the audited financial statements and key performance indicators to confirm the information contained in this website version of the financial statements and key performance indicators.

COLIN MURPHY
AUDITOR GENERAL
FOR WESTERN AUSTRALIA
Perth, Western Australia
21 September 2016

Certification of financial statements

METROPOLITAN HEALTH SERVICE

CERTIFICATION OF FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2016

The accompanying financial statements of the Metropolitan Health Service have been prepared in compliance with the provisions of the *Financial Management Act 2006* from proper accounts and records to represent fairly the financial transactions for the financial year ending 30 June 2016 and financial position as at 30 June 2016.

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

Dr D J Russell-Weisz
DIRECTOR GENERAL
DEPARTMENT OF HEALTH
REPORTING OFFICER

15 September 2016

Financial statements

The Minister for Health in his Capacity as the Deemed Board of Metropolitan Public Hospitals

Statement of Comprehensive Income

For the year ended 30 June 2016

	Note	2016 $000	2015 $000
COST OF SERVICES			
Expenses			
Employee benefits expense	7	3,609,669	3,548,255
Fees for visiting medical practitioners		56,789	60,011
Contracts for services	8	661,962	489,170
Patient support costs	9	801,319	740,588
Finance costs	10	17,378	17,720
Depreciation and amortisation expense	11	249,860	234,570
Loss on disposal of non-current assets	12	2,504	-
Repairs, maintenance and consumable equipment	13	151,974	125,608
Fiona Stanley Hospital set-up costs	14	-	87,023
Other supplies and services	15	74,748	39,952
Other expenses	16	359,043	345,898
Total cost of services		**5,985,246**	**5,688,795**
INCOME			
Revenue			
Patient charges	17	261,728	228,302
Other fees for services	18	274,331	224,849
Commonwealth grants and contributions	19(i)	1,391,157	1,419,712
Other grants and contributions	19(ii)	423,876	378,731
Donation revenue	20	32,393	12,716
Interest revenue		269	340
Commercial activities	21	3,544	4,250
Other revenue	22	36,273	49,306
Total revenue		2,423,571	2,318,206
Gains			
Gain on disposal of non-current assets	12	-	1,586
Total Gains		-	1,586
Total income other than income from State Government		**2,423,571**	**2,319,792**
NET COST OF SERVICES		**3,561,675**	**3,369,003**
INCOME FROM STATE GOVERNMENT			
Service appropriations	23	3,700,854	3,334,144
Assets (transferred)/assumed	24	(1,922)	(11,243)
Services received free of charge	25	4,199	4,662
Royalties for Regions Fund	26	200	1,365
Total income from State Government		**3,703,331**	**3,328,928**
SURPLUS/(DEFICIT) FOR THE PERIOD		**141,656**	**(40,075)**
OTHER COMPREHENSIVE INCOME/(LOSS)			
Items not reclassified subsequently to profit or loss			
Changes in asset revaluation reserve	43	(110,009)	56,496
TOTAL COMPREHENSIVE INCOME/(LOSS) FOR THE PERIOD		**31,647**	**16,421**

Refer also to note 61 'Schedule of Income and Expenses by Service'.
The Statement of Comprehensive Income should be read in conjunction with the accompanying notes.

The Minister for Health in his Capacity as the Deemed Board of Metropolitan Public Hospitals

Statement of Financial Position

As at 30 June 2016

	Note	2016 $000	2015 $000
ASSETS			
Current Assets			
Cash and cash equivalents	27	36,164	58,840
Restricted cash and cash equivalents	28	118,291	107,116
Receivables	29	160,500	128,334
Inventories	31	20,964	21,430
Other current assets	32	18,298	10,523
Non-current assets classified as held for sale	33	-	800
Total Current Assets		354,217	327,043
Non-Current Assets			
Amounts receivable for services	30	1,752,939	1,388,473
Receivables	29	3,502	-
Property, plant and equipment	34	5,941,152	6,010,375
Intangible assets	36	276,240	253,610
Other non-current assets	32	810	-
Total Non-Current Assets		7,974,643	7,652,458
Total Assets		**8,328,860**	**7,979,501**
LIABILITIES			
Current Liabilities			
Payables	38	357,159	395,832
Borrowings	39	71,597	64,937
Provisions	40	640,908	669,368
Other current liabilities	41	1,757	1,906
Total Current Liabilities		1,071,421	1,132,043
Non-Current Liabilities			
Borrowings	39	240,324	273,630
Provisions	40	164,279	165,791
Other non-current liabilities	41	687	-
Total Non-Current Liabilities		405,290	439,421
Total Liabilities		**1,476,711**	**1,571,464**
NET ASSETS		**6,852,149**	**6,408,037**
EQUITY			
Contributed equity	42	6,209,866	5,797,401
Reserves	43	964,756	1,074,765
Accumulated deficit	44	(322,473)	(464,129)
TOTAL EQUITY		**6,852,149**	**6,408,037**

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

The Minister for Health in his Capacity as the Deemed Board of Metropolitan Public Hospitals

Statement of Changes in Equity

For the year ended 30 June 2016

	Note	2016 $000	2015 $000
CONTRIBUTED EQUITY	42		
Balance at start of period		5,797,401	5,329,077
Transactions with owners in their capacity as owners:			
Capital appropriations		344,550	504,094
Other contributions by owners		70,171	-
Distributions to owners		(2,256)	(35,770)
Balance at end of period		6,209,866	5,797,401
RESERVES	43		
Asset Revaluation Reserve			
Balance at start of period		1,074,765	1,018,269
Other Comprehensive income/(loss) for the period		(110,009)	56,496
Balance at end of period		964,756	1,074,765
ACCUMULATED DEFICIT	44		
Balance at start of period		(464,129)	(424,054)
Surplus/(deficit) for the period		141,656	(40,075)
Balance at end of period		(322,473)	(464,129)
TOTAL EQUITY			
Balance at start of period		6,408,037	5,923,292
Total comprehensive income/(loss) for the period		31,647	16,421
Transactions with owners in their capacity as owners		412,465	468,324
Balance at end of period		**6,852,149**	**6,408,037**

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

The Minister for Health in his Capacity as the Deemed Board of Metropolitan Public Hospitals

Statement of Cash Flows

For the year ended 30 June 2016

	Note	2016 $000 Inflows (Outflows)	2015 $000 Inflows (Outflows)
CASH FLOWS FROM STATE GOVERNMENT			
Service appropriations		3,405,740	3,049,048
Capital appropriations		339,788	499,855
Royalties for Regions Fund		200	1,365
Net cash provided by State Government	45	**3,745,728**	**3,550,268**
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Employee benefits		(3,751,524)	(3,453,756)
Supplies and services		(2,029,172)	(1,888,219)
Finance costs		(15,815)	(13,480)
Other payments		(2,504)	-
Receipts			
Receipts from customers		250,735	217,006
Commonwealth grants and contributions		1,391,157	1,419,712
Other grants and contributions		423,876	378,731
Donations received		31,278	10,697
Interest received		225	340
Other receipts		296,819	297,089
Net cash used in operating activities	45	**(3,404,925)**	**(3,031,880)**
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments			
Payment for purchase of non-current physical and intangible assets		(289,801)	(446,542)
Receipts			
Proceeds from sale of non-current physical assets		3,420	17,797
Net cash used in investing activities		**(286,381)**	**(428,745)**
CASH FLOWS FROM FINANCING ACTIVITIES			
Payments			
Repayment of finance lease liabilities		(62,535)	(46,400)
Net cash used in financing activities		**(62,535)**	**(46,400)**
Net increase / (decrease) in cash and cash equivalents		(8,113)	43,243
Cash and cash equivalents at the beginning of the period		165,956	150,852
Cash transferred to Department of Health	24	(1,132)	(11,254)
Cash transferred to Treasury	42	(2,256)	(16,885)
CASH AND CASH EQUIVALENTS AT THE END OF PERIOD	45	**154,455**	**165,956**

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

Notes to the Financial Statements
For the year ended 30 June 2016

Note 1 Australian Accounting Standards

General

The Health Service's financial statements for the year ended 30 June 2016 have been prepared in accordance with Australian Accounting Standards. The term 'Australian Accounting Standards' includes Standards and Interpretations issued by the Australian Accounting Standards Board (AASB).

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

Early adoption of standards

The Health Service cannot early adopt an Australian Accounting Standard unless specifically permitted by Treasurer's Instruction 1101 '*Application of Australian Accounting Standards and Other Pronouncements*'. Partial exemption permitting early adoption of AASB 2015-7 '*Amendments to Australian Accounting Standards - Fair Value Disclosures of Non-for-Profit Public Sector Entities*' has been granted. Aside from AASB 2015-7, there has been no early adoption of any other Australian Accounting Standards that have been issued or amended (but not operative) by the Health Service for the annual reporting period ended 30 June 2016.

Note 2 Summary of significant accounting policies

(a) General statement

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

The *Financial Management Act 2006* and the Treasurer's instructions impose legislative provisions that govern the preparation of financial statements and take precedence over the Australian Accounting Standards, the Framework, Statements of Accounting Concepts and other authoritative pronouncements of the Australian Accounting Standards Board.

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

(b) Basis of preparation

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

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

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

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

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

(c) Contributed equity

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

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

See also note 42 'Contributed equity'.

The Minister for Health in his Capacity as the Deemed Board of Metropolitan Public Hospitals

Notes to the Financial Statements
For the year ended 30 June 2016

Note 2 Summary of significant accounting policies (continued)

(d) Income

Revenue recognition

Revenue is recognised by reference to the stage of completion of the transaction. The following specific recognition criteria must also be met before revenue is recognised:

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

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

Interest
Revenue is recognised as the interest accrues.

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

See also note 23 'Service appropriations' for further information.

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

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

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

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

(e) Borrowing costs

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

(f) Property, plant and equipment

Site infrastructure
In current financial year, reclassification has been made to separate site infrastructure from buildings. Site infrastructure include roads, footpaths, paved areas, at-grade car parks, boundary walls, boundary fencing, boundary gates, covered ways, landscaping and improvements, external stormwater and sewer drainage, external water, gas and electricity supply, and external communication cables.

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

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

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

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

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

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

Notes to the Financial Statements
For the year ended 30 June 2016

Note 2 Summary of significant accounting policies (continued)

(f) Property, plant and equipment (continued)

Subsequent measurement (continued)
When buildings and site infrastructure are revalued, the accumulated depreciation is eliminated against the gross carrying amount of the asset and the net amount restated to the revalued amount.

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

Site infrastructure are independently valued by the Rider Levett Bucknall WA Pty Ltd (Quantity Surveyor) and recognised to ensure that the carrying amount does not differ materially from the asset's fair value at the end of the reporting period.

The most significant assumptions 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.

See also note 34 'Property, plant and equipment and note 35 'Fair value measurement' for further information on revaluation'.

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

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

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

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

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

Buildings	50 years
Site infrastruture	50 years
Leasehold improvements	Term of the lease
Computer equipment	4 to 20 years
Furniture and fittings	2 to 20 years
Motor vehicles	3 to 10 years
Medical equipment	2 to 25 years
Other plant and equipment	3 to 25 years

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

(g) Intangible assets

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

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

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

Amortisation for intangible assets with finite useful lives is calculated for the period of the expected benefit (estimated useful life which is reviewed annually) on the straight line basis. All intangible assets controlled by the Health Service have a finite useful life and zero residual value.

Estimated useful life of intangible asset is:

Computer software	5 - 15 years

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

The Minister for Health in his Capacity as the Deemed Board of Metropolitan Public Hospitals

Notes to the Financial Statements
For the year ended 30 June 2016

Note 2 Summary of significant accounting policies (continued)

(h) Impairment of assets

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

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

Intangible assets not yet available for use are tested for impairment at the end of each reporting period irrespective of whether there is any indication of impairment.

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

See also note 37 'Impairment of assets' for the outcome of impairment reviews and testing.
Refer also to note 2(p) 'Receivables' and note 29 'Receivables' for impairment of receivables.

(i) Non-current assets (or disposal groups) classified as held for sale

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

(j) Leases

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

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

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

(k) Financial instruments

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

Financial instruments have been disaggregated into the following classes:

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

Financial liabilities:
* Payables
* Department of Treasury loans
* Finance lease liabilities

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

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

Notes to the Financial Statements
For the year ended 30 June 2016

Note 2 Summary of significant accounting policies (continued)

(l) Cash and cash equivalents

For the purpose of the Statement of Cash Flows, cash and cash equivalent (and restricted cash and cash equivalent) assets comprise cash on hand, cash at bank 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.

(m) Accrued salaries

Accrued salaries (see note 38 'Payables') represent the amount due to employees but unpaid at the end of the financial year, as the pay date for the last pay period for that financial year does not coincide with the end of the financial year. Accrued salaries are settled within a fortnight of the financial year end. The Health Service considers the carrying amount of accrued salaries to be equivalent to its fair value.

(n) Amounts receivable for services (holding account)

The Health Service receives service appropriation funding from the State Government partly in cash and partly as an asset (holding account receivable). The holding account receivable balance is accessible on the emergence of the cash funding requirement to cover leave entitlements and asset replacement.
See also note 23 'Service appropriations' and note 30 'Amounts receivable for services'.

(o) Inventories

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

Inventories not held for resale are measured at cost unless they are no longer required, in which case they are measured at net realisable value (See note 31 ' Inventories').

(p) Receivables

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

See also note 2(k) 'Financial Instruments' and note 29 'Receivables'.

Accounting procedure for Goods and Services Tax
Rights to collect amounts receivable from the Australian Taxation Office (ATO) and responsibilities to make payments for GST have been assigned to the 'Department of Health'. This accounting procedure was a result of application of the grouping provisions of "A New Tax System (Goods and Services Tax) Act 1999" whereby the Department of Health became the Nominated Group Representative (NGR) for the GST Group as from 1 July 2012. The 'Minister for Health in his Capacity as the Deemed Board of the Metropolitan Public Hospitals' (Metropolitan Health Services) was the NGR in previous financial years. The entities in the GST group include the Department of Health, Mental Health Commission, Metropolitan Health Service, WA Country Health Service, QE II Medical Centre Trust, and Health and Disability Services Complaints Office.

GST receivables on accrued expenses are recognised by the Health Service. Upon the receipt of tax invoices, GST receivables for the GST group are recorded in the accounts of the Department of Health.

(q) Payables

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

See also note 2(k) 'Financial instruments' and note 38 'Payables'.

(r) Borrowings

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

See also note 2(k) 'Financial instruments' and note 39 'Borrowings'.

(s) Provisions

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

See also note 40 'Provisions'.

The Minister for Health in his Capacity as the Deemed Board of Metropolitan Public Hospitals

Notes to the Financial Statements
For the year ended 30 June 2016

Note 2 Summary of significant accounting policies (continued)

(s) Provisions (continued)
Provisions - employee benefits

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

Annual Leave and Time Off in Lieu Leave

Annual leave and time off in lieu leave are not expected to be settled wholly within 12 months after the end of the reporting period and is therefore considered to be 'other long-term employee benefits'. The annual leave liability and time off in lieu leave liability are recognised and measured at the present value of amounts expected to be paid when the liabilities are settled using the remuneration rate expected to apply at the time of settlement.

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

The provisions for annual leave and time off in lieu leave are classified as a current liability as the Health Service does not have an unconditional right to defer settlement of the liability for at least 12 months after the end of the reporting period.

Long service leave

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

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

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

Sick Leave

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

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

Deferred Salary Scheme

The provision for the deferred salary scheme relates to Health Service employees who have entered into an agreement to self-fund an additional twelve months leave in the fifth year of the agreement. The provision recognises the value of salary set aside for employees to be used in the fifth year. The liability is measured on the same basis as annual leave. It is reported as a current provision as employees can leave the scheme at their discretion at any time.

Superannuation

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.

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

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

Notes to the Financial Statements
For the year ended 30 June 2016

Note 2 Summary of significant accounting policies (continued)

(s) Provisions (continued)

Superannuation (continued)

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

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

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

Employment on-costs

Employment on-costs (workers' compensation insurance) are not employee benefits and are recognised separately as liabilities and expenses when the employment to which they relate has occurred. Employment on-costs are included as part of 'Other expenses' and are not included as part of the Health Service's 'Employee benefits expense'. Any related liability is included in 'Employment on-costs provision'.
See also note 16 'Other expenses' and note 40 'Provisions'.

(t) Superannuation expense

Superannuation expense in the Statement of Comprehensive Income comprises employer contributions paid to the GSS (concurrent contributions), WSS, GESBS, and other superannuation funds.

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

Services received free of charge or for nominal cost, that the Health Service would otherwise purchase if not donated, are recognised as income at the fair value of the services where they can be reliably measured. A corresponding expense is recognised for services received.

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

(v) Assets transferred between Government Agencies

Discretionary transfers of net assets (assets and liabilities) between State Government agencies free of charge, are measured at the fair value of those net assets that the Health Service would otherwise pay for, and are reported under Income from State Government. Transfers of assets and liabilities in relation to a restructure of administrative arrangements are recognised as distribution to owners by the transferor and contribution by owners by the transferee under AASB 1004 '*Contributions*' in respect of the net assets transferred.

(w) Comparative figures

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

(x) Trust accounts

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

Details of Trust Accounts are reported as a note to the financial statements (refer to note 57).

The Minister for Health in his Capacity as the Deemed Board of Metropolitan Public Hospitals

Notes to the Financial Statements
For the year ended 30 June 2016

Note 3 Judgements made by management in applying accounting policies

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

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

Buildings

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

Finance Leases

During the 2011-12 financial year, the Health Service entered into a facilities management contract for a minimum period of 10 years for the Fiona Stanley Hospital with Serco Limited, whereby, subject to approval by the Health Service, Serco is to acquire specified assets for use at the hospital. The specified assets are to be acquired under a lease facility with a bank. Under the terms of the Facilities Management Contract and the related agreements, an element of the fee paid to Serco is linked to the fixed lease payments detailed on each leasing schedule for each group of assets, and at the end of the lease period for each group of assets, the Health Service is required to take ownership directly or dispose of the asset.

Although the arrangement, that is under a Tripartite Agreement between the Minister for Health, the private sector provider (Serco) and the bank, is not in the legal form of a lease, the Health Service concluded that the arrangement contains a lease of assets, because fulfilment of the arrangement is economically dependent on the use of the assets and the Health Service receives the full service potential from the assets through the services provided at the Fiona Stanley Hospital. The leases are classified as finance leases.

The Health Service is able to determine the fair value of the lease element of the Facilities Management Contract with direct reference to the underlying lease payments agreed on each leasing schedule between Serco and the bank, which has been authorised by the Health Service. Therefore, at lease inception, being the various dates on which the leasing schedules for the individual assets are entered into, the Health Service recognises the leased asset and liability at the lower of the fair value or present value of future lease payments. The imputed finance costs on the liability were determined based on the interest rate implicit in the lease.

Note 4 Key sources of estimation uncertainty

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

Buildings

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

Employee benefits provision

In estimating the non-current long service leave liabilities, employees are assumed to leave the Health Service each year on account of resignation or retirement at 7.5%. This assumption was based on an analysis of the turnover rates exhibited by employees over a five year period. Employees with leave benefits to which they are fully entitled are assumed to take all available leave uniformly over the following five years or to age 65 if earlier.

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

Notes to the Financial Statements
For the year ended 30 June 2016

Note 5 Disclosure of changes in accounting policy and estimates

Initial application of an Australian Accounting Standard

The Health Service has applied the following Australian Accounting Standards effective for annual reporting periods beginning on or after 1 July 2015 that impacted on the Health Service.

Title	
AASB 2013-9	*Amendments to Australian Accounting Standards - Conceptual Framework, Materiality and Financial Instruments.* Part C of this Standard defers the application of AASB 9 to 1 January 2017. The application date of AASB 9 was subsequently deferred to 1 January 2018 by AASB 2014-1. The Health Service has not yet determined the application or the potential impact of AASB 9.
AASB 2014-8	*Amendments to Australian Accounting Standards arising from AASB 9 (December 2014) – Application of AASB 9 (December 2009) and AASB 9 (December 2010) [AASB 9 (2009 & 2010)]* This Standard makes amendments to AASB 9 *Financial Instruments* (December 2009) and AASB 9 *Financial Instruments* (December 2010), arising from the issuance of AASB 9 *Financial Instruments* in December 2014. The Health Service has not yet determined the application or the potential impact of AASB 9.
AASB 2015-3	*Amendments to Australian Accounting Standards arising from the Withdrawal of AASB 1031 Materiality.* This Standard completes the withdrawal of references to AASB 1031 in all Australian Accounting Standards and Interpretations, allowing that Standard to effectively be withdrawn. There is no financial impact.

Future impact of Australian Accounting Standards not yet operative

The Health Service cannot early adopt an Australian Accounting Standard unless specifically permitted by TI 1101 *Application of Australian Accounting Standards and Other Pronouncements* or by an exemption from TI 1101. By virtue of a limited exemption, the Health Service has early adopted AASB 2015-7 *Amendments to Australian Accounting Standards - Fair Value Disclosures of Non-for-Profit Public Sector Entities*. Where applicable, the Health Service plans to apply the following Australian Accounting Standards from their application date.

Title		Operative for reporting periods beginning on/after
AASB 9	*Financial Instruments* This Standard supersedes AASB 139 *Financial Instruments: Recognition and Measurement*, introducing a number of changes to accounting treatments. The mandatory application date of this Standard is currently 1 January 2018 after being amended by AASB 2012-6, AASB 2013-9 and AASB 2014-1 *Amendments to Australian Accounting Standards*. The Health Service has not yet determined the application or the potential impact of the Standard.	1 Jan 2018
AASB 15	*Revenue from Contracts with Customers* This Standard establishes the principles that the Health Service shall apply to report useful information to users of financial statements about the nature, amount, timing and uncertainty of revenue and cash flows arising from a contract with a customer. The Health Service has not yet determined the application or the potential impact of the Standard.	1 Jan 2018
AASB 16	*Leases* This Standard introduces a single lessee accounting model and requires a lessee to recognise assets and liabilities for all leases with a term of more than 12 months, unless the underlying asset is of low value. The Health Service has not yet determined the application or the potential impact of the Standard.	1 Jan 2019

The Minister for Health in his Capacity as the Deemed Board of Metropolitan Public Hospitals

Notes to the Financial Statements
For the year ended 30 June 2016

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

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

Title		Operative for reporting periods beginning on/after
AASB 1057	*Application of Australian Accounting Standards* This Standard lists the application paragraphs for each other Standard (and Interpretation), grouped where they are the same. There is no financial impact.	1 Jan 2016
AASB 2010-7	*Amendments to Australian Accounting Standards arising from AASB 9 (December 2010) [AASB 1, 3, 4, 5, 7, 101, 102, 108, 112, 118, 120, 121, 127, 128, 131, 132, 136, 137, 139, 1023 & 1038 and Int 2, 5, 10, 12, 19 & 127]* This Standard makes consequential amendments to other Australian Accounting Standards and Interpretations as a result of issuing AASB 9 in December 2010. The mandatory application date of this Standard has been amended by AASB 2012-6 and AASB 2014-1 to 1 January 2018. The Health Service has not yet determined the application or the potential impact of the Standard.	1 Jan 2018
AASB 2014-1	*Amendments to Australian Accounting Standards* Part E of this standard makes amendments to AASB 9 and consequential amendments to other Standards. It has not yet been assessed by the Health Service to determine the application or potential impact of the Standard.	1 Jan 2018
AASB 2014-4	*Amendments to Australian Accounting Standards – Clarification of Acceptable Methods of Depreciation and Amortisation [AASB 116 & 138]* The adoption of this Standard has no financial impact for the Health Service as depreciation and amortisation is not determined by reference to revenue generation, but by reference to consumption of future economic benefits.	1 Jan 2016
AASB 2014-5	*Amendments to Australian Accounting Standards arising from AASB 15* This Standard gives effect to the consequential amendments to Australian Accounting Standards (including Interpretations) arising from the issuance of AASB 15. The Health Service has not yet determined the application or the potential impact of the Standard.	1 Jan 2018
AASB 2014-7	*Amendments to Australian Accounting Standards arising from AASB 9 (December 2014)* This Standard gives effect to the consequential amendments to Australian Accounting Standards (including Interpretations) arising from the issuance of AASB 9 (December 2014). The Health Service has not yet determined the application or the potential impact of the Standard.	1 Jan 2018
AASB 2015-1	*Amendments to Australian Accounting Standards - Annual Improvements to Australian Accounting Standards 2012-2014 Cycle (AASB 1, 2, 3, 5, 7, 11, 110, 119, 121, 133, 134, 137 & 140)* These amendments arise from the issuance of International Financial Reporting Standard Annual Improvements to IFRSs 2012-2014 Cycle in September 2014, and editorial corrections. The Health Service has not yet determined the application or the potential impact of the Standard.	1 Jan 2016

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

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

Title		Operative for reporting periods beginning on/after
AASB 2015-2	*Amendments to Australian Accounting Standards - Disclosure Initiative: Amendments to AASB 101 (AASB 7, 101, 134 & 1049)* This Standard amends AASB 101 to provide clarification regarding the disclosure requirements in AASB 101. Specifically, the Standard proposes narrow-focus amendments to address some of the concerns expressed about existing presentation and disclosure requirements and to ensure entities are able to use judgement when applying a Standard in determining what information to disclose in their financial statements. There is no financial impact.	1 Jan 2016
AASB 2015-6	*Amendments to Australian Accounting Standards - Extending Related Party Disclosures to Not-for-Profit Public Sector Entities (AASB 10, 124 & 1049)* The amendments extend the scope of AASB 124 to include application by not-for-profit public sector entities. Implementation guidance is included to assist application of the Standard by not-for-profit public sector entities. There is no financial impact.	1 Jul 2016
AASB 2015-8	*Amendments to Australian Accounting Standards – Effective Date of AASB 15* This Standard amends the mandatory effective date (application date) of AASB 15 *Revenue from Contracts with Customers* so that AASB 15 is required to be applied for annual reporting periods beginning on or after 1 January 2018 instead of 1 January 2017. The Health Service has not yet determined the application or the potential impact of AASB 15.	1 Jan 2017
AASB 2016-2	*Amendments to Australian Accounting Standards – Disclosure Initative: Amendments to AASB 107* This Standard amends AASB 107 *Statement of Cash Flows* (August 2015) to require disclosures that enable users of financial statements to evaluate changes in liabilities arising from financing activities, including both changes arising from cash flows and non-cash changes. There is no financial impact.	1 Jan 2017
AASB 2016-3	*Amendments to Australian Accounting Standards – Clarifications to AASB 15* This Standard clarifies identifying performance obligations, principal versus agent considerations, timing of recognising revenue from granting a licence, and, provides further transitional provisions to AASB 15. The Health Service has not yet determined the application or the potential impact.	1 Jan 2018
AASB 2016-4	*Amendments to Australian Accounting Standards – Recoverable Amount of Non-Cash-Generating Specialised Assets of Not-for-Profit Entities* This Standard clarifies that the recoverable amount of primarily non-cash-generating assets of not-for-profit entities, which are typically specialised in nature and held for continuing use of their service capacity, is expected to be materially the same as fair value determined under AASB 13 *Fair Value Measurement*. The Health Service has not yet determined the application or the potential impact.	1 Jan 2017

The Minister for Health in his Capacity as the Deemed Board of Metropolitan Public Hospitals

Notes to the Financial Statements
For the year ended 30 June 2016

Note 6 Services of the Health Service

Information about the Health Service's services and the expenses and revenues which are reliably attributable to those services are set out in note 61. The key services of the Health Service are:

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

Home-Based Hospital Programs
The 'Hospital in the Home' (HITH) and 'Mental Health in the Home' (MITH) programs provide short-term acute care in the patient's home for those who can be safely cared for without constant monitoring for conditions that traditionally required hospital admission and inpatient treatment. These services involve daily home visits by nurses, with medical governance usually by a hospital-based doctor. This service also includes the 'Friends-in-Need-Emergency' (FINE) program which delivers similar care interventions for older and chronically ill patients who have a range of short-term clinical care requirements.

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

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

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

Dental Health
Dental health services include the school dental service, providing dental health assessment and treatment for school children, the adult dental service for financially and/or geographically disadvantaged people and specialist and general dental and oral healthcare provided by the Oral Health Centre of Western Australia to holders of a Health Care Card. Services are provided through government funded dental clinics, itinerant services and private dental practitioners participating in the metropolitan, country and orthodontic patient dental subsidy schemes.

Mental Health
Contracted mental health services describe inpatient care in an authorised ward and community mental health services provided by Health Services under an agreement with the Mental Health Commission for specialised admitted and community mental health.

Note 7 Employee benefits expense

	2016 $000	2015 $000
Salaries and wages (a)	3,310,141	3,258,902
Superannuation - defined contribution plans (b)	299,528	289,353
	3,609,669	3,548,255

(a) Includes the value of the fringe benefits to the employees plus the fringe benefits tax component, the value of the superannuation contribution component of leave entitlements and redundancy expenses of $45.784 million ($24.887 million for 2015).

(b) Defined contribution plans include West State, Gold State and GESB Super and other eligible funds.

Employment on-costs expenses (workers' compensation insurance) are included at note 16 'Other expenses'.

Notes to the Financial Statements
For the year ended 30 June 2016

	2016 $000	2015 $000
Note 8 Contracts for services		
Public patients services (a)	589,760	419,759
Mental Health	30,930	22,122
Other aged care services	12,257	17,583
Child, community and primary health	10,832	10,124
Other contracts	18,183	19,582
	661,962	489,170

(a) Private hospitals and non-government organisations are contracted to provide various services to public patients and the community.

Note 9 Patient support costs		
Medical supplies and services	617,106	578,806
Domestic charges	89,198	63,016
Fuel, light and power	40,792	45,371
Food supplies	29,604	31,665
Patient transport costs	12,956	12,112
Research, development and other grants	11,663	9,618
	801,319	740,588
Note 10 Finance costs		
Finance lease charges	16,581	16,638
Interest expense	797	1,082
	17,378	17,720
Note 11 Depreciation and amortisation expense		
Depreciation		
Buildings	115,036	115,520
Site infrastructure	13,182	15,124
Leasehold improvements	1,681	1,677
Computer equipment	35,632	23,195
Furniture and fittings	4,025	2,853
Motor vehicles	491	754
Medical equipment	41,730	49,655
Other plant and equipment	8,360	6,417
	220,137	215,195
Amortisation		
Computer software	29,723	19,375
	249,860	234,570
Note 12 Loss/(Gain) on disposal of non-current assets		
Carrying amount of non-current assets disposed:		
Property, plant and equipment	9,424	16,211
Proceeds from disposal of non-current assets:		
Property, plant and equipment	(6,920)	(17,797)
Net loss/(gain)	2,504	(1,586)

See note 34 'Property, plant and equipment'.

Note 13 Repairs, maintenance and consumable equipment		
Repairs and maintenance	106,907	83,776
Consumable equipment	45,067	41,832
	151,974	125,608

The Minister for Health in his Capacity as the Deemed Board of Metropolitan Public Hospitals

Notes to the Financial Statements
For the year ended 30 June 2016

	2016 $000	2015 $000
Note 14 Fiona Stanley Hospital set-up costs		
Transitional costs (a)	-	87,023
	-	87,023

(a) In the 2014-15 financial year, the Health Service completed the transitional phase which involved the provision of operational services, management of staff and asset transfers from other hospitals, inventory procurement, testing of equipment and service interfaces, and other related services for the opening of the Fiona Stanley Hospital.

Note 15 Other supplies and services		
Sanitisation and waste removal services	7,922	7,059
Administration and management services	56,370	26,952
Interpreter services	5,331	4,019
Security services	993	1,204
Other	4,132	718
	74,748	39,952
Note 16 Other expenses		
Communications	23,478	20,411
Computer services	92,816	78,796
Workers compensation insurance (a)	63,072	59,675
Operating lease expenses	35,459	35,677
Other insurances	33,753	32,262
Consultancy fees	10,985	19,319
Other employee related expenses	14,811	14,440
Printing and stationery	13,938	15,207
Doubtful debts expense	24,487	15,443
Freight and cartage	5,785	5,757
Periodical subscription	6,108	5,692
Write-down of inventories	317	3,605
Write-down of assets (b)	11,981	8,651
Motor vehicle expenses	3,875	3,957
Other	18,178	27,006
	359,043	345,898

(a) The employment on-costs include workers' compensation insurance only. Any on-costs liability associated with the recognition of annual and long service leave liabilities is included at note 40 'Provisions'. Superannuation contributions accrued as part of the provision for leave are employee benefits and are not included in employment on-costs.

(b) See note 34 'Property, plant and equipment' and note 36 'Intangible assets'.

Note 17 Patient charges		
Inpatient bed charges	163,236	139,828
Inpatient other charges	23,142	18,073
Outpatient charges	28,568	25,562
Pathology services to patients	46,782	44,839
	261,728	228,302
Note 18 Other fees for services		
Recoveries from the Pharmaceutical Benefits Scheme (PBS)	144,861	114,617
Clinical services to other health organisations	58,099	45,063
Non clinical services to other health organisations	24,820	20,148
Pathology services to other organisations	16,900	17,139
Other	29,651	27,882
	274,331	224,849

Notes to the Financial Statements
For the year ended 30 June 2016

	2016 $000	2015 $000
Note 19 Grants and contributions		
i) Commonwealth grants and contributions		
Capital Grants:		
Midland Health Campus	600	50,000
Project funded under the National Partnership Agreement	931	14,909
Project funded under the Four Hour Rule Initiative	-	39
Digital mammography technology	1,602	1,174
Cardiac Imaging System Lab	1,342	-
Other	-	6
Recurrent Grants:		
National Health Reform Agreement (funding via Department of Health) (a)	1,242,702	1,204,801
National Health Reform Agreement (funding via Mental Health Commission) (a)	141,319	146,897
Other	2,661	1,886
	1,391,157	1,419,712
ii) Other grants and contributions		
Mental Health Commission – service delivery agreement	399,982	352,757
Mental Health Commission – other	10,648	9,067
Disability Services Commission - community aids & equipment program	4,905	4,897
Lotteries Commission	22	45
Princess Margaret Hospital Foundation	792	1,261
Other	7,527	10,704
	423,876	378,731

(a) As from 1 July 2012, activity based funding and block grant funding have been received from the Commonwealth Government under the National Health Reform Agreement for services, health teaching, training and research provided by local hospital networks (Health Services). The new funding arrangement established under the Agreement requires the Commonwealth Government to make funding payments to the State Pool Account from which distributions to the local hospital networks (Health Services) are made by the Department of Health and Mental Health Commission. Prior to the 2012-13 financial year, the equivalent Commonwealth funding was received in the form of Service Appropriations from the State Treasurer, via the Department of Health.

Note 20 Donation revenue

Sarich Neuroscience Research Institute	25,450	1,000
Telethon grants	1,503	6,000
General public contributions	5,440	5,716
	32,393	12,716

Note 21 Commercial activities

Sales:		
Coffee shop sales revenue	5,432	6,514
Car parking fees revenue	2,180	1,900
	7,612	8,414
Cost of sales (a)	(4,068)	(4,164)
Gross profit	3,544	4,250

(a) The cost of sales does not include salaries or other costs.

The Minister for Health in his Capacity as the Deemed Board of Metropolitan Public Hospitals

Notes to the Financial Statements
For the year ended 30 June 2016

	2016 $000	2015 $000
Note 22 Other revenue		
Use of hospital facilities	7,593	15,152
Rent from commercial properties	3,501	3,790
Rent from residential properties	642	652
Boarders' accommodation	1,439	1,251
RiskCover insurance premium rebate	4,809	346
Parking	9,535	6,707
Research and clinical trial revenue	888	4,912
Sale of radiopharmacies	1,050	934
Revenue from training	1,778	1,001
Catering Functions	130	627
Act of Grace payments received for patients (note 29)	-	5,904
Other	4,908	8,030
	36,273	49,306

Note 23 Service appropriations

Appropriation revenue received during the period:

Service appropriations (funding via the Department of Health)	3,700,854	3,334,144

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

Note 24 Assets (transferred)/assumed

Assets transferred from/(to) other State government agencies during the period:

- Transfer of cash to the Department of Health	(1,132)	(11,254)
- Transfer of equipment from the Department of Health	-	11
- Transfer of medical equipment to WA Country Health Service	(867)	-
- Transfer of medical equipment from the Department of Health	77	-
	(1,922)	(11,243)

Discretionary transfers of net assets (assets and liabilities) between State Government agencies free of charge, are reported under Income from State Government. Transfers of assets and liabilities in relation to a restructure of administrative arrangements are recognised as distribution to owners by the transferor and contribution by owners by the transferee under AASB 1004 '*Contributions*' in respect of net assets transferred.

Note 25 Services received free of charge

Services received free of charge from other State government agencies during the period:

Department of Finance - integrated procurement services and government accommodation - leasing	4,199	4,662

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

Note 26 Royalties for Regions Fund

Regional Community Services Account	-	968
Regional Infrastructure and Headworks Account	200	397
	200	1,365

This is a sub-fund within the over-arching 'Royalties for Regions Fund' established under the Royalty for Regions Act 2009. The recurrent funds were for the payment of additional district allowances as an incentive for dental and pathology staff working in the regional areas of Western Australia.

Notes to the Financial Statements

For the year ended 30 June 2016

	2016 $000	2015 $000
Note 27 Cash and cash equivalents		
Current	36,164	58,840

Includes cash assigned to meet ongoing internal obligations arising from allocated donations, research program commitments, education and training grants, funds directed and quarantined under medical industrial agreement and funds directed and quarantined under previous Ministerial Directive.

Note 28 Restricted cash and cash equivalents

Current		
Capital grant from the Commonwealth Government for Fiona Stanley Hospital (a)	-	2,600
Other capital grants from the Commonwealth Government	396	693
Capital appropriation from the Fiona Stanley Hospital Construction Account (c)	20,876	20,658
Fiona Stanley Hospital - Upgrade Works Account (d)	444	229
Restricted cash assets held for other specific purposes (b)	95,277	82,209
Mental Health Commission Funding (e)	1,298	727
	118,291	107,116

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

(a) These unspent funds from the Commonwealth Government are committed to the construction of the Fiona Stanley State Rehabilitation Centre.

(b) These include medical research grants, donations for the benefits of patients, medical education, scholarships, capital projects, employee contributions and staff benevolent funds.

(c) The moneys appropriated to the Fiona Stanley Hospital Construction Account must be used for the purposes of the construction and establishment of the Fiona Stanley Hospital.

(d) The moneys deposited to the Fiona Stanley Hospital Upgrade Works Account must be used for the purposes of the upgrade works in respect of the building and site services assets.

(e) See Note 58 'Special purpose accounts'

Note 29 Receivables

Current		
Patient fee debtors (a)	140,646	108,381
Other receivables	33,607	20,634
Less: Allowance for impairment of receivables	(71,111)	(49,839)
Accrued revenue	41,384	35,337
GST Receivables	15,974	13,821
	160,500	128,334
Non-Current		
Other receivables	3,502	-
	3,502	-
Reconciliation of changes in the allowance for impairment of receivables:		
Balance at start of period	49,839	43,842
Doubtful debts expense (note 16)	24,487	15,443
Amounts written off during the period	(3,215)	(3,542)
Amount recovered during the period (a)	-	(5,904)
Balance at end of period	71,111	49,839

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

(a) $5.904 million of act of grace payments were received in 2014-15 for patient fee debts which were impaired in previous years. Under the Private Patient Scheme approved by the State Government, the Department of Health has commenced the ex-gratia payments towards patient fee debts in July 2015. The total amounts of ex-gratia payments is $6.409 million for 2015-16.

See also note 2(p) 'Receivables' and note 60 'Financial instruments'.

The Minister for Health in his Capacity as the Deemed Board of Metropolitan Public Hospitals

Notes to the Financial Statements

For the year ended 30 June 2016

	2016 $000	2015 $000
Note 30 Amounts receivable for services (Holding Account)		
Non-current	1,752,939	1,388,473

Represents the non-cash component of service appropriations. It is restricted in that it can only be used for asset replacement or payment of leave liability. See note 2(n) 'Amounts receivable for services'.

Amounts receivable for services associated with Joondalup and Peel Health Campuses ($70.171 million) were transferred from the Department of Health to the Health Service in 2015-16. See also Note 42 (f) 'Contributed equity' for further information on the transfer.

Note 31 Inventories

Current		
Pharmaceutical stores - at cost	19,166	19,663
Engineering stores - at cost	1,798	1,767
	20,964	21,430

See also note 2(o) 'Inventories'.

Note 32 Other assets

Current		
Prepayments	14,521	7,635
Other	3,777	2,888
Total current	18,298	10,523
Non-current		
Prepayments	810	-
Total non-current	810	-

Note 33 Non-current assets classified as held for sale

Opening balance	800	-
Land reclassified as held for sale	-	650
Buildings reclassified as held for sale	-	150
Disposal of land and building	(800)	-
Closing balance	-	800
Assets reclassified as held for sale		
Land	-	650
Buildings	-	150
	-	800

Notes to the Financial Statements
For the year ended 30 June 2016

	2016 $000	2015 $000
Note 34 Property, plant and equipment		
Land		
At fair value (a)	523,899	541,552
Buildings		
At fair value (a) (b)	3,451,332	3,295,128
Accumulated depreciation	-	-
	3,451,332	3,295,128
Site infrastructure		
At fair value (a) (b)	271,623	325,580
Accumulated depreciation	-	-
	271,623	325,580
Total land, buildings and site infrastructure	4,246,854	4,162,260
Leasehold improvements		
At cost	7,583	9,753
Accumulated depreciation	(3,397)	(7,870)
	4,186	1,883
Computer equipment		
At cost	197,309	188,380
Accumulated depreciation	(68,219)	(52,424)
	129,090	135,956
Furniture and fittings		
At cost	43,903	40,297
Accumulated depreciation	(15,825)	(13,559)
	28,078	26,738
Motor vehicles		
At cost	4,152	4,231
Accumulated depreciation	(4,014)	(3,659)
	138	572
Medical equipment		
At cost	537,910	537,660
Accumulated depreciation	(274,811)	(269,021)
	263,099	268,639
Other plant and equipment		
At cost	159,666	140,236
Accumulated depreciation	(36,497)	(31,158)
	123,169	109,078
Works in progress		
Buildings under construction (at cost)	1,043,439	1,271,714
Other works in progress (at cost)	100,588	32,237
	1,144,027	1,303,951
Artworks		
At cost	2,511	1,298
Total property, plant and equipment	5,941,152	6,010,375

(a) Land and buildings were revalued as at 1 July 2015 by the Western Australian Land Information Authority (Valuation Services). The valuations were performed during the year ended 30 June 2016 and recognised at 30 June 2016. In undertaking the revaluation, fair value was determined by reference to market values for land: $71.384 million and buildings: $5.149 million. For the remaining balance, fair value of buildings was determined on the basis of depreciated 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). See also note 2(f) 'Property, plant and equipment'.

(b) Site infrastructure were revalued as at 1 July 2015 by Rider Levett Bucknall WA Pty Ltd (Quantity Surveyor). The valuations were performed during the year ended 30 June 2016 and recognised at 30 June 2016. Fair value of site infrastruture was determined on the basis of depreciated replacement cost. See note 2(f) 'Property, plant and equipment'.

Site infrastructure include roads, footpaths, paved areas, car parks, boundary walls, boundary fencing, boundary gates, covered ways, landscaping and improvements, external stormwater and sewer drainage, external water, gas and electricity supply, and external communication cables.

(c) Information on fair value measurements is provided in Note 35.

The Minister for Health in his Capacity as the Deemed Board of Metropolitan Public Hospitals

Notes to the Financial Statements
For the year ended 30 June 2016

	2016 $000	2015 $000
Note 34 Property, plant and equipment (continued)		
Reconciliations		
Reconciliations of the carrying amounts of property, plant and equipment at the beginning and end of the reporting period are set out below:		
Land		
Carrying amount at start of period	541,552	589,109
Transfers from Work in Progress	34	-
Transfer to other reporting entities	-	(18,885)
Disposals	(5,834)	(4,100)
Classified as held for sale	-	(650)
Revaluation increments/(decrements)	(25,117)	(23,922)
Transfer between asset classes	13,264	-
Carrying amount at end of period	523,899	541,552
Buildings		
Carrying amount at start of period	3,295,128	1,752,392
Additions	5,283	4,149
Transfer from works in progress	282,342	1,579,588
Disposals	(385)	(7,541)
Classified as held for sale	-	(150)
Revaluation increments/(decrements)	(2,736)	82,211
Depreciation	(115,036)	(115,520)
Transfers between asset classes	(13,264)	-
Carrying amount at end of period	3,451,332	3,295,128
Site infrastructure		
Carrying amount at start of period	325,580	227,257
Additions		-
Transfer from works in progress	41,381	117,798
Disposals	-	(2,559)
Revaluation increments/(decrements)	(82,156)	(1,793)
Depreciation	(13,182)	(15,124)
Carrying amount at end of period	271,623	325,580
Leasehold improvements		
Carrying amount at start of period	1,883	1,726
Additions	3,984	1,834
Depreciation	(1,681)	(1,677)
Carrying amount at end of period	4,186	1,883
Computer equipment		
Carrying amount at start of period	135,956	26,841
Additions	26,387	8,146
Transfer from works in progress	1,085	69,022
Disposals	(4)	-
Depreciation	(35,632)	(23,195)
Transfer between asset classes	1,298	55,142
Carrying amount at end of period	129,090	135,956
Furniture and fittings		
Carrying amount at start of period	26,738	13,164
Additions	5,982	2,255
Transfer from works in progress	1,261	14,360
Transfer from other reporting entities	-	6
Disposals	(65)	(177)
Depreciation	(4,025)	(2,853)
Transfer between asset classes	(1,813)	(17)
Carrying amount at end of period	28,078	26,738

	2016 $000	2015 $000
Note 34 Property, plant and equipment (continued)		
Motor vehicles		
Carrying amount at start of period	572	1,157
Additions	20	113
Transfer from works in progress	37	66
Disposals	-	(10)
Depreciation	(491)	(754)
Carrying amount at end of period	138	572
Medical equipment		
Carrying amount at start of period	268,639	163,894
Additions	38,928	29,580
Transfers from works in progress	(1,100)	126,478
Transfers from/(to) other reporting entities	(825)	-
Disposals	(2,178)	(1,660)
Depreciation	(41,730)	(49,655)
Transfers between asset classes	1,365	2
Carrying amount at end of period	263,099	268,639
Other plant and equipment		
Carrying amount at start of period	109,078	99,283
Additions	11,738	2,705
Transfers from works in progress	10,388	13,658
Transfers from other reporting entities	35	5
Disposals	(158)	(164)
Depreciation	(8,360)	(6,417)
Transfers between asset classes	448	8
Carrying amount at end of period	123,169	109,078
Works in progress		
Carrying amount at start of period	1,303,951	2,774,985
Additions	187,698	453,485
Capitalised to asset classes	(335,641)	(1,920,970)
Write-down of assets (a)	(11,981)	(3,549)
Carrying amount at end of period	1,144,027	1,303,951
Artworks		
Carrying amount at start of period	1,298	1,298
Additions	1,000	-
Transfers from works in progress	213	-
Carrying amount at end of period	2,511	1,298
Total property, plant and equipment		
Carrying amount at start of period	6,010,375	5,651,106
Additions	281,020	502,266
Disposals	(8,624)	(16,211)
Transfers from/(to) other reporting entities	(790)	(18,874)
Classified as held for sale	-	(800)
Revaluation increments/(decrements)	(110,009)	56,496
Depreciation	(220,137)	(215,195)
Reclassification of intangible assets	1,298	55,135
Write-down of assets (a)	(11,981)	(3,549)
Carrying amount at end of period (b)	5,941,152	6,010,375

(a) Works in progress capitalised in prior years but expensed in the current financial year. Refer to note 16 'Other expenses'.

(b) At 30 June 2016, the net carrying amount includes leased medical, computer and other plant and equipment of $243.497 million (2015: $266.906 million). Refer details at note 39 'Borrowings'.

The Minister for Health in his Capacity as the Deemed Board of Metropolitan Public Hospitals

Notes to the Financial Statements
For the year ended 30 June 2016

Note 35 Fair value measurements

(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).

The following table represents the Health Service's assets measured and recognised at fair value at 30 June 2016.

	Level 1 $000	Level 2 $000	Level 3 $000	Total $000
Land				
Vacant land	-	27,850	-	27,850
Residential	-	128	-	128
Specialised	-	43,406	452,515	495,921
Buildings				
Residential and commercial car park	-	2,979	1,428,926	1,431,905
Specialised	-	2,170	2,017,257	2,019,427
Site infrastructure	-	-	271,623	271,623
	-	76,533	4,170,321	4,246,854

The following table represents the Health Service's assets measured and recognised at fair value at 30 June 2015.

	Level 1 $000	Level 2 $000	Level 3 $000	Total $000
Non-current assets classified as held for sale (Note 33)	-	800	-	800
Land				
Vacant land	-	38,940	-	38,940
Residential	-	285	-	285
Specialised	-	50,711	451,616	502,327
Buildings				
Residential and commercial car park	-	3,365	1,596,231	1,599,596
Specialised	-	2,235	1,693,297	1,695,532
Site infrastructure	-	-	325,580	325,580
	-	96,336	4,066,724	4,163,060

(b) Valuation techniques used to derive level 2 and level 3 fair values

The Health Service obtains independent valuations of land and buildings from the Western Australian Land Information Authority (Landgate Valuation Services) annually. The independent valuations of site infrastructure are performed in this financial year by Rider Levett Buchnall WA Pty Ltd (Quantity Surveyor) and by Landgate Valuation Services in previous financial years. Two principal valuation techniques are applied to the measurement of fair values:

Market Approach (Comparable Sales)
The Health Service's residential properties, commercial car park and vacant land are valued under the market approach. This approach provides an indication of value by comparing the asset with identical or similar properties for which price information is available. Analysis of comparable sales information and market data provides the basis for fair value measurement.

The best evidence of fair value is current prices in an active market for similar properties. Where such information is not available, Landgate Valuation Services considers current prices in an active market for properties of different nature or recent prices of similar properties in less active markets, and adjusts the valuation for differences in property characteristics and market conditions.

For properties with buildings and other improvements, the land value is measured by comparison and analysis of open market transactions on the assumption that the land is in a vacant and marketable condition. The amount determined is deducted from the total property value and the residual amount represents the building value.

The Health Service's residential properties mainly consist of residential buildings that have been re-configured to be used as health centres or clinics.

Note 35 Fair value measurements (continued)

(b) Valuation techniques used to derive level 2 and level 3 fair values (continued)

Cost Approach

Properties of a specialised nature that are rarely sold in an active market or are held to deliver public services are referred to as non-market or current use type assets. These properties do not normally have a feasible alternative use due to restrictions or limitations on their use and disposal. The existing use is their highest and best use.

For current use land assets, fair value is measured firstly by establishing the opportunity cost of public purpose land, which is termed the hypothetical alternate land use value. This approach assumes unencumbered land use based upon potential highest and best alternative use as represented by surrounding land uses and market analysis.

Fair value of the land is then determined on the assumption that the site is rehabilitated to a vacant marketable condition. This requires costs associated with rehabilitation to be deducted from the hypothetical alternate land use value of the land. Costs may include building demolition, clearing, planning approvals and time allowances associated with realising that potential.

In some instances the legal, physical, economic and socio political restrictions on a land results in a minimal or negative current use land value. In this situation the land value adopted is the higher of the calculated rehabilitation amount or the amount determined on the basis of comparison to market corroborated evidence of land with low level utility. Land of low level utility is considered to be grazing land on the urban fringe of the metropolitan area with no economic farming potential or foreseeable development or redevelopment potential at the measurement date.

The Health Service's hospitals and medical centres are specialised buildings and site infrastructure valued under the cost approach. Staff accommodation on hospital grounds is also considered as specialised buildings for valuation purpose. This approach uses the depreciated replacement cost method which estimates the current cost of reproduction or replacement of the buildings and site infrastructure, on its current site, less deduction for physical deterioration and relevant forms of obsolescence. Depreciated replacement cost is the current replacement cost of an asset less, where applicable, accumulated depreciation calculated on the basis of such cost to reflect the already consumed or expired future economic benefits of the asset.

The valuation under cost approach commences in the fourth year subsequent to the building commissioning, as the actual construction cost, with adjustment of the annual movement in building cost index, is an approximation of current replacement cost in the first three years. The building cost index is published by the Department of Finance's Building Management and Works.

The techniques involved in the determination of the current replacement costs include:

a) Review and updating of the 'as-constructed' drawing documentation;
b) Categorisation of the drawings using the Building Utilisation Categories (BUC's) which designate the functional areas typically provided by the following types of clinical facilities. Each BUC has different cost rates which are calculated from the historical construction costs of similar clinical facilities and are adjusted for the year-to-year change in building costs using building cost index.
   • Nursing Posts and Medical Centres
   • Metropolitan Secondary Hospitals
c) Measurement of the general floor areas;
d) Application of the BUC cost rates per square meter of general floor areas;
e) Application of the applicable regional cost indices, which are used throughout the construction industry to estimate the additional costs associated with building construction in locations outside of the Perth area.

The maximum effective age used in the valuation of specialised buildings and site infrastructure is 50 years. The effective age of buildings and site infrastructure is initially calculated from the commissioning date, and is reviewed after the buildings and site infrastructure have undergone substantial renewal, upgrade or expansion.

The straight line method of depreciation is applied to derive the depreciated replacement cost, assuming a uniform pattern of consumption over the initial 37 years of asset life (up to 75% of current replacement costs). All specialised buildings and site infrastructure are assumed to have a residual value of 25% of their current replacement costs.

The valuations are prepared on a going concern basis until the year in which the current use is discontinued.

Buildings with definite demolition plan are not subject to annual revaluation. The depreciated replacement costs at the last valuation dates for these buildings are written down to the Statement of Comprehensive Income as depreciation expenses over their remaining useful life.

The Minister for Health in his Capacity as the Deemed Board of Metropolitan Public Hospitals

Notes to the Financial Statements
For the year ended 30 June 2016

Note 35 Fair value measurements (continued)

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

The following table represents the changes in level 3 items for the period ended 30 June 2016:

2016	Land $000	Buildings $000	Site infrastructure $000
Fair value at start of period	451,616	3,289,529	325,580
Additions	13,264	274,363	41,381
Revaluation increments/(decrements)	(14,365)	(2,501)	(82,156)
Transfers from/(to) Level 2	2,000	-	-
Disposals	-	(340)	-
Depreciation	-	(114,868)	(13,182)
Fair value at end of period	452,515	3,446,183	271,623

The following table represents the changes in level 3 items for the period ended 30 June 2015:

2015	Land $000	Buildings $000	Site infrastructure $000
Fair value at start of period	496,694	1,741,446	224,698
Additions	-	1,583,513	117,798
Revaluation increments/(decrements)	(26,193)	79,820	(1,793)
Disposals	(18,885)	-	-
Depreciation	-	(115,250)	(15,124)
Fair value at end of period	451,616	3,289,529	325,580

(d) Valuation processes

The Department of Health manages the valuation processes for the Health Service. These include the provision of property information to quantity surveyor and Landgate Valuation Services and the review of the valuation reports. Valuation processes and results are discussed with the chief finance officer at least once every year.

Landgate Valuation Service determines the fair values of the Health Service's land and buildings, and prior to 1 July 2014, also determined the fair values of site infrastructure. A quantity surveyor is engaged by the Department of Health to provide an update of the current replacement costs for specialised buildings and site infrastructure. The Landgate Valuation Services endorses the current replacement costs calculated by the quantity surveyor for specialised buildings and calculates the depreciated replacement costs.

Notes to the Financial Statements
For the year ended 30 June 2016

	2016 $000	2015 $000
Note 36 Intangible assets		
Computer software		
At cost	271,766	260,361
Accumulated amortisation	(75,848)	(54,717)
	195,918	205,644
Works in progress		
Computer software under development (at cost)	80,322	47,966
Total intangible assets	276,240	253,610
Reconciliations:		
Reconciliations of the carrying amount of intangible assets at the beginning and end of the reporting period are set out below:		
Computer software		
Carrying amount at start of period	205,644	108,960
Additions	16,289	32,713
Transfers from works in progress	5,006	138,481
Amortisation expense	(29,723)	(19,375)
Transfers between asset classes	(1,298)	(55,135)
Carrying amount at end of period	195,918	205,644
Works in progress		
Carrying amount at start of period	47,966	156,184
Additions	37,362	35,365
Capitalised to computer software	(5,006)	(138,481)
Write-down of assets (b)	-	(5,102)
Carrying amount at end of period	80,322	47,966
Total intangible assets		
Carrying amount at start of period	253,610	265,144
Additions	53,651	68,078
Write-down of assets (b)	-	(5,102)
Amortisation expense	(29,723)	(19,375)
Reclassification to property, plant and equipment	(1,298)	(55,135)
Carrying amount at end of period (a)	276,240	253,610
(a) At 30 June 2016, the net carrying amount of leased computer software was $13.617 million (2015: $15.872 million). Also refer to note 39 'Borrowings'."		
(b) Works in progress capitalised in prior years but expensed in the current financial year. Refer to note 16 'Other expenses'.		
Note 37 Impairment of assets		
There were no indications of impairment to property, plant and equipment and intangible assets at 30 June 2016.		
The Health Service held no goodwill or intangible assets with an indefinite useful life during the reporting period. At the end of the reporting period there were no intangible assets not yet available for use.		
Note 38 Payables		
Current		
Trade creditors	74,556	61,964
Other creditors (a)	22,623	302
Accrued expenses	220,744	182,421
Accrued salaries	39,177	151,062
Accrued interest	59	83
	357,159	395,832
See also note 2(q) 'Payables' and note 60 'Financial instruments'.		
(a) Includes $22.273 million PAYG (Pay As You Go) tax due to the Australian Taxation Office for the last pay in 2015-16.		

The Minister for Health in his Capacity as the Deemed Board of Metropolitan Public Hospitals

Notes to the Financial Statements
For the year ended 30 June 2016

	2016 $000	2015 $000
Note 39 Borrowings		
Current		
Department of Treasury loans (a)	4,610	4,445
Finance lease liabilities - Fiona Stanley Hospital (b)	61,317	54,477
Finance lease liabilities - Joondalup Health Campus (c)	4,513	4,151
Finance lease liabilities - Data Centres (d)	1,149	1,864
Finance lease liabilities - Other	8	-
	71,597	64,937
Non-current		
Department of Treasury loans (a)	15,177	20,104
Finance lease liabilities - Fiona Stanley Hospital (b)	219,507	242,235
Finance lease liabilities - Joondalup Health Campus (c)	2,572	7,086
Finance lease liabilities - Data Centres (d)	3,056	4,205
Finance lease liabilities - Other	12	-
	240,324	273,630
Total borrowings	311,921	338,567
(a) This debt relates to funds advanced to the Health Service via the now defunct General Loan and Capital Works Fund. Funds advanced and related interest costs are repaid to the Department of Treasury by the Department of Health on behalf of the Health Service. Interest rates are linked to the State Government's debt servicing costs.		
(b) Equipment and intangible assets for the Fiona Stanley Hospital are procured by a private sector provider through a leasing facility with a bank. Although the arrangement, that is under a Tripartite Agreement between the Minister for Health, the private sector provider and the bank, is not in the legal form of a lease, it is accounted for as such based on its terms and conditions. The first finance lease payment (including the finance lease charges) was made on 1 May 2014.		
During the year, leased assets of $37.712 million (2015: $110.471 million) was acquired and $2.154 million (2015: $4.668 million) of procurement, bank and legal fees were expensed to the Statement of Comprehensive Income.		
The carrying amounts of non-current assets pledged as security are:		
Leased computer software	13,617	15,872
Leased computer equipment	111,978	114,961
Leased medical equipment	108,709	120,397
Leased other plant and equipment	17,583	21,877
	251,887	273,107
(c) The finance lease contract is for the initial construction of the public hospital facility at the Joondalup Health Campus in 1996. Since September 2009, the public hospital facility has undergone significant redevelopment which is fully funded by the State Government. Consequently, the carrying amounts of the existing buildings for the public hospital facility are above the total amounts of the finance lease liabilities. Lease liabilities are effectively secured as the rights to the leased assets revert to the lessor in the event of default.		
The total carrying amounts of buildings (included in note 34) for the public hospital facility at the Joondalup Health Campus includes the amount pledged as security:	107,545	104,552
(d) The finance leases relate to the right to use Racking and Computer Servers in the Data Centres supplied by a private sector provider to the Health Service. The carrying amounts of non-current assets pledged as security:		
Leased computer equipment	5,227	9,671

Notes to the Financial Statements

For the year ended 30 June 2016

	2016 $000	2015 $000
Note 40 Provisions		
Current		
Employee benefits provision		
Annual leave (a)	310,394	321,787
Time off in lieu leave (a)	106,016	99,903
Long service leave (b)	218,500	243,085
Deferred salary scheme (c)	5,998	4,593
	640,908	669,368
Non-current		
Employee benefits provision		
Long service leave (b)	164,279	165,791
Total provisions	805,187	835,159

(a) Annual leave liabilities and time off in lieu leave liabilities have been classified as current as there is no unconditional right to defer settlement for at least 12 months after the end of the reporting period. Assessments indicate that actual settlement of the liabilities is expected to occur as follows:

Within 12 months of the end of the reporting period	288,506	295,616
More than 12 months after the end of the reporting period	127,904	126,074
	416,410	421,690

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

Within 12 months of the end of the reporting period	43,106	47,350
More than 12 months after the end of the reporting period	339,673	361,526
	382,779	408,876

(c) Deferred salary scheme liabilities have been classified as current where there is no unconditional right to defer settlement for at least 12 months after the end of the reporting period. Assessments indicate that actual settlement of the liabilities is expected to occur as follows:

Within 12 months of the end of the reporting period	2,002	940
More than 12 months after the end of the reporting period	3,996	3,653
	5,998	4,593

Note 41 Other liabilities		
Current		
Income received in advance	101	237
Refundable deposits	1,054	936
Lease discount received in advance	474	124
Paid parental leave scheme	27	404
Other	101	205
	1,757	1,906
Non-Current		
Lease discount received in advance	687	-

The Minister for Health in his Capacity as the Deemed Board of Metropolitan Public Hospitals

Notes to the Financial Statements

For the year ended 30 June 2016

	2016 $000	2015 $000
Note 42 Contributed equity		
Balance at start of period	5,797,401	5,329,077
Contributions by owners (b)		
Capital appropriation (a)	344,550	504,094
Transfer of assets from the Department of Health (f)	70,171	-
	414,721	504,094
Distributions to owners (b) (c)		
Transfer of sale proceeds for Mirrabooka land to Treasury (d)	(1,498)	-
Transfer of net assets (other than cash) to other agencies (e)	-	(18,885)
Transfer of sale proceeds for house at Kaleeya Hospital to Treasury (d)	(758)	(16,885)
Balance at end of period	6,209,866	5,797,401

The Western Australian Government holds the equity interest in the Health Service on behalf of the community. Equity represents the residual interest in the net assets of the Health Service. The asset revaluation reserve represents that portion of equity resulting from the revaluation of non-current assets (note 43).

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

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

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

(c) TI 955 requires non-reciprocal transfers of net assets to Government to be accounted for as distribution to owners in accordance with AASB Interpretation 1038.

(d) TI 955 requires proceeds of the property sale to be paid to the Consolidated Account as distribution to owners.

(e) The transfer of Shenton Park property site to Landcorp occurred in 2014-15 after the relocation of patients from the Royal Perth Rehabilitation Hospital to the Fiona Stanley State Rehabilitation Centre.

(f) On 1 January 2014, the transfer of assets and liabilities associated with Joondalup Health Campus (JHC) and Peel Health Campus (PHC) from the Department of Health to the Health Service did not include the transfer of the related amounts receivable for services (holding accounts for asset replacement). In June 2016, the Minister directed to transfer the amounts receivable for services associated with JHC and PHC totalling to $70.171 million from the Department of Health to the Health Service. In accordance with AASB interpretation 1038 and Treasurer's Instruction 955 '*Contributions by Owners Made to Wholly-Owned Public Sector Entities*', the transfer is formally designated as a contribution by owner and forms part of the contributed equity of the Health Service.

Notes to the Financial Statements
For the year ended 30 June 2016

	2016 $000	2015 $000
Note 43 Reserves		
Asset revaluation reserve (a)		
Balance at start of period	1,074,765	1,018,269
Net revaluation increments/(decrements) (b):		
Land	(25,117)	(23,922)
Buildings	(2,736)	80,418
Site infrastructure	(82,156)	-
Balance at end of period	964,756	1,074,765

(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.

Note 44 Accumulated deficit		
Balance at start of period	(464,129)	(424,054)
Result for the period	141,656	(40,075)
Balance at end of period	(322,473)	(464,129)
Note 45 Notes to the Statement of Cash Flows		
Reconciliation of cash		
Cash assets at the end of the financial year as shown in the Statement of Cash Flows are reconciled to the related items in the Statement of Financial Position as follows:		
Cash and cash equivalents	36,164	58,840
Restricted cash and cash equivalents	118,291	107,116
	154,455	165,956
Reconciliation of net cost of services to net cash flows used in operating activities		
Net cash used in operating activities (Statement of Cash Flows)	(3,404,925)	(3,031,880)
Increase/(decrease) in assets:		
GST receivable	2,153	1,510
Other current receivables	51,285	(1,143)
Inventories	(466)	1,135
Prepayments and other current assets	7,775	(13,322)
Other non-current assets	(2,690)	-
Decrease/(increase) in liabilities:		
Payables	42,542	(5,087)
Current provisions	28,459	(49,112)
Non-current provisions	1,512	(16,528)
Other current liabilities	149	(331)
Other non-current liabilities	(687)	340
Non-cash items:		
Doubtful debts expense (note 16)	(24,487)	(15,443)
Write off of receivables (note 29)	3,215	3,542
Receivables amount recovered during the period (note 29)	-	5,904
Depreciation and amortisation expense (note 11)	(249,860)	(234,570)
Net gain/(loss) from disposal of non-current assets (note 12)	(2,504)	1,586
Interest paid by Department of Health	(820)	(1,113)
Capitalisation of finance lease charges	(765)	(3,160)
Capitalisation of fees for finance leases (note 39)	(2,154)	(4,668)
Net donation of non-current assets	1,115	2,020
Services received free of charge (note 25)	(4,199)	(4,662)
Write down of intangible assets (note 36)	-	(5,102)
Write down of property, plant and equipment (note 34)	(11,981)	(3,550)
Adjustment for other non-cash items	5,658	4,631
Net cost of services (Statement of Comprehensive Income)	(3,561,675)	(3,369,003)

The Minister for Health in his Capacity as the Deemed Board of Metropolitan Public Hospitals

Notes to the Financial Statements
For the year ended 30 June 2016

	2016 $000	2015 $000
Note 45 Notes to the Statement of Cash Flows (continued)		
Notional cash flows		
Service appropriations as per Statement of Comprehensive Income	3,700,854	3,334,144
Capital contributions credited directly to Contributed equity (Refer note 42)	344,550	504,094
Royalties for Regions Fund as per Statement of Comprehensive Income	200	1,365
	4,045,604	3,839,603
Less notional cash flows:		
Items paid directly by the Department of Health for the Health Service and are therefore not included in the Statement of Cash Flows:		
Interest paid to Department of Treasury	(820)	(1,113)
Repayment of interest-bearing liabilities to Department of Treasury	(4,762)	(4,238)
Accrual appropriations	(294,294)	(283,984)
	(299,876)	(289,335)
Cash Flows from State Government as per Statement of Cash Flows	3,745,728	3,550,268

At the end of the reporting period the Health Service had fully drawn on all financing facilities, details of which are disclosed in the financial statements.

Note 46 Revenue, public and other property written off		
a) Revenue and debts written off under the authority of the Accountable Authority	3,317	3,426
b) Public and other property written off under the authority of the Accountable Authority	88	132
c) Revenue and debts written off under the authority of the Minister	-	440
	3,405	3,998
Note 47 Losses of public moneys and other property		
Losses of public moneys and public or other property through theft or default	44	1
Less amount recovered	(10)	-
Net losses	34	1
Note 48 Services provided free of charge		
During the period the following services were provided to other agencies free of charge for functions outside the normal operations of the Health Service:		
Department of Education - school health services (c)	10,350	-
Mental Health Commission - contracted mental health services (a)	6,779	2,720
Mental Health Commission - support services (b) (c)	3,792	-
Health and Disability Services Complaints Office - support services (b) (c)	173	-
Disability Services Commission - paediatric services (c)	2,878	-
Department of Corrective Services - dental treatment	1,615	1,537
Disability Services Commission - dental treatment	1,548	1,538
Department of Corrective Services - radiology services	-	60
Aboriginal Community Controlled Health Services (ACCHS) - dental treatment	1,028	337
Department of Education - immunisation program	361	-
Department for Child Protection and Family Support - health assessments	305	-
	28,829	6,192

(a) The costs of mental health services provided under the Service Delivery Agreement is $6.779 million above the level of funding received from the Mental Health Commission.

(b) Health Support Services within the Health Service has provided supply services, IT services, human resource services, finance services to the Mental Health Commission and Health and Disability Services Complaints Office.

(c) The values of services had not been disclosed in the previous years because they could not be reliably measured.

Note 49 Remuneration of members of the Accountable Authority and senior officers

Remuneration of members of the Accountable Authority

The Director General of Health is the Accountable Authority for The Minister for Health in his Capacity as the Deemed Board of Metropolitan Public Hospitals. The remuneration of the Director General of Health is paid by the Department of Health.

Notes to the Financial Statements
For the year ended 30 June 2016

	2016	2015
Note 49 Remuneration of members of the Accountable Authority and senior officers (continued)		
Remuneration of senior officers		
The number of senior officers other than senior officers reported as members of the Accountable Authority, whose total fees, salaries, superannuation, non-monetary benefits and other benefits for the financial year, fall within the following bands are:		
$90,001 - $100,000	1	-
$100,001 - $110,000	1	-
$180,001 - $190,000	1	-
$190,001 - $200,000	1	-
$200,001 - $210,000	-	1
$220,001 - $230,000	-	1
$230,001 - $240,000	-	1
$240,001 - $250,000	-	1
$340,001 - $350,000	-	1
$510,001 - $520,000	1	-
$530,001 - $540,000	1	-
$540,001 - $550,000	-	1
$580,001 - $590,000	-	1
$610,001 - $620,000	-	1
$670,001 - $680,000	1	-
Total:	7	8
	$000	**$000**
Base remuneration and superannuation	2,076	2,717
Annual leave and long service leave accruals	182	208
Other benefits	40	70
Total remuneration of senior officers	2,298	2,995
The total remuneration includes the superannuation expense incurred by the Health Service in respect of senior officers other than senior officers reported as members of the Accountable Authority.		
Note 50 Remuneration of auditor		
Remuneration payable to the Auditor General in respect of the audit for the current financial year is as follows:		
Auditing the accounts, financial statements and key performance indicators	698	690
Note 51 Commitments		
The commitments below are inclusive of GST where relevant.		
Capital expenditure commitments:		
Capital expenditure commitments, being contracted capital expenditure additional to the amounts reported in the financial statements are payable as follows:		
Within 1 year	186,792	192,664
Later than 1 year, and not later than 5 years	5,795	773
	192,587	193,437
Operating lease commitments:		
Commitments in relation to non-cancellable leases contracted for at the end of the reporting period but not recognised as liabilities are payable as follows:		
Within 1 year	27,458	22,280
Later than 1 year, and not later than 5 years	66,213	64,413
Later than 5 years	53,391	78,190
	147,062	164,883
Operating lease commitments predominantly consist of contractual agreements for office accommodation and residential accommodation. The basis of which contingent operating leases payments are determined is the value for each lease agreement under the contract terms and conditions at current values.		

The Minister for Health in his Capacity as the Deemed Board of Metropolitan Public Hospitals

Notes to the Financial Statements
For the year ended 30 June 2016

	2016 $000	2015 $000
Note 51 Commitments (continued)		
Finance lease commitments:		
Minimum lease payment commitments in relation to finance leases are payable as follows:		
Within 1 year	81,120	76,343
Later than 1 year, and not later than 5 years	204,483	223,833
Later than 5 years	52,772	71,058
Minimum finance lease payments	338,375	371,234
Less future finance charges	(46,241)	(57,217)
Present value of finance lease liabilities (Refer note 39)	292,134	314,017
The present value of finance leases payable is as follows:		
Within 1 year	66,987	60,492
Later than 1 year, and not later than 5 years	177,655	190,309
Later than 5 years	47,492	63,216
Present value of finance lease liabilities	292,134	314,017
Included in the financial statements as:		
Current (note 39)	66,987	60,492
Non-current (note 39)	225,147	253,525
	292,134	314,017
Private sector contracts for the provision of health services:		
Expenditure commitments in relation to private sector organisations contracted for at the end of the reporting period but not recognised as liabilities, are payable as follows:		
Within 1 year	843,781	550,001
Later than 1 year and not later than 5 years	3,123,961	2,353,497
Later than 5 years and not later than 10 years	4,176,291	2,732,933
Later than 10 years	3,959,622	1,567,496
	12,103,655	7,203,927
Other expenditure commitments:		
Other expenditure commitments contracted for at the reporting period but not recognised as liabilities are payable as follows:		
Within 1 year	445,602	360,136
Later than 1 year, and not later than 5 years	1,042,681	908,531
Later than 5 years	55,929	285,853
	1,544,212	1,554,520
Note 52 Contingent liabilities and contingent assets		
Contingent liabilities		
In addition to the liabilities included in the financial statements, the Health Service has the following contingent liabilities:		
Litigation in progress		
Pending litigation that are not recoverable from RiskCover insurance and may affect the financial position of the Health Service.	14,383	5,560
Number of claims	14	11
Contaminated sites		
Under the *Contaminated Sites Act 2003* the Health Service is required to report known and suspected contaminated sites to the Department of Environment Regulation (DER). In accordance with the Act, DER classifies these sites on the basis of the risk to human health, the environment and environmental values. Where sites are classified as *contaminated – remediation required* or *possibly contaminated – investigation required*, the Health Service may have a liability in respect of investigation or remediation expenses.		
At the reporting date, the Health Service does not have any suspected contaminated sites reported under the Act.		
Contingent assets		
At the reporting date, the Health Service is not aware of any contingent assets.		

Notes to the Financial Statements
For the year ended 30 June 2016

Note 53 Events occurring after the end of the reporting period

The Health Services Act 2016 has been enacted to replace the Hospitals and Health Services Act 1927 as from 1 July 2016. Under the new Act, the Health Service will be restructured into five health service providers (Child and Adolescent Health Service, East Metropolitan Health Service, North Metropolitan Health Service, South Metropolitan Health Service and Health Support Services) that are separate statutory authorities.

This is the final financial year in which the Health Service operates as a statutory authority under the Hospitals and Health Services Act.

Note 54 Related bodies

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

The Health Service had no related bodies during the financial year.

Note 55 Affiliated bodies	**2016 $000**	**2015 $000**
An affiliated body is a body which receives more than half its funding and resources from the Health Service but is not subject to operational control by the Health Service.		
The nature of assistance provided in the form of grants and subsidies to all non-government agencies (whether affiliated or not) during the financial year is outlined below:		
Women's Health Programs	7,203	7,862
Community Health Services	-	1,309
	7,203	9,171

Note 56 Other statement of receipts and payments

Commonwealth Grant - Christmas and Cocos Island		
Balance at the start of period	-	-
Receipts		
Commonwealth grant	33	40
Payments		
Purchase of WA Health Services	(33)	(40)
Balance at the end of period	-	-

Note 57 Administered trust accounts

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

a) The Health Service administers a trust account for the purpose of holding patients' private moneys.

A summary of the transactions for this trust account is as follows:

Balance at the start of period	166	145
Add Receipts	1,081	1,196
	1,247	1,341
Less Payments	(1,083)	(1,175)
Balance at the end of period	164	166

b) The Health Service administers a trust account for medical practitioners exercising a 'right of private practice' when treating privately referred non-inpatients.

A summary of the transactions for this trust account is as follows:

Balance at the start of period	141	212
Add Receipts	273	641
	414	853
Less Payments	(396)	(712)
Balance at the end of period	18	141

The Minister for Health in his Capacity as the Deemed Board of Metropolitan Public Hospitals

Notes to the Financial Statements
For the year ended 30 June 2016

Note 57 Administered trust accounts (continued)	**2016 $000**	**2015 $000**
c) Other trust accounts not controlled by the Health Service.		
RF Shaw Foundation	1,174	1,189
RPH Private Trust Account	292	292
King Edward Memorial Clinical Staff Association	48	39
	1,514	1,520
Balance at the start of period	1,519	1,688
Add Receipts	53	62
	1,572	1,750
Less Payments	(58)	(231)
Balance at the end of period	1,514	1,519

Note 58 Special purpose accounts

Mental Health Commission Fund (Child and Adolescent 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 Child and Adolescent Health Service, in accordance with the annual Service Agreement and subsequent agreements.

Balance at the start of period	113	-
Add Receipts		
Service delivery agreement		
Commonwealth contributions	6,545	9,362
State contributions	48,659	46,764
Other	3,881	3,432
	59,085	59,558
Payments	(58,641)	(59,445)
Balance at the end of period	557	113

Mental Health Commission Fund (North Metropolitan 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 North Metropolitan Health Service, in accordance with the annual Service Agreement and subsequent agreements.

Balance at the start of period	576	-
Add Receipts		
Service delivery agreement		
Commonwealth contributions	75,479	79,443
State contributions	201,986	171,834
Other	5,842	5,196
	283,307	256,473
Payments	(283,199)	(255,897)
Balance at the end of period	684	576

Notes to the Financial Statements
For the year ended 30 June 2016

	2016 $000	2015 $000
Note 58 Special purpose accounts (continued)		
Mental Health Commission Fund (South Metropolitan 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 South Metropolitan Health Service, in accordance with the annual Service Agreement and subsequent agreements.		
Balance at the start of period	-	-
Add Receipts		
Service delivery agreement		
Commonwealth contributions	59,296	56,064
State contributions	149,338	131,652
Other	925	400
	209,559	188,116
Payments	(209,541)	(188,116)
Transferred from Mental Health Commission Fund (Fiona Stanley Hospital) Account	38	-
Balance at the end of period	56	-
Mental Health Commission Fund (Fiona Stanley Hospital) 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 Fiona Stanley Hospital, in accordance with the annual Service Agreement and subsequent agreements.		
Balance at the start of period	38	-
Add Receipts		
Service delivery agreement		
Commonwealth contributions	-	2,028
State contributions	-	2,507
Other	-	38
	-	4,573
Payments	-	(4,535)
Transferred to Mental Health Commission Fund (South Metropolitan Health Service) Account	(38)	-
Balance at the end of period	-	38
The Under Treasurer approved the closure of the Mental Health Commission Fund (Fiona Stanley Hospital) Account in June 2016.		
Mental Health Commission Fund (East Metropolitan 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 East Metropolitan Health Service, in accordance with the annual Service Agreement and subsequent agreements.		
The Mental Health Commission Fund (East Metropolitan Health Service) Account was established in June 2016. There were no transactions in 2015-16 financial year.		
Total Mental Health Commission special purpose accounts		
Balance at the start of period	727	-
Add Receipts		
Service delivery agreement		
Commonwealth contributions (note 19 (i))	141,320	146,897
State contributions (note 19 (ii))	399,983	352,757
Other (note 19 (ii))	10,648	9,066
	551,951	508,720
Payments	(551,380)	(507,993)
Balance at the end of period	1,298	727
The special purpose accounts are established under section 16(1)(d) of the Financial Management Act 2006.		

The Minister for Health in his Capacity as the Deemed Board of Metropolitan Public Hospitals

Notes to the Financial Statements
For the year ended 30 June 2016

Note 59 Explanatory statement

Significant variances between actual results for 2015 and 2016

Significant variations between actual results with the corresponding items of the preceding reporting period are detailed below. Significant variations are those greater than 10% or $50 million.

	Note	2016 Actual $000	2015 Actual $000	Variance $000
Expenses				
Employee benefits expense	(a)	3,609,669	3,548,255	61,414
Fees for visiting medical practitioners		56,789	60,011	(3,222)
Contracts for services	(b)	661,962	489,170	172,792
Patient support costs	(c)	801,319	740,588	60,731
Finance costs		17,378	17,720	(342)
Depreciation and amortisation expense		249,860	234,570	15,290
Loss on disposal of non-current assets		2,504	-	2,504
Repairs, maintenance and consumable equipment	(d)	151,974	125,608	26,366
Fiona Stanley Hospital set-up costs	(e)	-	87,023	(87,023)
Other supplies and services	(f)	74,748	39,952	34,796
Other expenses		359,043	345,898	13,145
Income				
Patient charges	(g)	261,728	228,302	33,426
Other fees for services	(h)	274,331	224,849	49,482
Commonwealth grants and contributions		1,391,157	1,419,712	(28,555)
Other grants and contributions	(i)	423,876	378,731	45,145
Donation revenue	(j)	32,393	12,716	19,677
Interest revenue		269	340	(71)
Commercial activities		3,544	4,250	(706)
Other revenue	(k)	36,273	49,306	(13,033)
Gain on disposal of non-current assets		-	1,586	(1,586)
Service appropriations	(l)	3,700,854	3,334,144	366,710
Assets (transferred)/assumed	(m)	(1,922)	(11,243)	9,321
Services received free of charge		4,199	4,662	(463)
Royalties for Regions Fund		200	1,365	(1,165)

(a) Employee benefits expense
The increase is largely as a result of industrial award increases during the 2015-16 financial year.

(b) Contracts for services
The increase is mainly attributable to the opening of St John of God Midland Public Hospital in November 2015 and increased activity at Joondalup Health Campus.

(c) Patient support costs
The increases in domestic charges, medical supplies and services mostly relate to the Fiona Stanley Hospital which is operational for a full year in 2015-16 as compared to part year in 2014-15. The Fiona Stanley Hospital was fully opened in February 2015.

(d) Repairs, maintenance and consumable equipment
Increase in expenses for repairs, maintenance and consumable equipment is mainly driven by the increases in operational services under the Serco Facilities Management Contract, as the Fiona Stanley Hospital has operated for a full year in 2015-16 whereas the Hospital operated for part year in 2014-15.

(e) Fiona Stanley Hospital set-up costs
As Fiona Stanley Hospital is fully operational in 2015-16, no set-up costs have been incurred.

(f) Other supplies and services
Increase in other supplies and services is mainly due to the increased expenses under the Serco Facilities Management Contract which have been incurred for a full year in 2015-16 as compared to part year in 2014-15.

(g) Patient charges
The increase in patient charges is primarily due to the full year operations of the Fiona Stanley Hospital in 2015-16 as compared to part year operations in 2014-15.

(h) Other fees for services
The significant increase in other fees for services is mainly from the increase in recoveries from the Pharmaceutical Benefit Scheme due to the opening of new hospitals and the recoups of medical doctors' salaries for St John of God Midland Public Hospital.

Note 59 Explanatory statement (continued)

(i) Other grants and contributions
Other grants and contributions largely comprised of funding from Mental Health Commission which has increased in line with the additional mental health services mostly driven by the full year operation of the Fiona Stanley Hospital and the opening of St John of God Midland Public Hospital in November 2015.

(j) Donation revenue
The significant increase relates to $25.450 million donation received in 2015-16 for construction of the Sarich Neuroscience Research Institute at the Queen Elizabeth II Medical Centre.

(k) Other revenue
The reduction of other revenue is mainly as a result of the decrease in recoveries from the use of hospital facilities and the decrease in research and clinical trial revenue.

(l) Service appropriations
The increase in service appropriations from State Government and the increase in funding from Commonwealth Government under the National Health Reform Agreement are mainly due to the full year operations of the Fiona Stanley Hospital and the opening of the St John of God Midland Public Hospital.

(m) Assets (transferred)/assumed
$10.122 million reduction in cash transferred from the Health Service to the Department of Health, $1.132 million in 2015-16 as compared to $11.254 million in 2014-15 (see note 24).

Significant variances between estimated and actual results for 2016

Significant variations between the estimates and actual results for 2016 are detailed below. Significant variations are considered to be those greater than 10% of the budget estimates.

	2016 Actual $000	2016 Estimates $000	Variance $000
Operating expenses			
Employee benefits expense	3,609,669	3,521,803	87,866
Other goods and services	2,375,577	2,184,623	190,954
Total expenses	5,985,246	5,706,426	278,820
Less: Revenues	(2,423,571)	(2,540,493)	116,922
Net cost of services	3,561,675	3,165,933	395,742

There are no significant variances between estimated and actual results for 2015-16.

Note 60 Financial instruments

a) **Financial risk management objectives and policies**

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

Credit risk

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

The maximum exposure to credit risk at the end of the reporting period in relation to each class of recognised financial assets is the gross carrying amount of those assets inclusive of any allowance for impairment as shown in the table at Note 60(c) 'Financial instrument disclosures' and note 29 Receivables.

Credit risk associated with the Health Service's financial assets is generally confined to patient fee debtors (see note 29). The main receivable of the Health Service is the amounts receivable for services (holding account). For receivables other than government agencies and patient fee debtors, the Health Service trades only with recognised, creditworthy third parties. The Health Service has policies in place to ensure that sales of products and services are made to customers with an appropriate credit history. In addition, receivable balances are monitored on an ongoing basis with the result that the Health Service's exposure to bad debts is minimised. At the end of the reporting period, there were no significant concentrations of credit risk.

All debts are individually reviewed, on a timely basis at 30, 60, 90 and 120 days. In circumstances where a third party is responsible for payment, or there are legal considerations, payment of accounts can be delayed considerably. Unpaid debts are referred to an external debt collection service within six months of the account being raised.

Allowance for impairment of financial assets is calculated based on objective evidence such as observable data indicating changes in client credit ratings. For financial assets that are either past due or impaired, refer to Note 60 (c) 'Financial instrument disclosures'.

Liquidity risk

Liquidity risk arises when the Health Service is unable to meet its financial obligations as they fall due. The Health Service is exposed to liquidity risk through its normal course of operations.

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

Market risk

Market risk is the risk that changes in market prices such as foreign exchange rates and interest rates will affect the Health Service's income or the value of its holdings of financial instruments. The Health Service does not trade in foreign currency and is not materially exposed to other price risks. The Health Service's exposure to market risk for changes in interest rates relates primarily to the long-term debt obligations. The Health Service's borrowings include the Department of Treasury (DT) loans and finance leases (fixed rates with varying maturities). The interest rate risk for the loans is managed by DT through portfolio diversification and variation in maturity dates.

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:

	2016 $000	2015 $000
Financial Assets		
Cash and cash equivalents	36,164	58,840
Restricted cash and cash equivalents	118,291	107,116
Loans and receivables (a)	1,900,967	1,502,986
Financial Liabilities		
Financial liabilities measured at amortised cost	669,080	734,399

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

Note 60 Financial instruments (continued)

c) **Financial instrument disclosures**

Credit risk

The following table discloses the Health Service's maximum exposure to credit risk and the ageing analysis of financial assets. The Health Service's maximum exposure to credit risk at the end of the reporting period is the carrying amount of financial assets as shown below. The table discloses the ageing of financial assets that are past due but not impaired and impaired financial assets. The table is based on information provided to senior management of the Health Service.

The Health Service does not hold any collateral as security or other credit enhancements relating to the financial assets it holds.

Aged analysis of financial assets

	Carrying amount	Not past due and not impaired	Past due but not impaired				Impaired Financial assets
			1 - 3 months	3 - 12 months	1-5 years	More than 5 years	
	$000	$000	$000	$000	$000	$000	$000
2016							
Cash and cash equivalents	36,164	36,164	-	-	-	-	-
Restricted cash and cash equivalents	118,291	118,291	-	-	-	-	-
Receivables (a)	148,028	81,926	33,283	20,812	10,393	1,614	-
Amounts receivable for services	1,752,939	1,752,939	-	-	-	-	-
	2,055,422	1,989,320	33,283	20,812	10,393	1,614	-
2015							
Cash and cash equivalents	58,840	58,840	-	-	-	-	-
Restricted cash and cash equivalents	107,116	107,116	-	-	-	-	-
Receivables (a)	114,513	78,319	11,266	14,294	7,934	2,700	-
Amounts receivable for services	1,388,473	1,388,473	-	-	-	-	-
	1,668,942	1,632,748	11,266	14,294	7,934	2,700	-

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

Note 60 Financial instruments (continued)

c) **Financial instrument disclosures (continued)**

Liquidity risk and interest rate exposure

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

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

		Interest rate exposure					Maturity dates			
	Weighted average effective interest rate	Carrying amount	Fixed interest rate	Variable interest rate	Non-interest bearing	Nominal Amount	Up to 3 months	3 months to 1 year	1-5 years	More than 5 years
	%	$000	$000	$000	$000	$000	$000	$000	$000	$000
2016										
Financial Assets										
Cash and cash equivalents	-	36,164	-	-	36,164	36,164	36,164	-	-	-
Restricted cash and cash equivalents	-	118,291	-	-	118,291	118,291	118,291	-	-	-
Receivables - non interest bearing (a)	-	144,526	-	-	144,526	144,526	144,526	-	-	-
Receivables - interest bearing	2.00%	3,502	-	3,502	-	3,780	-	-	3,780	-
Amounts receivable for services	-	1,752,939	-	-	1,752,939	1,752,939	-	-	-	1,752,939
		2,055,422	-	3,502	2,051,920	2,055,700	298,981	-	3,780	1,752,939
Financial Liabilities										
Payables	-	357,159	-	-	357,159	357,159	357,159	-	-	-
Department of Treasury Loans	3.26%	19,787	-	19,787	-	20,844	1,275	3,825	15,744	
Finance Lease Liabilities - Data Centres	8.67%	4,205	4,205			4,865	367	1,101	3,397	
Finance lease liabilities - Joondalup Health campus	9.46%	7,086	7,086	-	-	7,715	1,256	3,768	2,691	
Finance lease liabilities - Fiona Stanley Hospital	5.27%	280,822	280,822	-	-	325,773	18,120	56,499	198,381	52,773
Finance lease liabilities - Other	11.00%	21	21			22	2	7	13	
		669,080	292,134	19,787	357,159	716,378	378,179	65,200	220,226	52,773

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

Notes to the Financial Statements

For the year ended 30 June 2016

Note 60 Financial instruments (continued)

c) Financial instrument disclosures (continued)

Liquidity risk and interest rate exposure (continued)

		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 3 months	3 months to 1 year	1-5 years	More than 5 years
	%	$000	$000	$000	$000	$000	$000	$000	$000	$000
2015										
Financial Assets										
Cash and cash equivalents	-	58,840	-	-	58,840	58,840	58,840	-	-	-
Restricted cash and cash equivalents	-	107,116	-	-	107,116	107,116	107,116	-	-	-
Receivables (a)	-	114,513	-	-	114,513	114,513	114,513	-	-	-
Amounts receivable for services	-	1,388,473	-	-	1,388,473	1,388,473	-	-	-	1,388,473
		1,668,942	-	-	1,668,942	1,668,942	280,469	-	-	1,388,473
Financial Liabilities										
Payables	-	395,832	-	-	395,832	395,832	395,832	-	-	-
Department of Treasury Loans	4.11%	24,550	-	24,550	-	26,942	1,324	3,973	21,381	263
Finance Lease Liabilities - Data Centres	8.27%	6,069	6,069			7,168	576	1,728	4,865	-
Finance lease liabilities - Joondalup Health campus	9.46%	11,237	11,237	-	-	12,739	1,256	3,768	7,715	-
Finance lease liabilities - Fiona Stanley Hospital	5.28%	296,711	296,711	-	-	351,327	17,634	51,381	211,253	71,059
		734,399	314,017	24,550	395,832	794,008	416,623	60,850	245,214	71,322

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

Note 60 Financial instruments (continued)

c) **Financial instrument disclosures (continued)**

Interest rate sensitivity analysis

The following table represents a summary of the interest rate sensitivity of the Health Service's financial assets and liabilities at the end of the reporting period on the surplus for the period and equity for a 1% change in interest rates. It is assumed that the change in interest rates is held constant throughout the reporting period.

	Amount Exposed to Interest Rate Risk $000	-100 basis points		+100 basis points	
		Surplus $000	Equity $000	Surplus $000	Equity $000
2016					
Financial Assets					
Receivables	3,502	(35)	(35)	35	35
Financial Liabilities					
Department of Treasury Loans	19,787	198	198	(198)	(198)
Total Increase/(Decrease)		163	163	(163)	(163)
2015					
Financial Liabilities					
Department of Treasury Loans	24,550	245	245	(245)	(245)
Total Increase/(Decrease)		245	245	(245)	(245)

Fair values

All financial assets and liabilities recognised in the Statement of Financial Position, whether they are carried at cost or fair value, are recognised at amounts that represent a reasonable approximation of fair value unless otherwise stated in the applicable notes.

Notes to the Financial Statements

For the year ended 30 June 2016

Note 61 Schedule of income and expenses by service

	Public Hospital Admitted Patient		Home-Based Hospital Programs		Emergency Department		Public Hospital Non-Admitted Patients	
	2016 $000	2015 $000	2016 $000	2015 $000	2016 $000	2015 $000	2016 $000	2015 $000
COST OF SERVICES								
Expenses								
Employee benefits expense	2,263,961	2,224,492	3,545	12,899	330,715	294,926	456,904	479,342
Fees for visiting medical practitioners	36,271	38,293	57	222	5,298	5,077	7,320	8,252
Contracts for services	422,795	311,954	662	1,809	61,761	41,359	85,327	67,221
Patient support costs	502,662	465,217	787	2,698	73,428	61,679	101,445	100,247
Finance costs	11,100	11,308	17	66	1,621	1,499	2,240	2,436
Depreciation and amortisation expense	158,646	148,822	248	863	23,174	19,731	32,017	32,069
Loss on disposal of non-current assets	1,505	-	-	-	220	-	303	-
Repairs, maintenance and consumable equipment	95,316	78,530	149	455	13,924	10,412	19,236	16,922
Fiona Stanley Hospital set-up costs	-	67,695	-	-	-	7,362	-	11,966
Other supplies and services	47,613	25,373	75	147	6,956	3,364	9,610	5,468
Other expenses	224,273	216,696	351	1,257	32,761	28,730	45,262	46,695
Total cost of services	3,764,142	3,588,380	5,891	20,416	549,858	474,139	759,664	770,618
Income								
Patient charges	198,631	168,092	-	-	1,309	1,142	56,101	53,543
Other fees for services	175,061	143,225	274	830	25,572	18,989	35,330	30,862
Commonwealth grants and contributions	889,536	901,424	1,393	5,227	129,942	119,512	179,523	194,242
Other grants and contributions	8,761	10,843	14	63	1,280	1,438	1,769	2,336
Donation revenue	23,294	7,984	36	46	3,403	1,059	4,700	1,720
Interest revenue	171	216	-	1	25	29	35	47
Commercial activities	2,835	3,401	-	-	177	212	532	637
Other revenue	20,659	28,915	32	168	3,018	3,834	4,169	6,231
Gains								
Gain on disposal of non-current assets	-	1,009	-	6	-	134	-	218
Total income other than income from State Government	1,318,948	1,265,109	1,749	6,341	164,726	146,349	282,159	289,836
NET COST OF SERVICES	**2,445,194**	**2,323,271**	**4,142**	**14,075**	**385,132**	**327,790**	**477,505**	**480,782**
INCOME FROM STATE GOVERNMENT								
Service appropriations	2,539,943	2,297,373	4,302	13,919	400,056	324,136	496,007	475,422
Assets (transferred)/assumed	(1,228)	(7,174)	(2)	(42)	(179)	(951)	(248)	(1,546)
Services received free of charge	2,682	2,975	4	17	392	394	541	641
Royalties for Regions Fund	200	1,026	-	-	-	-	-	-
Total income from State Government	2,541,597	2,294,200	4,304	13,894	400,269	323,579	496,300	474,517
SURPLUS/(DEFICIT) FOR THE PERIOD	**96,403**	**(29,071)**	**162**	**(181)**	**15,137**	**(4,211)**	**18,795**	**(6,265)**

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

Notes to the Financial Statements

For the year ended 30 June 2016

Note 61 Schedule of income and expenses by service (continued)

	Prevention, Promotion & Protection		Dental Health		Mental Health (a)		Total	
	2016 $000	2015 $000	2016 $000	2015 $000	2016 $000	2015 $000	2016 $000	2015 $000
COST OF SERVICES								
Expenses								
Employee benefits expense	125,835	129,335	65,029	62,135	363,680	345,126	3,609,669	3,548,255
Fees for visiting medical practitioners	2,016	2,226	-	-	5,827	5,941	56,789	60,011
Contracts for services	23,500	18,137	-	291	67,917	48,399	661,962	489,170
Patient support costs	27,939	27,048	14,311	11,521	80,747	72,178	801,319	740,588
Finance costs	617	657	-	-	1,783	1,754	17,378	17,720
Depreciation and amortisation expense	8,818	8,653	1,473	1,342	25,484	23,090	249,860	234,570
Loss on disposal of non-current assets	84	-	150	-	242	-	2,504	-
Repairs, maintenance and consumable equipment	5,298	4,566	2,739	2,539	15,312	12,184	151,974	125,608
Fiona Stanley Hospital set-up costs	-	-	-	-	-	-	-	87,023
Other supplies and services	2,647	1,475	198	188	7,649	3,937	74,748	39,952
Other expenses	12,465	12,599	7,904	6,301	36,027	33,620	359,043	345,898
Total cost of services	209,219	204,696	91,804	84,317	604,668	546,229	5,985,246	5,688,795
Income								
Patient charges	-	-	5,687	5,525	-	-	261,728	228,302
Other fees for services	9,730	8,327	243	395	28,121	22,221	274,331	224,849
Commonwealth grants and contributions	49,442	52,410	-	-	141,321	146,897	1,391,157	1,419,712
Other grants and contributions	487	630	935	1,598	410,630	361,823	423,876	378,731
Donation revenue	248	464	-	204	712	1,239	32,393	12,716
Interest revenue	10	13	-	-	28	34	269	340
Commercial activities	-	-	-	-	-	-	3,544	4,250
Other revenue	1,148	1,681	3,928	3,991	3,319	4,486	36,273	49,306
Gains								
Gain on disposal of non-current assets	-	59	-	3	-	157	-	1,586
Total income other than income from State Government	61,065	63,584	10,793	11,716	584,131	536,857	2,423,571	2,319,792
NET COST OF SERVICES	**148,154**	**141,112**	**81,011**	**72,601**	**20,537**	**9,372**	**3,561,675**	**3,369,003**
INCOME FROM STATE GOVERNMENT								
Service appropriations	153,895	139,538	85,318	74,489	21,333	9,267	3,700,854	3,334,144
Assets (transferred)/assumed	(68)	(417)	-	-	(197)	(1,113)	(1,922)	(11,243)
Services received free of charge	149	173	-	-	431	462	4,199	4,662
Royalties for Regions Fund	-	-	-	339	-	-	200	1,365
Total income from State Government	153,976	139,294	85,318	74,828	21,567	8,616	3,703,331	3,328,928
SURPLUS/(DEFICIT) FOR THE PERIOD	**5,822**	**(1,818)**	**4,307**	**2,227**	**1,030**	**(756)**	**141,656**	**(40,075)**

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

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

Certification of key performance indicators

METROPOLITAN HEALTH SERVICE

CERTIFICATION OF KEY PERFORMANCE INDICATORS FOR THE YEAR ENDED 30 JUNE 2016

I hereby certify that the key performance indicators are based on proper records, are relevant and appropriate for assisting users to assess the Metropolitan Health Service's performance and fairly represent the performance of the Health Service for the financial year ended 30 June 2016.

Dr D J Russell-Weisz
DIRECTOR GENERAL
DEPARTMENT OF HEALTH
REPORTING OFFICER

15 September 2016

Key performance indicators

Outcome 1

Outcome 2

Percentage of public patients discharged to home after admitted hospital treatment

Outcome 1
Effectiveness KPI

Rationale

The main goals of healthcare provision are to ensure that people receive appropriate evidence-based healthcare without experiencing preventable harm, and that effective partnerships are forged between consumers, healthcare providers and organisations. Through achieving improvements in the specific priority areas that these goals describe, hospitals can deliver safer and higher-quality care, better outcomes for patients, and provide a more effective and efficient health system.

Measuring the number of patients discharged home after hospital care allows for the monitoring of changes over time that can enable the identification of the priority areas for improvement. This in turn enables the determination of targeted interventions and health promotion strategies aimed at ensuring optimal restoration of patients' health. This will go a long way to ensuring the WA health system is effective and efficient, yet delivers safe high-quality care and the best outcomes for patients.

Target

The 2015 target is ≥98.1 per cent.

The target is based on the best result achieved within the previous five years.

Improved or maintained performance is demonstrated by a result exceeding or equal to the target.

Results

During 2015, a total of 98.1 per cent of Metropolitan Health Service public patients across all ages were discharged home after receiving admitted hospital treatment (see Table 13). This result is in line with previous years.

Table 13: **Percentage of public patients discharged to home after admitted hospital treatment in Metropolitan Health Service public hospitals, by age group, 2011–2015**

Age group (years)	Calendar years				
	2011 (%)	2012 (%)	2013 (%)	2014 (%)	2015 (%)
0–39	98.5	98.4	98.5	98.6	**98.6**
40–49	97.5	97.7	97.5	97.9	**97.9**
50–59	98.2	98.3	98.1	98.2	**98.2**
60–69	98.4	98.3	98.3	98.5	**98.6**
70–79	97.9	98.0	98.1	98.1	**98.2**
80+	95.7	95.8	96.0	96.2	**96.0**
All ages	98.0	98.0	98.0	98.1	**98.1**
Target (≥)	98.1	98.1	98.1	98.2	**98.1**

Data source: Hospital Morbidity Data System.

Survival rates for sentinel conditions

Outcome 1
Effectiveness KPI

Rationale

Hospital survival indicators should be used as screening tools, rather than being assumed to be definitively diagnostic of poor quality and/or safety.

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

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

Patient survival after being admitted for one of these three sentinel conditions can be affected by many factors, which includes the diagnosis, the treatment given or procedure performed, age, co-morbidities at the time of the admission and complications that may have developed while in hospital.

Target

The 2015 target for each condition by age group:

Age group (years)	Sentinel condition		
	Stroke (%)	AMI (%)	FNOF (%)
0–49	≥95.3	≥99.5	Not reported
50–59	≥94.1	≥99.2	Not reported
60–69	≥93.3	≥98.4	Not reported
70–79	≥90.8	≥96.7	≥98.8
80+	≥83.3	≥92.7	≥96.4

The target is based on the best result achieved within the previous five years. If a result of 100 per cent is obtained the next best result is adopted to address the issue of small numbers.

Improved or maintained performance is demonstrated by a result exceeding or equal to the target.

Results

The performance of Metropolitan Health Service hospitals varies by sentinel condition. In 2015, the survival rate for stroke met the target for patients aged 80+ (see Table 14). The targets were not met for patients in all other age groups.

Table 14: **Survival rate for stroke, by age group, 2011–2015**

Age group (years)	Calendar years					
	2011 (%)	2012 (%)	2013 (%)	2014 (%)	2015 (%)	Target (%)
0–49	91.8	95.3	93.3	92.3	**94.8**	**≥95.3**
50–59	89.8	92.3	91.2	91.7	**92.8**	**≥94.1**
60–69	91.4	91.4	91.6	93.3	**92.9**	**≥93.3**
70–79	89.0	87.2	90.8	88.7	**89.8**	**≥90.8**
80+	81.5	81.2	81.7	83.3	**83.3**	**≥83.3**

Note: From 2014, targets and results have been modified to include public patients treated in private hospitals, hence the targets and results are not directly comparable with earlier years.

Data source: Hospital Morbidity Data System.

Survival rates for patients with an acute myocardial infarction were below the targets for all age groups (see Table 15).

Table 15: **Survival rate for acute myocardial infarction, by age group, 2011–2015**

Age group (years)	Calendar years					
	2011 (%)	2012 (%)	2013 (%)	2014 (%)	2015 (%)	Target (%)
0–49	99.1	99.5	99.0	98.5	**99.2**	**≥99.5**
50–59	98.5	99.2	98.9	98.8	**98.7**	**≥99.2**
60–69	98.4	97.4	96.8	98.2	**97.9**	**≥98.4**
70–79	94.5	95.8	96.0	96.7	**96.3**	**≥96.7**
80+	90.1	91.1	92.7	92.2	**92.3**	**≥92.7**

Note: From 2014, targets and results have been modified to include public patients treated in private hospitals, hence the targets and results are not directly comparable with earlier years.

Data source: Hospital Morbidity Data System.

The survival rate for patients aged 70–79 years with a fractured neck of femur (99.0 per cent) exceeded the target of 98.8 per cent in 2015 (see Table 16). The target was not met for patients aged 80 years and above.

Table 16: **Survival rate for fractured neck of femur, by age group, 2011–2015**

Age group (years)	Calendar years					
	2011 (%)	2012 (%)	2013 (%)	2014 (%)	2015 (%)	Target (%)
70–79	98.3	97.7	98.8	97.6	**99.0**	**≥98.8**
80+	96.2	95.5	96.0	96.4	**96.1**	**≥96.4**

Note: From 2014, targets and results have been modified to include public patients treated in private hospitals, hence the targets and results are not directly comparable with earlier years.

Data source: Hospital Morbidity Data System.

Unplanned hospital readmissions within 28 days for selected surgical procedures

Outcome 1
Effectiveness KPI

Rationale

Readmission rate is considered a global performance measure, as it potentially points to deficiencies in the functioning of the overall healthcare system. Good intervention, appropriate treatment together with good discharge planning will decrease the likelihood of unplanned hospital readmissions. There are some conditions that may require numerous admissions to enable the best level of care to be given. However, in most of these cases hospital readmission is planned.

A low unplanned readmission rate suggests that good clinical practice is in operation. These readmissions necessitate patients spending additional periods of time in hospital as well as utilising additional hospital resources.

By measuring and monitoring this indicator, the level of potentially avoidable hospital readmissions can be assessed in order to identify key areas for improvement. This in turn can facilitate the development and delivery of targeted care pathways and interventions, which can help to ensure effective restoration to health and improve the quality of life of Western Australians.

Target

As this is a new indicator for 2015–16, no target is available. From 2016–17, targets will be set using the best audited result recorded within the previous five years.

Results

In 2015, the percentage of unplanned readmissions with 28 days to a Metropolitan Health Service hospital for selected surgical procedure are presented in Table 17 below.

Table 17: **Percentage of unplanned readmissions within 28 days for selected surgical procedures 2015**

Surgical Procedure	2015 (%)
Knee replacement	2.2
Hip replacement	2.1
Tonsillectomy and Adenoidectomy	7.1
Hysterectomy	4.7
Prostatectomy	3.4
Cataract surgery	0.1
Appendicectomy	3.9

Data source: Hospital Morbidity Data System.

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

Outcome 1
Effectiveness KPI

Rationale

Readmission rate is considered a global performance measure because it potentially points to deficiencies in the functioning of the overall healthcare system. Admissions to a psychiatric facility following a recent discharge may indicate that inpatient treatment was incomplete or ineffective, or that follow-up care was inadequate to maintain the person out of hospital. These readmissions necessitate patients spending additional time in hospital and utilise additional hospital resources.

Good intervention and appropriate treatment together with good discharge planning will decrease the likelihood of unplanned hospital readmissions. A low unplanned readmission rate suggests that good clinical practice is in operation.

By measuring and monitoring this indicator, the level of potentially avoidable hospital readmissions for mental health patients can be assessed to identify key areas for improvement. This in turn can facilitate the development and delivery of targeted care pathways and interventions, which aim to improve mental health and the quality of life of Western Australians.

For this indicator a sample period of three months is used, and relevant data is subjected to clinical review to ensure the accuracy of the readmission status – unplanned or otherwise.

Target

The 2015 target is ≤5.6 per cent.

The target is based on the best result achieved within the previous five years, where the result is greater than zero.

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

Results

In 2015, the percentage of unplanned readmissions within 28 days to the same public hospital in metropolitan WA for a mental health condition was 7.9 per cent. This is above the target of 5.6 per cent (see Table 18).

Table 18: **Percentage of unplanned readmissions within 28 days to the same hospital relating to the previous mental health condition for which they were treated, 2011–2015**

	2011 (%)	2012 (%)	2013 (%)	2014 (%)	2015 (%)
Unplanned readmissions	6.8	7.8	6.6	7.6	**7.9**
Target	≤4.9	≤4.9	≤4.9	≤4.9	**≤5.6**

Note: This indicator is based on a 3 month period each year. For 2015, data is reported from 1 September – 30 November.

Data source: Hospital Morbidity Data System.

Percentage of liveborn infants with an Apgar score of three or less, five minutes post delivery

Outcome 1
Effectiveness KPI

Rationale

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 possible ten minutes after delivery to determine how well the infant is adapting outside the mother's womb. The higher the Apgar score the better the health of the newborn infant.

An Apgar score of three or less is considered to be critically low, and can indicate complications and compromise for the infant.

This indicator provides a means of monitoring the effectiveness of maternity care during pregnancy and birth by identifying the potential incidence of sub-optimal outcomes. This can lead to the development and delivery of improved care pathways and interventions to improve the health outcomes of WA infants.

Target

The 2015 target for liveborn infants with an Apgar score of three or less, by birth weight:

Birth weight (grams)	Percentage
0–1499	≤3.7
1500–1999	≤0.3
2000–2499	≤0.2
2500+	≤0.1

The target is based on the best result achieved within the previous five years, where the result is greater than zero.

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

Results

In 2015, the percentage of liveborn infants with an Apgar score of three or less was equal to or above the target for all birth weight categories (see Table 19).

Table 19: **Percentage of liveborn infants with an Apgar score of three or less, five minutes post-delivery, by birth weight, 2011–2015**

Birth weight (grams)	2011 (%)	2012 (%)	2013 (%)	2014 (%)	2015 (%)	Target (%)
0–1499	7.2	3.7	4.9	5.7	**3.8**	**≤3.7**
1500–1999	0.3	1.0	0.8	0.3	**0.3**	**≤0.3**
2000–2499	0.4	0.2	0.5	0.4	**0.4**	**≤0.2**
2500+	0.2	0.1	0.1	0.2	**0.2**	**≤0.1**

Note: Caution should be taken in the interpretation of results as:

- public births at contracted private hospitals have been included in the calculation of this indicator from 2011
- liveborn infant numbers used in the calculation of this measure are small and can result in significant variations between reporting years.

Data source: Midwives Notification System.

Average cost per casemix adjusted separation for tertiary hospitals

Outcome 1
Efficiency KPI
Service 1: Public hospital admitted patients

Rationale

WA Health aims to provide safe, high-quality healthcare to ensure healthier, longer, and better quality lives for all Western Australians.

Tertiary hospitals provide critical healthcare for Western Australians and generally treat patients with complex health needs. While the role of tertiary hospitals is constantly evolving to meet the changing needs and characteristics of the population, they still provide core healthcare services such as acute medical care, emergency and intensive care services, complex specialty procedures, clinical research and training.

Target

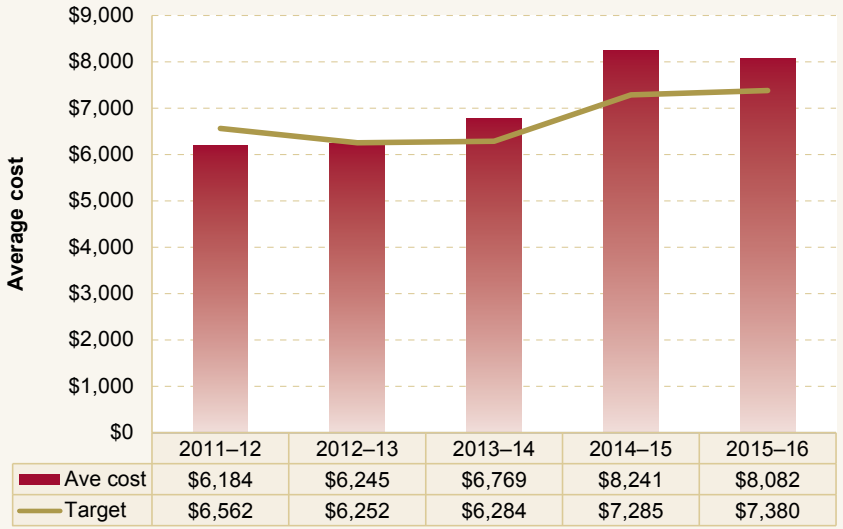
The target for 2015–16 is $7,380 per casemix weighted separation from a tertiary hospital.

A result below the target is desirable.

Results

The average cost per casemix adjusted separation for metropolitan tertiary hospitals was $8,082, which was above the target but lower than the previous year (see Figure 7). The lower expenditure is attributable to improved efficiency in service provision, particularly at Fiona Stanley Hospital, which had its first full year of operation. The average cost was also affected by the removal of Fremantle Hospital, which is now classified as a non-tertiary facility.

Figure 7: **Average cost per casemix weighted separation from a tertiary hospital, 2011–12 to 2015–16**



	2011–12	2012–13	2013–14	2014–15	2015–16
Ave cost	$6,184	$6,245	$6,769	$8,241	$8,082
Target	$6,562	$6,252	$6,284	$7,285	$7,380

Data source: Hospital Morbidity Data System, health service financial systems.

Note: From 2015–16, Fremantle Hospital is excluded from this KPI.

Average cost per casemix adjusted separation for non–tertiary hospitals

Outcome 1
Efficiency KPI
Service 1: Public hospital admitted patients

Rationale

WA Health aims to provide safe, high-quality healthcare to ensure healthier, longer, and better quality lives for all Western Australians. In order to improve, promote and protect the health of the WA population it is important that the health system is sustainable by providing effective and efficient care that best uses allocated funds and resources.

Non-tertiary hospitals provide critical healthcare for Western Australians. Similar to tertiary hospitals, while the role of non-tertiary hospitals is constantly evolving to meet the changing needs and characteristics of the population, they still provide comprehensive specialist healthcare services.

Through measuring the cost of a hospital stay by the range and type of patients (the casemix) treated in non-tertiary hospitals, this indicator can facilitate improved efficiency in these hospitals by providing a transparent understanding of the cost of care.

Target

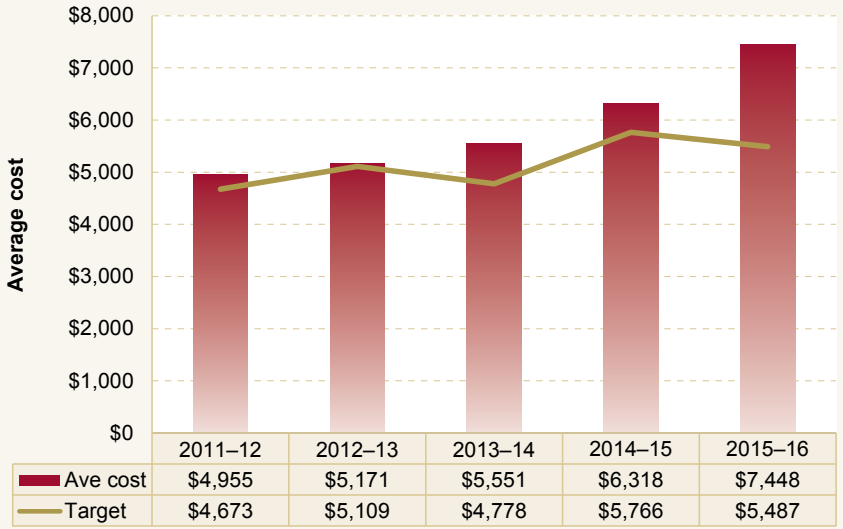
The target for 2015–16 is $5,487 per casemix weighted separation from a non–tertiary hospital.

A result below the target is desirable.

Results

The average cost per casemix adjusted separation for metropolitan non-tertiary hospitals was $7,448, which was above the target (see Figure 8). The higher average expenditure was affected by the closure of Swan District Hospital and the inclusion of Fremantle Hospital from 2015–16. The complexity of cases handled by Fremantle Hospital has increased since its reclassification as a non-tertiary hospital, which has increased the average cost.

Figure 8: **Average cost per casemix weighted separation from a non–tertiary hospital, 2011–12 to 2015–16**



	2011–12	2012–13	2013–14	2014–15	2015–16
Ave cost	$4,955	$5,171	$5,551	$6,318	$7,448
Target	$4,673	$5,109	$4,778	$5,766	$5,487

Data source: Hospital Morbidity Data System, health service financial systems.

Note: From 2015–16, Fremantle Hospital is included in this KPI.

Average cost of public admitted patient treatment episodes in private hospitals

Outcome 1
Efficiency KPI
Service 1: Public hospital admitted patients

Rationale

Western Australia's public health system aims to provide safe, high-quality healthcare that ensures healthier, longer and better quality lives for all Western Australians. In order to improve, promote and protect the health of Western Australians it is critical that the health system is sustainable by providing effective and efficient care that best uses allocated funds and resources.

To ensure all Western Australia's have timely access to effective healthcare, the Government has entered into collaborative agreement with private sector health providers in the State to deliver hospital services to the community.

Target

The target for 2015–16 is $3,494 per public admitted patient treatment episode in private hospitals.

A result below the target is desirable.

Results

The average cost of public admitted patient treatment episodes at contracted health services was above target at $3,933 (see Table 20). The higher average expenditure was affected by the opening of the St John of God Midland Public Hospital in 2015–16.

Table 20: **Average cost of public admitted patient treatment episodes in private hospitals, 2014 to 2015–16**

	January to June 2014 ($)	2014–15 ($)	2015–16 ($)
Average cost	$4,707	$3,385	**3,933**
Target	-	$3,380	**3,494**

Notes:

1. This KPI measures the average cost of public admitted patient treatment episodes at contracted health services that operate on behalf of the State Government.
2. Changes to contract arrangements came into effect 31 December 2013. This KPI was previously managed and reported in the Department of Health annual report. As such, for 2014–15, historic and target data are unavailable.
3. The 2014–15 target was revised to the 2014–15 budget figure within the 2015–16 budget papers.

Data source: Department of Health unpublished data.

Average cost per bed-day for admitted patients (small hospitals)

Outcome 1
Efficiency KPI
Service 1: Public hospital admitted patients

Rationale

WA Health aims to provide safe, high-quality healthcare to ensure healthier, longer, and better quality lives for all Western Australians.

Small hospitals provide essential healthcare and treatment within the metropolitan area in Western Australia.

Through measuring the cost of a hospital stay by the range and type of patients (the casemix) treated in non-tertiary hospitals, this indicator can facilitate improved efficiency in these hospitals by providing a transparent understanding of the cost of care.

Target

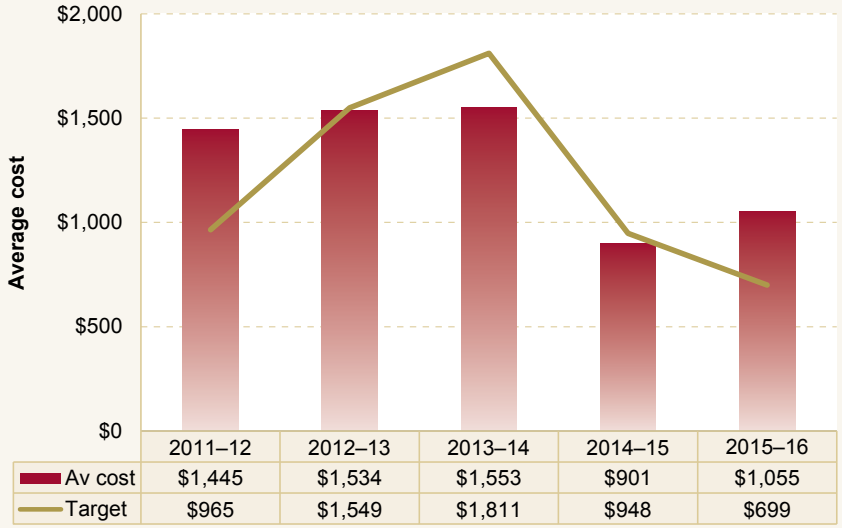
The target for 2015–16 is $699 per bed-day for admitted patients (small hospitals).

A result below the target is desirable.

Results

In 2015–16, the average cost per bed-day for admitted patients for small metropolitan public hospitals was above target at $1,055 (see Figure 9). The increase is attributable in part to a revision to the costing methodology to include some expenses that were previously excluded.

Figure 9: **Average cost per bed-day for admitted patients (small hospitals), 2011–12 to 2015–16**



	2011–12	2012–13	2013–14	2014–15	2015–16
Av cost	$1,445	$1,534	$1,553	$901	$1,055
Target	$965	$1,549	$1,811	$948	$699

Note: This key performance indicator measures the cost per bed-day for admitted patients at the Murray District Hospital.

Data sources: Hospital Morbidity Data System, health service financial systems.

Average cost per home based hospital patient day

Outcome 1
Efficiency KPI
Service 2: Home based hospital programs

Rationale

WA Health aims to provide safe, high-quality healthcare to ensure healthier, longer, and better quality lives for all Western Australians.

Home Based Hospital Programs have been implemented as a means of ensuring all Western Australians have timely access to effective healthcare. These home based programs, provided by the public health system, aim to provide safe and effective medical care for suitable patients in their home that would otherwise require admission to hospital.

Target

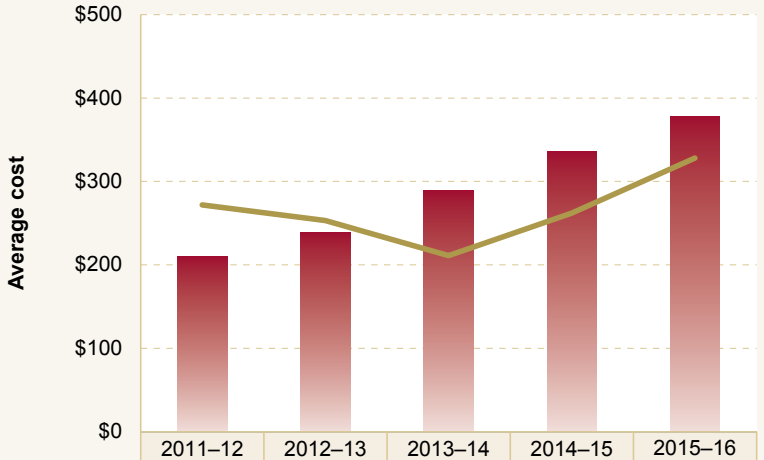
The target for 2015–16 is $328 per home based hospital patient day.

A result below the target is desirable.

Results

The average cost per home based hospital patient day in 2015–16 was $378, and above target (see Figure 10). The higher average cost is due to the reclassification of some services previously reported under Home-Based Hospital Programs to Public Hospital Admitted Patients. The counting and classification methodology is consistent with national definitions published by the Independent Hospital Pricing Authority.

Figure 10: **Average cost per home based hospital patient day, 2011–12 to 2015–16**



	2011–12	2012–13	2013–14	2014–15	2015–16
Av cost	$210	$239	$289	$336	$378
Target	$272	$253	$211	$262	$328

Note: The Rehabilitation in the Home model of care no longer meets national requirements for classification as inpatient substitution. To ensure compliance with national reporting, WA Rehabilitation in the Home activity has been collected, counted and reported in the Non-admitted Patient Data Collection from July 2013.

Data sources: Hospital Morbidity Data System, health service financial systems.

Average cost per client receiving contracted palliative care services

Outcome 1
Efficiency KPI
Service 3: Palliative care

Rationale

Western Australia's public health system aims to provide safe, high-quality healthcare that ensures healthier, longer and better quality lives for all Western Australians. In order to improve, promote and protect the health of Western Australians it is critical that the health system is sustainable by providing effective and efficient care that best uses allocated funds and resources.

Palliative care is aimed at improving the quality of life of patients and families who face life-threatening illness, by providing pain and symptom relief, spiritual and psychosocial support from diagnosis to the end of life and bereavement. In addition to palliative care services that are provided through the public health system, the State Government has entered into collaborative agreement with private sector health providers to provide palliative care services for those in need.

Target

The target for 2015–16 is $3,767 per client receiving contracted palliative care services.

A result below the target is desirable.

Results

The average cost per client receiving contracted palliative care services for 2015–16 was $2,084, and below target (see Table 21). The average cost can vary from year to year in large part due to the low levels of activity across a small number of facilities.

Table 21: **Average cost per client receiving contracted palliative care services, 2014 to 2015–16**

	January to June 2014 ($)	2014–15 ($)	2015-16 ($)
Average cost	1,359	1,405	**2,084**
Target	n/a	n/a	**3,767**

Notes:

1. This KPI measures the average cost per client receiving contracted palliative care services that operate on behalf of the State Government.
2. Changes to contract arrangements came into effect 31 December 2013. This KPI was previously managed and reported in the Department of Health annual report.

Data source: Department of Health unpublished data.

Average cost per emergency department attendance

Outcome 1
Efficiency KPI
Service 4: Emergency department

Rationale

WA Health aims to provide safe, high-quality healthcare to ensure healthier, longer, and better quality lives for all Western Australians.

Emergency departments are specialist multidisciplinary units with expertise in managing acutely unwell patients for the first few hours in hospital. With the ever 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.

Target

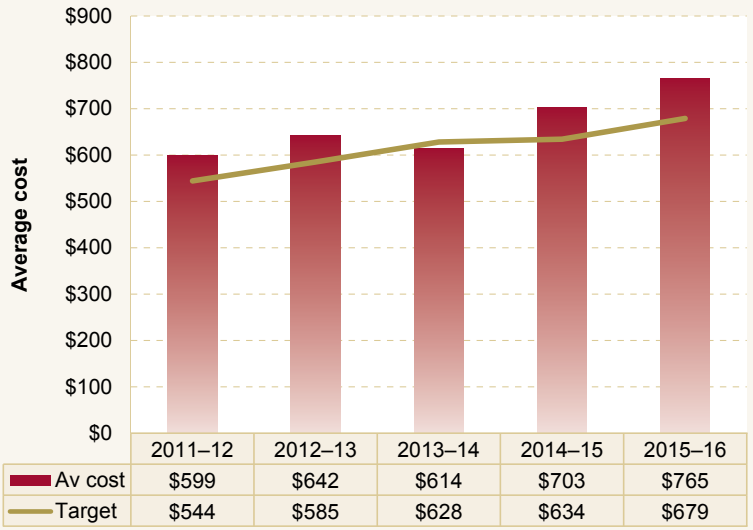
The target for 2015–16 is $679 per emergency department attendance.

A result below the target is desirable.

Results

For 2015–16, the average cost per emergency department attendance for Metropolitan Health Service hospitals was above target at $765 (see Figure 11). Some realignment of activity has occurred due to the closure of Swan District Hospital, the opening of St John of God Midland Public Hospital, and the first full year of operation of Fiona Stanley Hospital's emergency department. Closing Swan District Hospital and opening St John of God Midland Public Hospital incurred additional expenses that are reflected in the average cost.

Figure 11: **Average cost per emergency department attendance for Metropolitan Health Service hospitals including private/public contracts, 2011–12 to 2015–16**



	2011–12	2012–13	2013–14	2014–15	2015–16
Av cost	$599	$642	$614	$703	$765
Target	$544	$585	$628	$634	$679

Note: Metropolitan Health Service contracted hospitals contributing to this key performance indicator include Peel Health Campus, Joondalup Health Campus and St John of God Murdoch.

Data sources: Emergency Department Data Collection, health service financial systems.

Average cost per public patient non-admitted activity

Outcome 1
Efficiency KPI
Service 5: Public hospital non–admitted patients

Rationale

WA Health aims to provide safe, high-quality healthcare to ensure healthier, longer, and better quality lives for all Western Australians.

Non-admitted care is essentially the provision of medical or surgical services that do not require an admission to hospital, and is typically provided in an outpatient setting. The provision of non-admitted healthcare services, by health service providers other than doctors, aims to ensure patients have access to the care they need in the most appropriate setting to address the patient's clinical needs.

Target

As this is a new indicator for 2015–16, no target is available. From 2016–17 the target will be set in the annual budget setting process.

Results

For 2015–16, the average cost of public patient non-admitted activity in a Metropolitan Health Service hospital was $357 (see Table 22).

Table 22: **Average cost per public patient non-admitted activity, 2015–16**

	2015–16
Average cost	$357

Data sources: Non Admitted Patient Activity and Wait List Data Collection, Interim Collection of Aggregate Data, health service financial systems.

Average cost per trip of Patient Assisted Travel Scheme

Outcome 1
Efficiency KPI
Service 6: Patient transport

Rationale

WA Health aims to provide safe, high-quality healthcare to ensure healthier, longer, and better quality lives for all Western Australians.

The Patient Assisted Travel Scheme provides a subsidy towards the cost of travel and accommodation for eligible patients travelling long distances to seek certain categories of specialist medical services. The aim of Patient Assisted Travel Scheme is to help ensure that all Western Australians can access safe, high-quality healthcare when needed.

Target

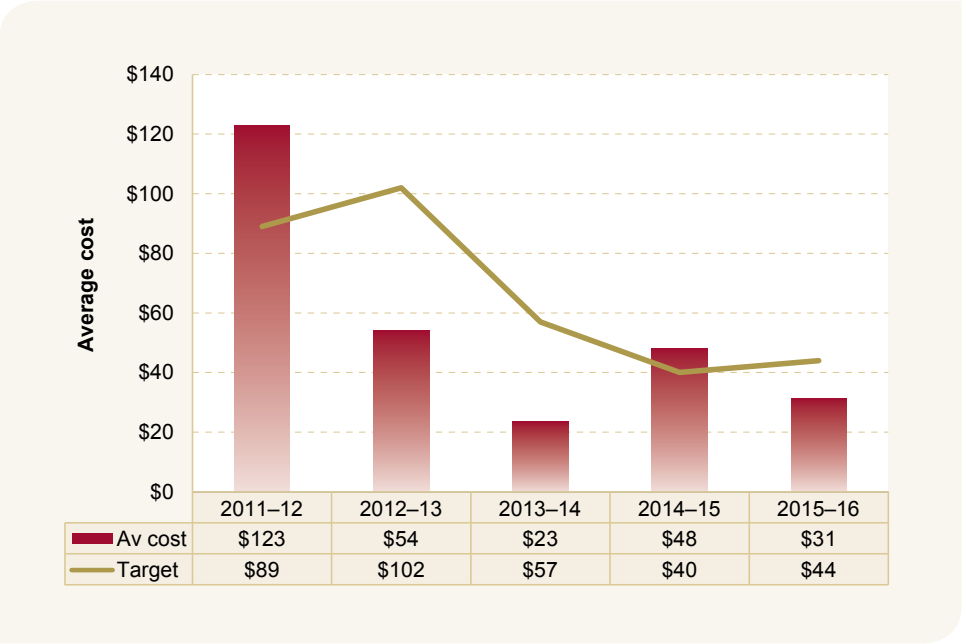
The target for 2015–16 is $44 per Patient Assisted Travel Scheme trip.

A result below the target is desirable.

Results

For 2015–16, the average cost per Patient Assisted Travel Scheme trip was $31, and below the target (see Figure 12).

Figure 12: **Average cost per Patient Assisted Travel Scheme trip, 2011–12 to 2015–16**



	2011–12	2012–13	2013–14	2014–15	2015–16
Av cost	$123	$54	$23	$48	$31
Target	$89	$102	$57	$40	$44

Note: This key performance indicator measures the cost per trip of patient assisted travel at the Peel Health Service.

Data sources: Patient Assisted Travel Scheme Online system, Peel Patient Assisted Travel Scheme and Patient Transport, health service financial systems.

Loss of life from premature death due to identifiable causes of preventable disease (breast and cervical cancer)

Outcome 2
Effectiveness KPI

Rationale

Cancer is a diverse group of diseases in which some of the body's cells become defective and multiply out of control. These abnormal cells invade and damage the tissue around them, sooner or later spreading (metastasising) to other parts of the body where they can cause further damage.

Cancer is Australia's leading cause of burden of disease, with one in four females being diagnosed with cancer and one in 12 being at risk of dying before age 75. Breast cancer is estimated to be the most commonly diagnosed cancer in women, while cervical cancer is estimated to be the twelfth most common cancer affecting Australian women.

Early detection is critical because it provides increased survival, increased treatment options and improved quality of life. This is why a key priority of the *WA Cancer Plan 2012–2017* is to improve survival in WA women through screening and early detection through the WA Cervical Cancer Prevention and BreastScreen programs.

This indicator measures the total years of life lost from all deaths associated with breast and cervical cancer. Through identifying the impact of potential years of life lost due to breast and cervical cancers, further targeted health promotion strategies and interventions can be monitored and delivered to ensure enhanced health and wellbeing of Western Australian women.

Target

The 2014 target by preventable disease:

Preventable disease	Target (in years)
Breast cancer	≤2.2
Cervical cancer	≤0.3

The 2013 National Person Years of Life Lost per 1,000 population is used as the target.

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

Results

In 2014, the number of person years of life lost for breast cancer was 1.7 per 1,000, which is below the target of 2.2. The number of person years of life lost for cervical cancer was equal to the target of 0.3 years (see Table 23).

Table 23: **Person years of life lost due to premature death associated with breast and cervical cancer, 2005–2014**

Condition	Calendar years										
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	Target
Breast cancer	2.3	2.8	2.4	2.8	2.7	2.2	2.2	2.1	**2.3**	**1.7**	**≤2.2**
Cervical cancer	0.5	0.3	0.5	0.3	0.4	0.5	0.4	0.4	**0.4**	**0.3**	**≤0.3**

Notes:

1. Age-standardised Person Years of Life Lost per 1,000 population.
2. The 2005–2012 deaths are final, 2013 deaths are revised and 2014 deaths are preliminary.
3. Minor methodological improvements and updates to death data mean that figures are not directly comparable with previous reports
4. The following ICD 10 codes were used:
   - Breast cancer C50 to C50.9 (females only)
   - Cervix cancer C53 to C53.9 (females only).

Data sources: Mortality database, Epidemiology Branch, Department of Health, Australian Bureau of Statistics.

Rate of hospitalisations for gastroenteritis in children (0–4 years)

Outcome 2
Effectiveness KPI

Rationale

Gastroenteritis is a common illness in infants and children. It is usually caused by viruses that infect the bowel and tends to be most common during winter months. Rotavirus gastroenteritis is the leading cause of severe gastroenteritis in children aged less than five years, but it is a vaccine-preventable disease.

The rotavirus vaccination program was added to the Australian publicly funded schedule in July 2007. Before the rotavirus vaccination program was introduced, this virus was responsible for more than 10,000 annual hospitalisations of children aged less than 5 years, placing significant burden on paediatric hospitals.

Surveillance of the hospitalisation of children with gastroenteritis can support the further development and delivery of targeted intervention and prevention programs to further reduce the impact of this disease on individuals and the community, ensuring enhanced health and wellbeing of WA children and the sustainability of the public health system.

Target

The target for 2015 is ≤3.7 hospitalisations per 1,000 children less than 5 years of age.

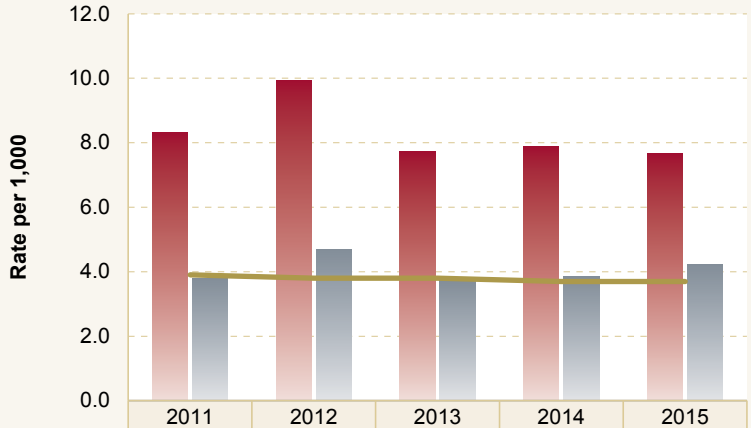
The target is based on the best result achieved within the previous five years for either population group reported i.e. Aboriginal and non-Aboriginal groups.

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

Results

In 2015, the rate of hospitalisation of non-Aboriginal children for gastroenteritis was 4.2 per 1,000 children (see Figure 13). The rate for Aboriginal children was nearly double at 7.7 per 1,000, which is consistent with previous years. Both results are above the target of 3.7 per 1,000 children.

Figure 13: **Rate of hospitalisations for gastroenteritis per 1,000 children aged 0–4 years, 2011–2015**



	2011	2012	2013	2014	2015
Aboriginal	8.3	9.9	7.7	7.9	7.7
Non-Aboriginal	3.8	4.7	3.7	3.9	4.2
Target	3.9	3.8	3.8	3.7	3.7

Notes:

1. The total population used in the calculation of this KPI is based on the Australian Bureau of Statistics Estimated Resident Population for 2014, as defined by the Australian Statistical Geography Standard.
2. Caution should be taken in the interpretation of the rates of hospitalisation of Aboriginal children for gastroenteritis due to small population numbers that can result in significant variations across reporting years.

Data sources: Hospital Morbidity Data System, Australian Bureau of Statistics.

Rate of hospitalisation for selected respiratory conditions

Outcome 2
Effectiveness KPI

Rationale

Respiratory disease refers to a number of conditions that affect the lungs or their components. Each of these conditions is characterised by some level of impairment of the lungs in performing the essential functions of gas exchange.

Respiratory disease is associated with a number of contributing factors, including poor environmental conditions, socioeconomic disadvantage, smoking, alcohol use, substance use and previous medical conditions. Children under the age of five years are particularly susceptible to developing respiratory conditions due to low levels of childhood immunisations, parental smoking, poor nutrition, and poor environmental conditions.

While there are many respiratory conditions that cause hospitalisation, some of the more common conditions that have a substantial impact on the community include acute asthma, acute bronchitis, acute bronchiolitis and croup.

The implementation of initiatives that help prevent and better manage these respiratory conditions, such as the WA Health Asthma Model of Care, go a long way to reducing the impacts to individuals and the community from these conditions.

Surveillance of hospitalisations for these common respiratory conditions can ensure that changes over time are identified in order to drive improvements in the quality of care and facilitate the development and delivery of effective targeted intervention and prevention programs, thus enhancing the overall health and wellbeing of Western Australians.

Target

The 2015 targets, by respiratory condition, are outlined in the table below. The targets are based on the best result recorded within the previous five years for either population group reported, i.e. Aboriginal and non-Aboriginal groups.

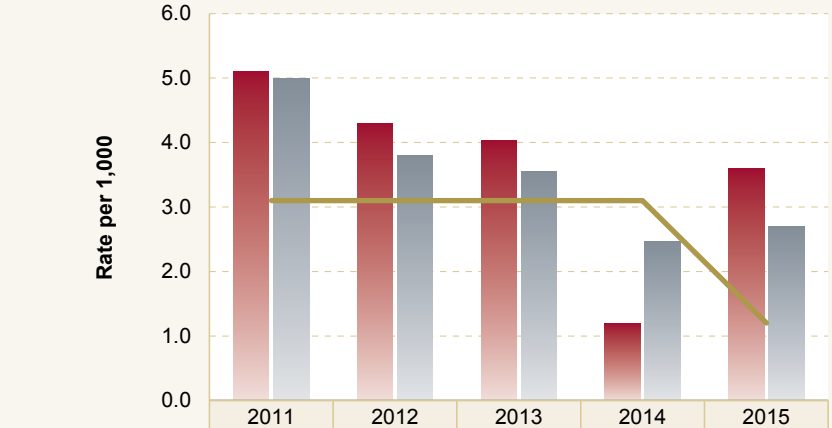
Respiratory condition	Age group (years)	Target
Asthma	0–4	≤ 1.2
	5–12	≤ 1.8
	13–18	≤ 0.2
	19–34	≤ 0.4
	35+	≤ 0.6
Acute Bronchitis	0–4	≤ 0.1
Bronchiolitis	0–4	≤ 7.7
Croup	0–4	≤ 2.1

Results

Acute asthma

For Aboriginal and non-Aboriginal children aged 0–4 years, hospitalisation rates for asthma were above the target of 1.2 per 1,000 children (see Figure 14).

Figure 14: **Rate of hospitalisation for acute asthma per 1,000 children aged 0–4 years, 2011–2015**



	2011	2012	2013	2014	2015
Aboriginal	5.1	4.3	4.0	1.2	3.6
Non-Aboriginal	5.0	3.8	3.6	2.5	2.7
Target	3.1	3.1	3.1	3.1	1.2

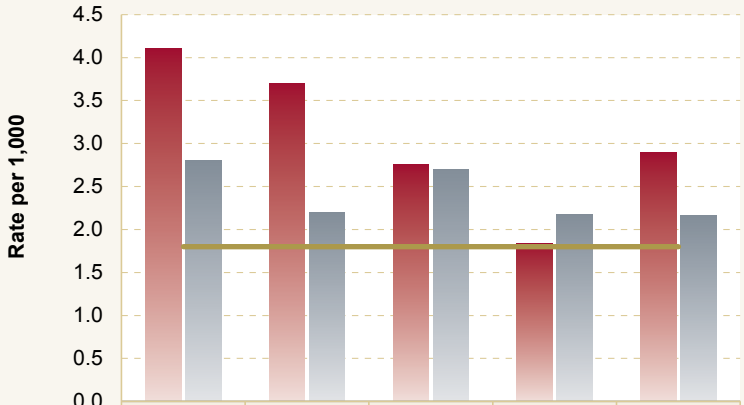
Notes:

1. The total population used in the calculation of this KPI is based on the Australian Bureau of Statistics Estimated Resident Population for 2014, as defined by the Australian Statistical Geography Standard.
2. Caution should be taken in the interpretation of the rates of hospitalisation of Aboriginal children for acute asthma due to small population numbers that can result in significant variations across reporting years.

Data sources: Hospital Morbidity Data System, Australian Bureau of Statistics.

The rate of hospitalisation of Aboriginal children aged 5–12 years for asthma was 2.9 per 1,000, which is above the target of 1.8 per 1,000. For non-Aboriginal children it was also above the target at 2.2 per 1,000 (see Figure 15).

Figure 15: **Rate of hospitalisation for acute asthma per 1,000 children aged 5–12 years, 2011–2015**



	2011	2012	2013	2014	2015
Aboriginal	4.1	3.7	2.8	1.8	2.9
Non-Aboriginal	2.8	2.2	2.7	2.2	2.2
Target	1.8	1.8	1.8	1.8	1.8

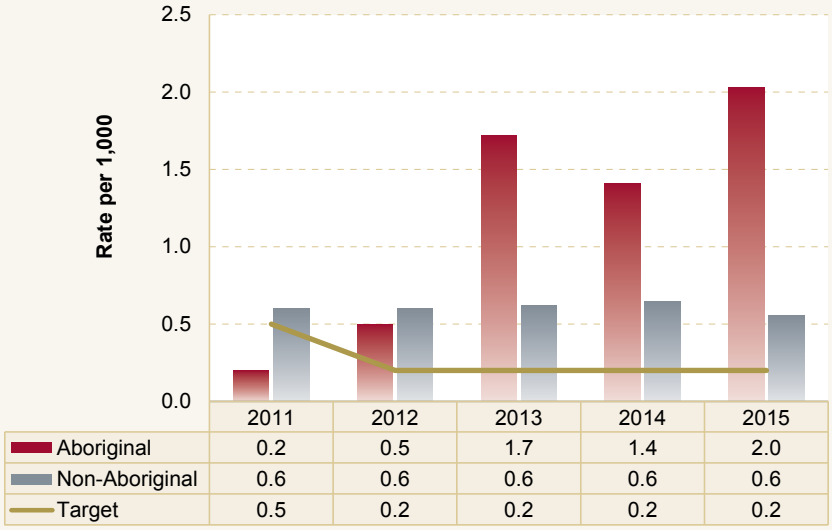
Notes:

1. The total population used in the calculation of this KPI is based on the Australian Bureau of Statistics Estimated Resident Population for 2014, as defined by the Australian Statistical Geography Standard.
2. Caution should be taken in the interpretation of the rates of hospitalisation of Aboriginal children for acute asthma due to small population numbers that can result in significant variations across reporting years.

Data sources: Hospital Morbidity Data System, Australian Bureau of Statistics.

For children aged 13–18 years, hospitalisation rates for asthma were above target of 0.2 per 1,000 children. Aboriginal children in this age range were hospitalised at a rate of 2.0 per 1,000, and non-Aboriginal children at a rate of 0.6 per 1,000 (see Figure 16).

Figure 16: **Rate of hospitalisation for acute asthma per 1,000 children aged 13–18 years, 2011–2015**



	2011	2012	2013	2014	2015
Aboriginal	0.2	0.5	1.7	1.4	2.0
Non-Aboriginal	0.6	0.6	0.6	0.6	0.6
Target	0.5	0.2	0.2	0.2	0.2

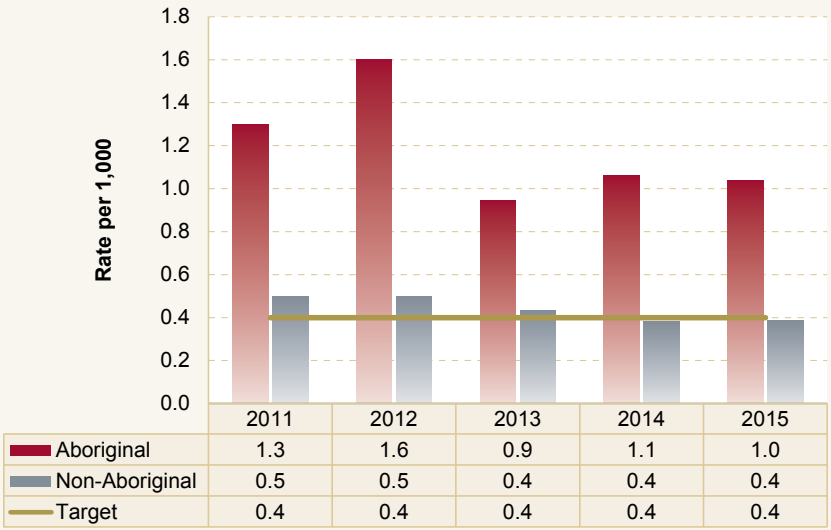
Notes:

1. The total population used in the calculation of this KPI is based on the Australian Bureau of Statistics Estimated Resident Population for 2014, as defined by the Australian Statistical Geography Standard.
2. Caution should be taken in the interpretation of the rates of hospitalisation of Aboriginal children for acute asthma due to small population numbers that can result in significant variations across reporting years.

Data sources: Hospital Morbidity Data System, Australian Bureau of Statistics.

Non-aboriginal adults aged 19–34 were hospitalised for asthma at a rate equal to the target of 0.4 per 1,000. In contrast, Aboriginal people aged 19–34 were hospitalised for asthma at the rate of 1.0 per 1,000 (see Figure 17).

Figure 17: **Rate of hospitalisation for acute asthma per 1,000 persons aged 19–34 years, 2011–2015**



	2011	2012	2013	2014	2015
Aboriginal	1.3	1.6	0.9	1.1	1.0
Non-Aboriginal	0.5	0.5	0.4	0.4	0.4
Target	0.4	0.4	0.4	0.4	0.4

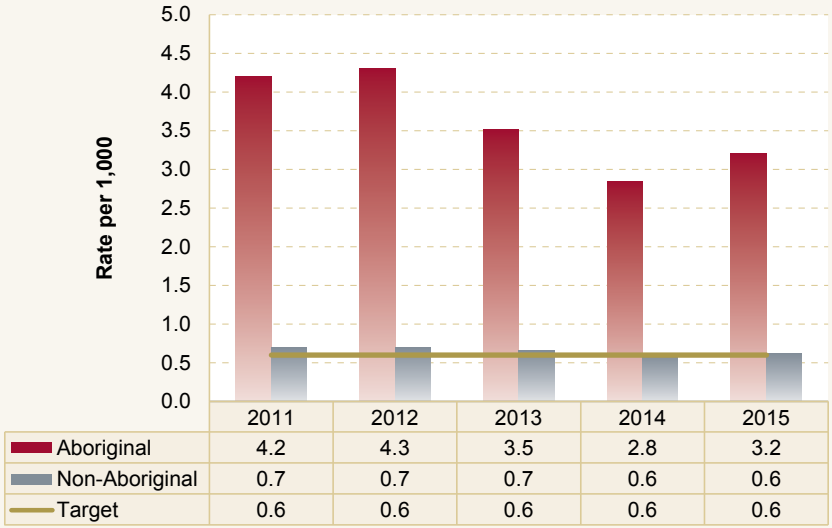
Notes:

1. The total population used in the calculation of this KPI is based on the Australian Bureau of Statistics Estimated Resident Population for 2014, as defined by the Australian Statistical Geography Standard.
2. Caution should be taken in the interpretation of the rates of hospitalisation of Aboriginal people for acute asthma due to small population numbers that can result in significant variations across reporting years.

Data sources: Hospital Morbidity Data System, Australian Bureau of Statistics.

Hospitalisation rates for asthma in adults aged 35 years and older equalled the target rate of 0.6 per 1,000 for non-Aboriginal people, and exceeded the target for Aboriginal people at 3.2 per 1,000 (see Figure 18).

Figure 18: **Rate of hospitalisation for acute asthma per 1,000 persons aged 35 years and older, 2011–2015**



	2011	2012	2013	2014	2015
Aboriginal	4.2	4.3	3.5	2.8	3.2
Non-Aboriginal	0.7	0.7	0.7	0.6	0.6
Target	0.6	0.6	0.6	0.6	0.6

Notes:

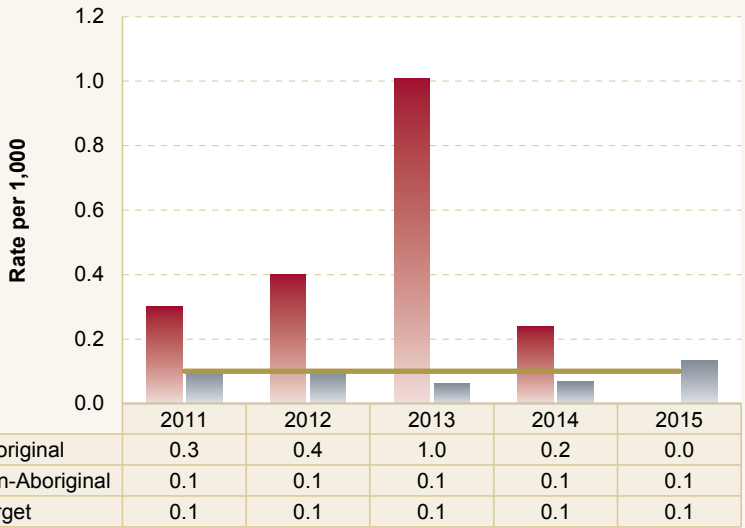
1. The total population used in the calculation of this KPI is based on the Australian Bureau of Statistics Estimated Resident Population for 2014, as defined by the Australian Statistical Geography Standard.
2. Caution should be taken in the interpretation of the rates of hospitalisation of Aboriginal people for acute asthma due to small population numbers that can result in significant variations across reporting years.

Data sources: Hospital Morbidity Data System, Australian Bureau of Statistics.

Acute bronchitis

In 2015, the rate of non-Aboriginal children aged 0–4 years hospitalised for acute bronchitis was equal to the target of 0.1 per 1,000 children, which is consistent with previous years. There were no Aboriginal children aged 0–4 years hospitalised for acute bronchitis (see Figure 19).

Figure 19: **Rate of hospitalisation for acute bronchitis per 1,000 children aged 0–4 years, 2011–2015**



	2011	2012	2013	2014	2015
Aboriginal	0.3	0.4	1.0	0.2	0.0
Non-Aboriginal	0.1	0.1	0.1	0.1	0.1
Target	0.1	0.1	0.1	0.1	0.1

Notes:

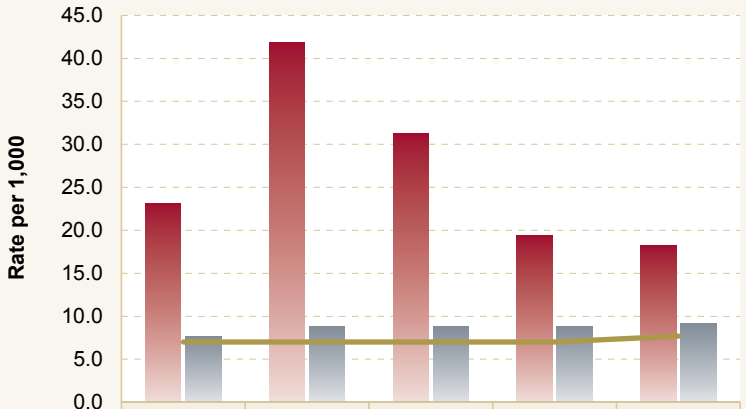
1. The total population used in the calculation of this KPI is based on the Australian Bureau of Statistics Estimated Resident Population for 2014, as defined by the Australian Statistical Geography Standard.
2. Caution should be taken in the interpretation of the rates of hospitalisation of Aboriginal children for acute bronchitis due to small population numbers that can result in significant variations across reporting years.

Data sources: Hospital Morbidity Data System, Australian Bureau of Statistics.

Bronchiolitis

In 2015, the rate of non-Aboriginal children aged 0–4 years hospitalised for bronchiolitis was 9.2 per 1,000 (see Figure 20), which is slightly higher than recent years. In comparison, the rate of hospitalisation for bronchiolitis for Aboriginal children was 18.2 per 1,000, which is lower than previous years. During 2015, the hospitalisation rates for both non-Aboriginal and Aboriginal children aged 0–4 years were above the target of 7.7 per 1,000.

Figure 20: **Rate of hospitalisation for bronchiolitis per 1,000 children aged 0–4 years, 2011–2015**



	2011	2012	2013	2014	2015
Aboriginal	23.1	41.8	31.3	19.4	18.2
Non-Aboriginal	7.7	8.8	8.8	8.8	9.2
Target	7.0	7.0	7.0	7.0	7.7

Notes:

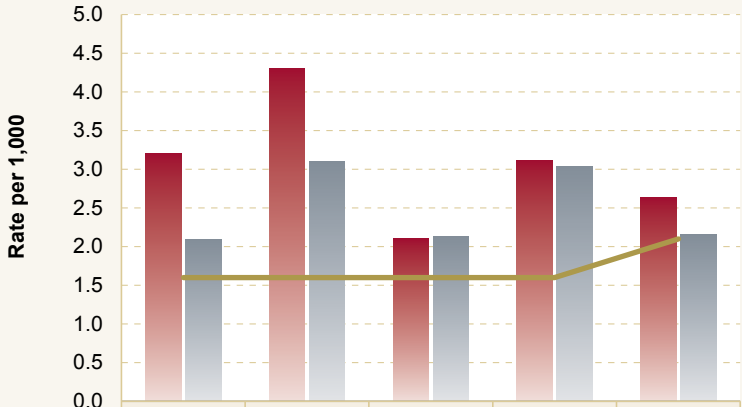
1. The total population used in the calculation of this KPI is based on the Australian Bureau of Statistics Estimated Resident Population for 2014, as defined by the Australian Statistical Geography Standard.
2. Caution should be taken in the interpretation of the rates of hospitalisation of Aboriginal children for bronchiolitis due to small population numbers that can result in significant variations across reporting years.

Data sources: Hospital Morbidity Data System, Australian Bureau of Statistics.

Croup

Aboriginal children aged 0–4 had a slightly higher rate of hospitalisation for croup at 2.6 per 1,000, compared with 2.2 per 1,000 for non-Aboriginal children in 2015 (see Figure 21). Both rates are above the target of 2.1 per 1,000 children.

Figure 21: **Rate of hospitalisations for croup per 1,000 children aged 0–4 years, 2011–2015**



	2011	2012	2013	2014	2015
Aboriginal	3.2	4.3	2.1	3.1	2.6
Non-Aboriginal	2.1	3.1	2.1	3.0	2.2
Target	1.6	1.6	1.6	1.6	2.1

Notes:

1. The total population used in the calculation of this KPI is based on the Australian Bureau of Statistics Estimated Resident Population for 2014, as defined by the Australian Statistical Geography Standard.
2. Caution should be taken in the interpretation of the rates of hospitalisation of Aboriginal children for croup due to small population numbers that can result in significant variations across reporting years.

Data sources: Hospital Morbidity Data System, Australian Bureau of Statistics.

Rate of hospitalisation for falls in older persons

Outcome 2
Effectiveness KPI

Rationale

Falls occur at all ages, but the frequency and severity of falls-related injury increases with age. The increase in falls as people age is associated with decreased muscle tone, strength and fitness as a result of physical inactivity. Certain medications, previous falls and predisposing medical conditions such as stroke, dementia, incontinence and visual problems can contribute to an increased risk of falls.

Fall-related injury among older people is a major public health issue that can result in emergency department attendances and hospitalisation, and can lead to substantial loss of independence. With the growth of the ageing population, fall-related injuries threaten to significantly increase demand on the public hospital system.

By assessing the impact of falls on the public hospital system and by measuring the rate of hospitalisation for falls in older persons, effective intervention and prevention programs can be delivered. Successful interventions and prevention programs, such as the Falls Prevention Model of Care for the Older Person in Western Australia, can reduce the number and severity of falls in older persons thus, enhancing their overall health and wellbeing, enabling them to remain independent and productive members of their community.

Target

The target is 0.5 per cent per annum reduction in the rate of hospitalisations for falls for sustained period for both Aboriginal and non-Aboriginal populations, by 2020.

Results

Hospitalisation rates due to falls for both Aboriginal and non-Aboriginal population groups generally increase with age (see Table 24). In 2015, the rate of hospitalisation for falls decreased for the Aboriginal population aged between 65–79 and the non-Aboriginal population aged 80 years and over. These exceeded the targeted reduction of 0.5 per cent per annum. All other population groups demonstrated increased rates of hospitalisation for falls and therefore did not meet the target.

Table 24: **Rate of hospitalisations for falls per 1,000 by age group, 2011 to 2015**

Age group (years)		Year					
		2011	2012	2013	2014	2015	Target
55–64	Aboriginal	19.6	18.3	21.5	11.1	**17.9**	0.5 per cent per annum reduction for a sustained period for both subgroup populations by 2020
	Non-Aboriginal	6.7	6.7	6.7	6.4	**6.8**	
65–79	Aboriginal	51.1	54.1	33.8	34.2	**27.2**	
	Non-Aboriginal	22.5	23.3	23.4	21.8	**22.0**	
80+	Aboriginal	73.7	116.5	84.1	27.0	**247.9**	
	Non-Aboriginal	124.8	130.9	128.1	128.6	**125.1**	

Notes:

1. The total population used in the calculation of this KPI is based on the Australian Bureau of Statistics Estimated Resident Population for 2014, as defined by the Australian Statistical Geography Standard.
2. Caution needs to be taken in the interpretation of the rate of hospitalisation for falls (per 1,000 population) among the Aboriginal population. Small population numbers have resulted in significant variations across the years and comparison is not recommended.

Data sources: Hospital Morbidity Data System, Australian Bureau of Statistics.

Rate of childhood dental screening

Outcome 2
Effectiveness KPI

Rationale

Early detection and prevention of dental health problems, such as dental decay (also known as dental caries) in children, can ensure better health outcomes and improved quality of life throughout the crucial childhood development years and into adult life.

While dental disease is common in children, it is largely preventable through population-based interventions and individual practices such as personal oral hygiene, better diet and regular preventive dental care.

The School Dental Service program ensures early identification of dental problems and, where appropriate, provides treatment.

By measuring the percentage of school children enrolled in the program, the number of children proactively involved in publicly funded dental care can be determined in order to gauge the effectiveness of the program. This in turn can help identify potential areas that require more focused intervention, prevention and health promotion strategies to help ensure the improved dental health and wellbeing of WA children.

Target

The 2015 targets are as follows:

a. Percentage of eligible school children (pre-primary, primary and secondary) who are enrolled in the School Dental Service program.

	Enrolled
Pre-primary program	≥69%
Primary program	≥69%
Secondary program	≥69%

b. Percentage of school children (all ages) who are free of dental caries when initially examined and/or re-called for examination: ≥65 per cent.

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

Results

Children at all stages in the school system are enrolled in the school dental program at rates at or above the target of 69 per cent (see Table 25). The rates for primary school children have increased over the past year to 84.0 per cent.

Table 25: **Percentage of pre-primary, primary and secondary school children who are enrolled in the school dental program, 2011–2015**

		Year					
		2011 (%)	2012 (%)	2013 (%)	2014 (%)	2015 (%)	Target (%)
Pre-primary school children	Enrolled in program	72.7	54.9	84.6	73.1	69.0	**≥69**
Primary school children	Enrolled in program	78.0	80.0	73.0	82.7	84.0	**≥69**
Secondary school children	Enrolled in program	77.3	83.3	87.5	93.8	76.0	**≥69**

Note: From 2012 two data collection methods have been used to provide the results for this key performance indicator. This is a result of the ongoing transition toward the implementation of the electronic database "DenIM" resulting in a number of school dental clinics using the electronic system, while others continue to use manual paper-based recording. DHS achieved full computerisation in March 2015.

Data source: Dental Information Management (DenIM) – Dental Health Services.

The 'Free of Active Caries on Recall' rate improved to 69.0 per cent in 2015, which exceeded the target of 65 per cent (see Table 26).

Table 26: **Percentage of children free of dental caries when initially examined and/or recalled for examination, 2011–2015**

	Year					
	2011 (%)	2012 (%)	2013 (%)	2014 (%)	2015 (%)	Target (%)
Children free of dental caries	67.1	66.9	66.3	62.3	69.0	**≥65**

Notes:

1. From 2012 two data collection methods have been used to provide the results for this key performance indicator. This is a result of the ongoing transition toward the implementation of the electronic database "DenIM" resulting in a number of school dental clinics using the electronic system, while others continue to use manual paper-based recording. DHS achieved full computerisation in March 2015.
2. Results are indicative of all dental healthcare activity and expenditure across WA.
3. 'Enrolled in program' – Where a parent/guardian has consented to dental examination and screening of their child and are participating in the School Dental Service program.

Data source: Dental Information Management (DenIM) – Dental Health Services.

Dental health status of target clientele

Outcome 2
Effectiveness KPI

Rationale

Oral healthcare is fundamental to overall health, wellbeing and quality of life, with poor oral health likely to exist when general health is poor and vice versa.

Dental health is influenced by many factors, including nutrition, water fluoridation, hygiene, access to dental treatment, income, lifestyle factors and trauma. Dental diseases place a considerable burden on individuals and communities. While dental disease is common, it is largely preventable through population-based interventions and individual practices such as personal oral hygiene and regular preventive dental care. Costly treatment and high demand on public dental health services emphasises the need for a focus on prevention and health promotion.

This indicator enables the monitoring of the dental health status of adults and children within specific age groups in order to assess the effectiveness of dental health practices, interventions and programs. Evidence-based accessible and affordable interventions that have a strong focus on dental health promotion, prevention and early identification of dental disease can then be implemented to improve the dental health of Western Australians.

Target

The 2015–16 target is applicable to children aged 12 years.

The International Benchmark is 0.6–1.7 decayed, missing or filled teeth (DMTF).

Standardised data collection protocols ensure values used are comparable to International Benchmarks. Six countries with populations and service delivery models closest to the WA population and service structure were used to determine local targets.

International benchmarks for 12 year olds:

Country	Decayed, missing or filled teeth
Austria (2007)	1.4
Denmark (2012)	0.6
Finland (2009)	0.7
Germany (2009)	0.7
Italy (2004)	1.1
Norway (2004)	1.7

Results

The average number of decayed, missing and filled teeth in children has remained effectively consistent over the past five years (see Table 27). The result of 0.60 for 12 year olds is at the bottom end of the target range and compares very favourably with international benchmarks.

Table 27: **Average number of decayed, missing or filled teeth for school children, 2011 to 2015**

Average number of DMFT for children by age	Year				
	2011	2012	2013	2014	2015
5 Years	1.19	1.09	1.33	1.37	**1.10**
8 Years	0.27	0.18	0.18	0.16	**0.16**
12 Years	0.79	0.69	0.65	0.61	**0.60**
15 Years	1.37	1.38	1.48	1.28	**1.22**

Data source: Dental Health Services.

The average number of decayed, missing or filled teeth for adults in 2015–16 was 8.4, which is a slight increase on the previous year (see Table 28).

Table 28: **Average number of decayed, missing or filled teeth for adults, 2011–12 to 2015–2016**

Average number of DMFT for adults	Year				
	2011–12	2012–13	2013–14	2014–15	2015–16
35–44 years	9.8	12.8	10.3	8.3	**8.4**

Notes:

1. The results are indicative of all dental healthcare activity and expenditure across WA.
2. The average number of DMFT is based on a randomly selected sub–sample of the total number of patients from the national Adult Dental Health Service patient oral health survey. The average number of DMFT for adults aged 35–44 years at a confidence interval of 95% is 7.6–9.2.

Data source: Dental Health Services.

Access to dental treatment services for eligible people

Outcome 2
Effectiveness KPI

Rationale

Oral health, including dental health is fundamental to overall health, wellbeing and quality of life with poor oral health likely to exist when general health is poor and vice versa. This makes access to timely dental treatment services critical in reducing the burden of dental disease on individuals and communities, as it can enable early detection and diagnosis with the use of preventative interventions rather than extensive restorative or emergency treatments.

To facilitate the equity of access to dental healthcare for all Western Australians, dental treatment services (including both emergency care and non-emergency care) are provided through subsidised dental programs to eligible Western Australians in need. This indicator measures the level of access to subsidised public general dental health services by monitoring the proportion of all eligible people receiving the services.

Through measuring the use and amount of dental health services provided to eligible people, the percentage of eligible people proactively involved in publicly funded dental care can be determined. This in turn can help identify potential areas that require more focused intervention, prevention and health promotion strategies to help ensure the improved dental health and wellbeing of Western Australians with the greatest need.

Target

The 2015–16 targets are outlined below.

a. Eligible people who accessed subsidised public general dental health services: ≥15 per cent
b. Eligible people who have completed emergency or non-emergency dental treatment:
   i. Emergency ≤50 per cent
   ii. Non-Emergency ≥50 per cent

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

Results

In 2015–16, the percentage of eligible adults who accessed subsidised public general dental health services was 15 per cent (see Table 29), which is equal to the target.

Table 29: **Percentage of eligible people that accessed dental treatment services, 2011–12 to 2015–16**

	Year					
	2011–12 (%)	2012–13 (%)	2013–14 (%)	2014–15 (%)	2015–16 (%)	Target (%)
Eligible persons who accessed dental health services (adult)	17	18	16	15	15	**≥15**

Data source: Dental Health Services.

In 2015–16, 41 per cent of eligible people received emergency dental care, which is consistent with recent years and below the target of 50 per cent (see Table 30). The percentage of eligible people who received non-emergency dental care remained above the 50 per cent target in 2015–16, at 59 per cent. The results meet the targets, demonstrating a higher proportion of non-emergency treatments to emergency treatments.

Table 30: **Percentage of complete dental care, 2011–12 to 2015–16**

	Year					
	2011–12 (%)	2012–13 (%)	2013–14 (%)	2014–15 (%)	2015–16 (%)	Target (%)
Emergency completed dental treatments	47	43	39	41	41	**≤50**
Non-emergency completed dental treatments	53	57	61	59	59	**≥50**

Notes:

1. The results are indicative of all dental healthcare activity and expenditure across Western Australia.
2. Prior year published results for the key performance indicator Access to dental treatment services for eligible people were reported as per calendar year. However, results are calculated based on financial year data and this has been amended accordingly as at 2012–13.

Data source: Dental Health Services.

Average waiting times for dental services

Outcome 2
Effectiveness KPI

Rationale

Oral health, including dental health, is fundamental to overall health, wellbeing and quality of life, with poor oral health likely to exist when general health is poor and vice versa. This makes access to timely dental services critical in reducing the burden of dental disease on individuals and communities, as it can enable early detection and diagnosis with the use of preventative interventions rather than extensive restorative or emergency treatments.

Costly treatment and high demand on public general dental health services emphasises the need for a focus on prevention and health promotion, which can be achieved through timely access to dental services.

Through monitoring waiting times for access to public general dental health services targeted strategies can be implemented to ensure timely access to affordable dental care, which ultimately can lead to better health outcomes for Western Australians.

Target

The target for 2015–16 was ≤24 months.

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

Results

In 2015–16, the average waiting time for public general dental services was 4 months against the target of 24 months, which is a marked improvement since 2012–13 (see Table 31). Since 1 July 2013, the Dental Health Service has been the lead service provider for WA in the National Partnership Agreement with the Commonwealth government to reduce waitlists. This year the Dental Health Service offered oral health care to over 22,000 patients on the waitlists, with approximately 16,000 patients accepting treatment.

Table 31: **Average waiting times, in months, per patient removed from the waiting list, 2011–12 to 2015–16**

	Year					
	2011–12	2012–13	2013–14	2014–15	2015–16	Target
Waiting times for non–urgent dental care (months)	21	24	13	6	4	**≤24**

Note: The results are indicative of all dental healthcare activity and expenditure across WA.

Data source: Dental Health Services.

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

Outcome 2
Effectiveness KPI

Rationale

The impact of mental illness within the Australian population has become increasingly apparent, with mental illness being one of the leading causes of non-fatal burden of disease in Australia. The *2007 National Survey of Mental Health and Wellbeing* found that an estimated 3.2 million Australians aged between 16 and 85 years had a mental disorder. That's why it is crucial to ensure effective and appropriate care is provided not only in a hospital setting, but also in the community care setting.

A large proportion of treatment of mental illness is carried out in community care setting through ambulatory mental health services. The aim is to provide the best health outcomes for the individual through the provision of accessible and appropriate community mental healthcare, thus, alleviating the need for, or assisting with improving the management of, admissions to hospital-based inpatient care for mental illness.

Monitoring the level of accessibility to community mental health services pre-admission to hospital can be gauged in order to assist in the development of effective programs and interventions. This in turn can help to improve the health and wellbeing of Western Australians with mental illness and ensure sustainability of the public health system.

Target

The target for 2015 was 70 per cent.

This target was endorsed by the Australian Health Ministers' Advisory Council Mental Health Standing Committee in May 2011.

The target of 70 per cent is based on a national definition, with the majority of jurisdictions, including WA, being unable to achieve this aspirational target from 2007–08.

Results

In 2015, 56.4 per cent of people who were admitted to a metropolitan public mental health unit had been in contact with a community-based public mental health non-admitted health service in the previous seven days. This is the highest result in the past five years (see Table 32).

Table 32: **Percentage of contacts with a community-based mental health non-admitted service seven days prior to admission, 2011–2015**

	Year					
	2011 (%)	2012 (%)	2013 (%)	2014 (%)	2015 (%)	Target (%)
Pre-admission community based contact	53.0	51.6	51.5	49.0	56.4	**70**

Data sources: Mental Health Information System, Hospital Morbidity Data System.

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

Outcome 2
Effectiveness KPI

Rationale

The *2007 National Survey of Mental Health and Wellbeing* found that an estimated 3.2 million Australians aged between 16 and 85 years had a mental disorder. Therefore, it is crucial to ensure effective and appropriate care is provided not only in a hospital setting, but also in the community care setting.

A large proportion of treatment of mental illness is carried out in the community care setting through ambulatory mental health services post-discharge from hospital.

Post-discharge community mental health services are critical in maintaining clinical and functional stability and to reducing vulnerability in individuals with mental illness by providing much needed support and care. This support and care can go a long way to ensuring the best health outcomes for the individual and to reducing the need for hospital readmission.

Monitoring the level of accessibility to community mental health services post-admission to hospital can help assist in the development of effective programs and interventions. This in turn can help to improve the health and wellbeing of Western Australians with mental illness and ensure the sustainability of the public health system.

Target

In 2015 the target was 75 per cent.

This target was endorsed by the Australian Health Ministers' Advisory Council Mental Health Standing Committee in May 2011.

The target is considered aspirational, as the measure only includes follow-up by public community mental health services.

Results

In 2015, 58.9 per cent of people who were admitted to a metropolitan public mental health unit were contacted by a community-based mental health non-admitted service within seven days of discharge (see Table 33). This result is up from 2014 (58.3 per cent), and the upward trend over five years remains.

Table 33: **Percentage of contacts with a community-based mental health non-admitted service seven days post discharge, 2011–2015**

	Year					
	2011 (%)	2012 (%)	2013 (%)	2014 (%)	2015 (%)	Target (%)
Post-admission community based contact	49.2	52.2	56.2	58.3	58.9	**75**

Data sources: Mental Health Information System, Hospital Morbidity Data System.

Note: An updated method to link inpatient and community health data has been developed and applied. Previously reported results no longer considered appropriate are as follows:

	2011 (%)	2012 (%)	2013 (%)	2014 (%)
Post-admission community based contact	49.6	52.3	56.1	54.1

Average cost per capita of Population Health Units

Outcome 2
Efficiency KPI
Service 7: Prevention, promotion & protection

Rationale

WA Health aims to provide safe, high-quality healthcare to ensure healthier, longer, and better quality lives for all Western Australians.

Population health units support individuals, families and communities to increase control over and improve their health. With the aim of improving health, population health works to integrate all activities of the health sector and link them with broader social and economic services and resources by utilising the *WA Health Promotion Strategic Framework 2012–2016*. This is based on the growing understanding of the social, cultural and economic factors that contribute to a person's health status.

Target

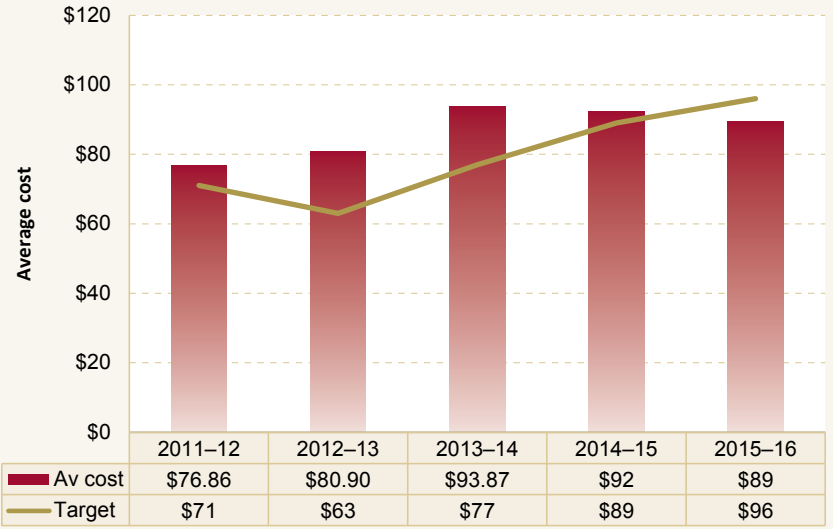
The target for 2015–16 is $96 per capita of population health units.

A result below the target is desirable.

Results

For 2015–16, the average cost per capita of Metropolitan Population Health Units was $89, which is below the target (see Figure 22).

Figure 22: **Average cost per capita of Metropolitan Population Health Units, 2011–12 to 2015–16**



	2011–12	2012–13	2013–14	2014–15	2015–16
Av cost	$76.86	$80.90	$93.87	$92	$89
Target	$71	$63	$77	$89	$96

Notes:

1. The total population used in the calculation of this KPI is based on the Australian Bureau of Statistics Estimated Resident Population for 2014, as defined by the Australian Statistical Geography Standard.
2. Population Health Units function within area boundaries defined by postcodes.

Data sources: Australian Bureau of Statistics, health service financial systems.

Average cost per breast screening

Outcome 2
Efficiency KPI
Service 7: Prevention, promotion & protection

Rationale

WA Health aims to provide safe, high-quality healthcare to ensure healthier, longer, and better quality lives for all Western Australians.

Breast cancer remains the most common cause of cancer death in women under 65 years. Early detection through screening and early diagnosis can increase the survival rate of women significantly. Breast screening mammograms are offered through BreastScreen WA for women aged 40 years or over as a preventative initiative.

Target

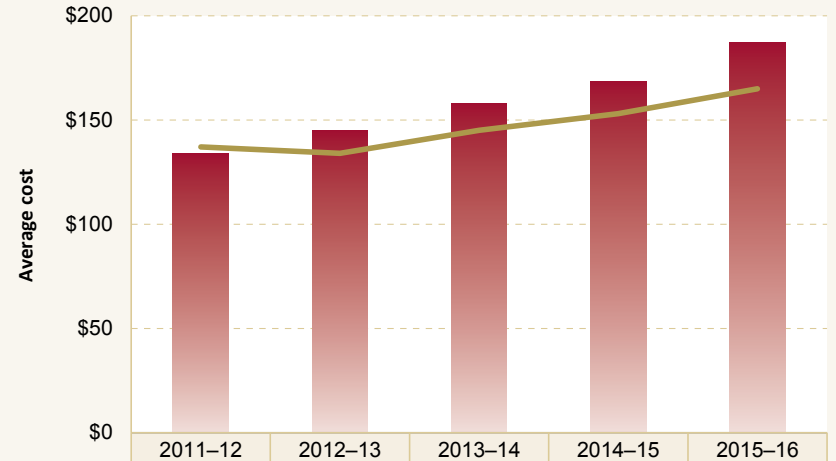
The target for 2015–16 is $165 per breast screening.

A result below the target is desirable.

Results

In 2015–16, the average cost per breast screen was $187, and above the target (see Figure 23). The additional expenditure is due to additional Commonwealth funded investment to establish capacity to increase the number of women aged 70–74 years being screened in future years.

Figure 23: **Average cost per breast screening, 2011–12 to 2015–16**



	2011–12	2012–13	2013–14	2014–15	2015–16
Av cost	$134	$145	$158	$169	$187
Target	$137	$134	$145	$153	$165

Notes:

1. Breast Assessment clinic expenditure at Royal Perth Hospital and Sir Charles Gairdner Hospital are excluded in the calculation of this key performance indicator.

Data sources: Mammography Screening Registry, BreastScreen WA, health service financial systems.

Average cost of service for school dental service

Outcome 2
Efficiency KPI
Service 8:
Dental health

Rationale

WA Health aims to provide safe, high-quality healthcare to ensure healthier, longer, and better quality lives for all Western Australians.

Early detection and prevention of dental health problems in children can ensure better health outcomes and improved quality of life throughout the crucial childhood development years and into adult life. While dental disease is common in children, it is largely preventable through population-based interventions and individual practices such as personal oral hygiene, better diet, and regular preventive dental care. The school dental service program ensures early identification of dental problems and where appropriate, provides treatment.

Target

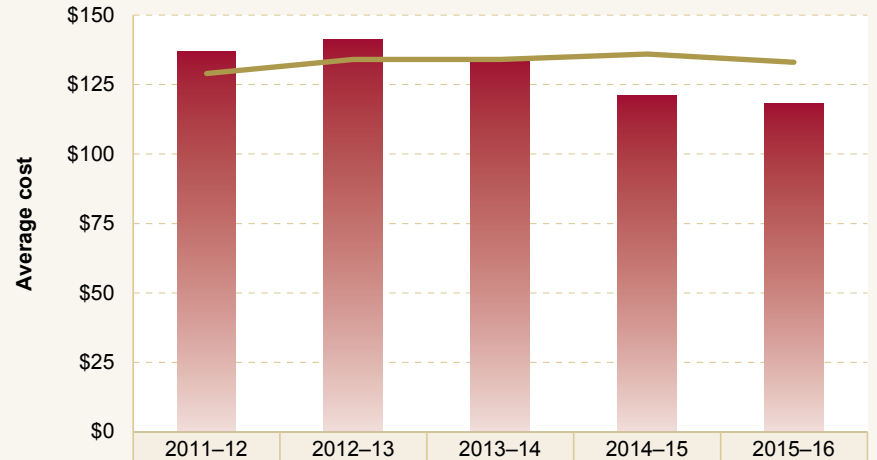
The target for 2015–16 is $133 to provide public general dental services to school aged children.

A result below the target is desirable.

Results

For 2015–16, the average cost to provide public general dental services to school aged children was $118, which is below the target (see Figure 24). Fully computerised records of activity since March 2015 have led to a more accurate determination of average cost in 2015–16.

Figure 24: **Average cost of service for school dental care, 2011–12 to 2015–16**



	2011–12	2012–13	2013–14	2014–15	2015–16
Av cost	$137	$141	$135	$121	$118
Target	$129	$134	$134	$136	$133

Notes:

1. From 2014–15 the number of enrolled children in the school dental program was taken at 30 June where previously it was taken at the end of the calendar year.
2. From 2012–13 two data collection methods have been used to provide the results for this key performance indicator. This is due to the ongoing transition toward the implementation of the electronic database DenIM, resulting in a number of school dental clinics using the electronic system, while others continue to use manual paper based recording. DHS achieved full computerisation in March 2015.
3. Results are indicative of all dental healthcare activity and expenditure across Western Australia.

Data sources: Dental Information Management (DenIM) – Dental Health Services.

Average cost of completed courses of adult dental care

Outcome 2
Efficiency KPI
Service 8:
Dental health

Rationale

WA Health aims to provide safe, high-quality healthcare to ensure healthier, longer, and better quality lives for all Western Australians.

Dental health is influenced by many factors, including nutrition, water fluoridation, hygiene, access to dental treatment, income, lifestyle factors, and trauma. Dental disease places a considerable burden on individuals and communities. While dental disease is common, they are largely preventable through population-based interventions, and individual practices such as personal oral hygiene and regular preventive dental care. Costly treatment and high demand on public dental health services emphasises the need for a focus on prevention and health promotion.

Target

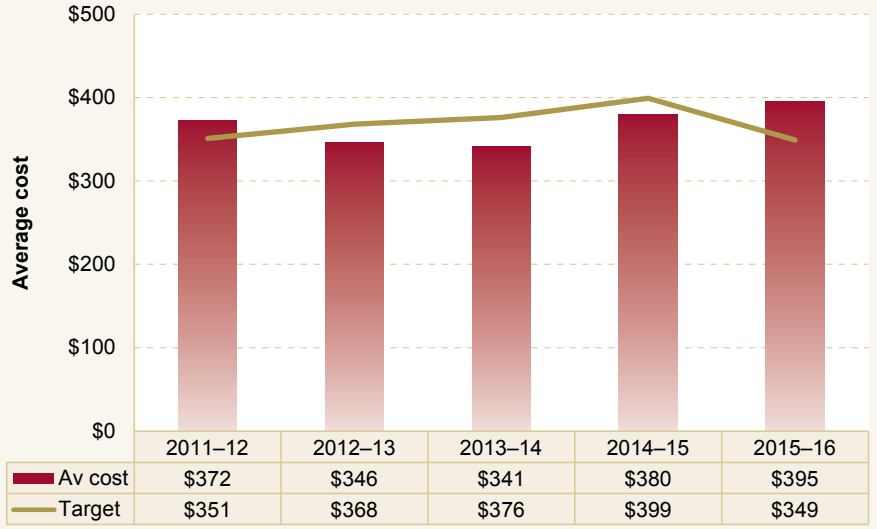
The target for 2015–16 is $349 per completed courses of adult dental care.

A result below the target is desirable.

Results

The average cost of completed courses of adult dental care in 2015–16 was $395, which is above the target (see Figure 25). The higher average cost is attributable to increased service delivery via the Commonwealth funded National Partnership Agreement for Treating More Adult Public Dental Patients.

Figure 25: **Average cost of completed courses of adult dental care, 2011–12 to 2015–16**



	2011–12	2012–13	2013–14	2014–15	2015–16
Av cost	$372	$346	$341	$380	$395
Target	$351	$368	$376	$399	$349

Notes:

1. Results are indicative of all dental healthcare activity and expenditure across Western Australia.
2. This key performance indicator is based on the cost per adult dental treatment for non-specialist Dental Health Services.

Data sources: Adult dental clinics – Dental Health Services.

Average cost per bed-day in specialised mental health inpatient units

Outcome 2
Efficiency KPI
Service 10: Contracted mental health

Rationale

The *2007 National Survey of Mental Health and Wellbeing* found that an estimated 3.2 million Australians, aged between 16 and 85 years, had a mental disorder in the 12 months prior to the survey. Therefore, it is important to ensure effective and appropriate care is provided to mental health clients in the community, as well as through specialised mental health inpatient units.

Target

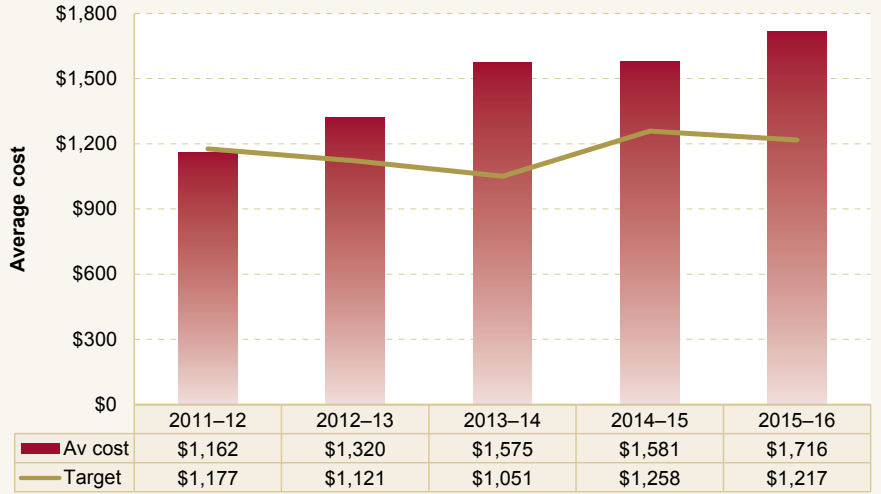
The target for 2015–16 is $1,217 per bed-day in a specialised mental health unit.

A result below the target is desirable.

Results

For 2015–16, the average cost per bed-day in specialised mental health inpatient units was $1,716, which is above the target (see Figure 26). The higher expenditure to target is attributable to an overestimate of activity used when deriving the target.

Figure 26: **Average cost per bed-day in specialised mental health inpatient units, 2011–12 to 2015–16**



	2011–12	2012–13	2013–14	2014–15	2015–16
Av cost	$1,162	$1,320	$1,575	$1,581	$1,716
Target	$1,177	$1,121	$1,051	$1,258	$1,217

Notes:

1. The average unit cost for the delivery of mental health services include statewide corporate overheads that incorporate costs borne by WA Health that are not included in the target methodology and Mental Health Commission service provision agreement.

Data sources: Mental Health Information System, BedState, health service financial systems.

Average cost per three month period of care for community mental health

Outcome 2
Efficiency KPI
Service 10: Contracted mental health

Rationale

Mental health is having an increasing impact on the Australian population and is one of the leading causes of disability burden in Australia. The *2007 National Survey of Mental Health and Wellbeing* found that an estimated 3.2 million Australians, aged between 16 and 85 years, had a mental disorder in the 12 months prior to the survey. Therefore, it is important to ensure effective and appropriate care is provided to mental health clients not only in a hospital setting but also in the community care setting, through the provision of community mental health services.

Community mental health services comprise of a range of community-based services such as emergency assessment and treatment, case management, day programs, rehabilitation, psychosocial, and residential services. The aim is to provide the best health outcomes for the individual through the provision of accessible and appropriate community mental healthcare.

Target

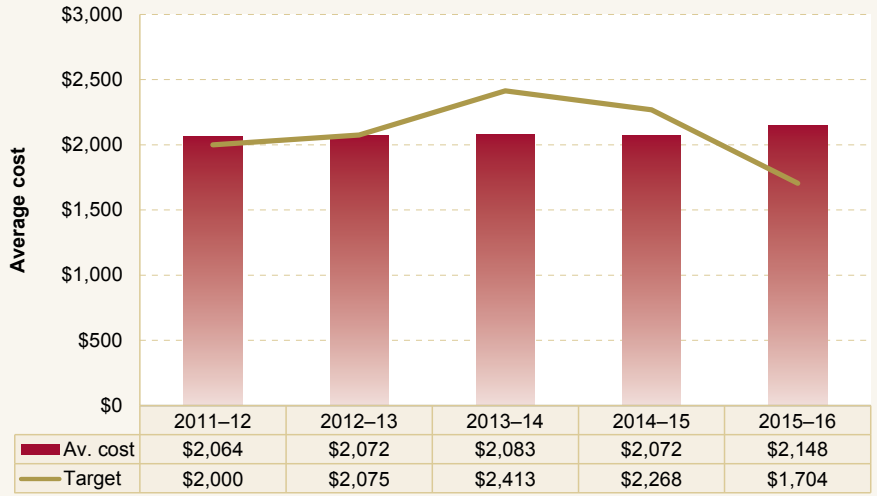
The target for 2015–16 is $1,704 per three month period of care for a person receiving public community mental health services.

A result below the target is desirable.

Results

For 2015–16, the average cost per three month period of care for a person receiving public community mental health services was $2,148, which is above target and in line with previous years (see Figure 27). The higher expenditure to target is attributable to an overestimate of activity used when deriving the target.

Figure 27: **Average cost per three month period of care for a person receiving public community mental health services, 2011–12 to 2015–16**



	2011–12	2012–13	2013–14	2014–15	2015–16
Av. cost	$2,064	$2,072	$2,083	$2,072	$2,148
Target	$2,000	$2,075	$2,413	$2,268	$1,704

Note: The average unit cost for the delivery of mental health services include statewide corporate overheads that incorporate costs borne by WA Health that are not included in the target methodology and Mental Health Commission service provision agreement.

Data sources: Mental Health Information System, health service financial systems.

Ministerial directives

Treasurer's Instructions 902 (12) requires disclosing information on any Ministerial directives relevant to the setting of desired outcomes or operational objectives, the achievement of desired outcomes or operational objectives, investment activities, and financing activities.

WA Health has received no Ministerial directives related to this requirement.

Summary of board and committee remuneration

The total annual remuneration for each board or committee is listed below (see Table 34). For details of individual board or committee members please refer to Appendix 2.

Table 34: **Summary of State Government boards and committees within the Metropolitan Health Service, 2015–16**

Board/Committee name	Total remuneration
Armadale District Aboriginal Health Action Group	$6,720
Armadale Health Service (AHS) Community Advisory Council	$11,060
Bentley District Aboriginal Health Action Group	$8,430
Bentley Health Service Community Advisory Council	$720
BreastScreen WA General Practitioner Advisory Committee	$5,040
Eating Disorders Program Consumer Advisory Group	$1,080
Fremantle District Aboriginal Health Action Group	$9,480
King Edward Memorial Hospital Community Advisory Committee (Name changed to Women's and Newborns' Health Service Community Advisory Council)	$0
North Metropolitan Health Service Community Advisory Council	$1,860
Osborne Park Hospital Community Advisory Council	$2,460
Peel District Aboriginal Health Action Group (Name changed to Mandurah District Aboriginal Health Action Group)	$7,740
Queen Elizabeth II Medical Centre Trust	$48,650
Rockingham General Hospital Community Advisory Council (Name changed to Rockingham Peel Group Community Advisory Council)	$4,950
Rockingham General Hospital Medical Advisory Committee	$0
Rockingham Kwinana Aboriginal District Health Action Group	$5,100
Royal Perth Hospital Animal Ethics Committee	$12,236
Royal Perth Hospital Community Advisory Council (Name changed to Royal Perth Hospital Consumer Advisory Committee)	$6,540
South Metropolitan Area Aboriginal Health Action Group	$3,840
South Metropolitan Area Health Service Consumer Advisory Council	$1,304

Other financial disclosures

Pricing policy

The National Health Reform Agreement sets the policy framework for the charging of public hospital fees and charges. Under the Agreement an eligible person who receives public hospital services as a public patient in a public hospital or a publicly contracted bed in a private hospital is treated 'free of charge'. This arrangement is consistent with the Medicare principles, which are embedded in the *Hospitals and Health Services Act 1927 (WA)*.

The majority of hospital fees and charges for public hospitals are set under Schedule 1 of the *Hospitals (Services Charges) Regulations 1984* and the *Hospitals (Services Charges for Compensable Patients) Determination 2005* and are reviewed annually.

Please refer to the *Department of Health Annual Report 2015–16* for further information on the pricing policy.

Capital works

WA Health has a substantial Asset Investment Program that facilitates remodelling and development of health infrastructure. Program initiatives include the continuation of major projects to reconfigure metropolitan general and tertiary hospitals, and significant investment in regional hospital infrastructure.

Please refer to the *Department of Health Annual Report 2015–16* for financial details of the full Metropolitan Health Service capital works program.

Employment profile

Government agencies are required to report a summary of the number of employees, by category, compared with the preceding financial year. Table 35 shows the year-to-date (June 2016) number of Metropolitan Health Service full-time equivalent employees for 2014–15 and 2015–16.

Table 35: **Metropolitan Health Service total full-time employees by category**

Category	Definition	2014–15	2015–16
Administration and clerical	Includes all clerical-based occupations together with patient-facing (ward) clerical support staff.	5,369	5,252
Agency	Includes the following occupational categories: administration and clerical, medical support, hotel services, site services, medical salaried (excludes visiting medical practitioners) and medical sessional.	491	494
Agency nursing	Includes workers engaged on a 'contract for service' basis. Does not include workers employed by NurseWest.	152	136
Assistants in nursing	Support registered nurses and enrolled nurses in delivery of general patient care.	189	206
Dental nursing	Includes registered dental nurses and dental clinic assistants.	302	311
Hotel services	Includes catering, cleaning, stores/supply laundry and transport occupations.	2,457	2,179
Medical salaried	Includes all salary-based medical occupations including interns, registrars and specialist medical practitioners.	3,403	3,490
Medical sessional	Includes specialist medical practitioners that are engaged on a sessional basis.	354	352

Category	Definition	2014–15	2015–16
Medical support	Includes all allied health and scientific/ technical related occupations.	5,199	5,226
Nursing	Includes all nursing occupations. Does not include agency nurses.	9,927	9,831
Site services	Includes engineering, garden and security-based occupations.	416	409
Other categories	Includes Aboriginal and ethnic health worker related occupations.	64	59
	Total	**28,323**	**27,945**

Notes

1. Data Source: HR Data Warehouse.
2. The Metropolitan Health Service includes North Metropolitan Health Service, South Metropolitan Health Service, Child and Adolescent Health Service, PathWest Laboratory Medicine WA, Health Corporate Network (HCN), Health Information Network (HIN) and Dental Health Services.
3. The Drug and Alcohol Office, Mental Health Commission WA, Office of Health Review, Peel Health Campus and Joondalup Health Campus have been excluded.
4. FTE is calculated as the monthly average FTE and is the average hours worked during a period of time divided by the Award Full Time Hours for the same period. Hours include ordinary time; overtime; all leave categories; public holidays, Time Off in Lieu, Workers Compensation.
5. FTE figures provided are based on Actual (Paid) month to date FTE.

Staff development

The Metropolitan Health Service is committed to training and development of staff to support the delivery of quality health services.

Essential corporate training is provided to all new staff and includes accountable and ethical decision making, record keeping awareness, and occupational health and safety. Additional ongoing training is available to staff in the areas of human resource management, cultural diversity and professional codes of conduct.

Specific role-related clinical and non-clinical training and education is provided by health service sites, delivered either internal or external to the organisation and through online e-learning resources.

In 2015–16, a new agency-wide WA Health Aboriginal Cultural eLearning Program was implemented as a mandatory staff development module. Additionally, ongoing undergraduate, graduate, staff training and leadership development programs were available to employees. These include:

North Metropolitan Health Service

- specific training courses such as Activity Based Funding and Management, and leadership and management training programs
- inclusion of a Learning and Development Department, accredited as a Registered Training Organisation, which provides training, advice and nationally recognised qualifications.

South Metropolitan Health Service

- recruitment initiatives such as supporting trainees in the Public Sector Commission Aboriginal Traineeship program, collaboration with Rocky Bay Employment Services to provide work experience to people with disability, and promoting the Health Service at the Australian College of Nursing Expo
- professional development programs such as new eLearning packages for smart phone and graduate programs and training for registered nurses
- the first WA Health Allied Health Education Director and Allied Health Educator roles were created to deliver education and training services to the allied health workforce.

Child and Adolescent Health Service

- change management training for managers and employees in preparation for staff moving to the new Perth Children's Hospital
- development and implementation of the iLearn Learning Management System – a single point of access for online learning which facilitates scheduling and reporting on training.

Industrial relations

The WA Health Industrial Relations Service provides advisory, representation and consultancy support in industrial relations. Additionally, the service supports significant workforce management issues for the metropolitan, country and other health services comprising WA Health.

For further details please refer to the *Department of Health Annual Report 2015–16*.

Workers' Compensation

The WA Workers' Compensation system was established by the State Government and exists under the statute of the *Workers' & Injury Management Act 1981*.

The Metropolitan Health Service is committed to providing staff with a safe and healthy work environment, and recognises this as pivotal in attracting and maintaining the workforce necessary to deliver effective and efficient health care services. In 2015–16, a total of 828 workers' compensation claims were made (see Table 36).

Table 36: **Number of Metropolitan Health Service workers' compensation claims in 2015–16**

Employee Category	Number
Nursing Services/Dental Care Assistants	396
Administration and Clerical	64
Medical Support	98
Hotel Services	180
Maintenance	64
Medical (salaried)	26
Total	**828**

Note: For the purpose of the annual report, employee categories are defined as:

- Administration and clerical – includes administration staff and executives, ward clerks, receptionists and clerical staff
- Medical support – includes physiotherapists, speech pathologists, medical imaging technologists, pharmacists, occupational therapists, dieticians and social workers
- Hotel services – includes cleaners, caterers, and patient service assistants.

Unauthorised use of credit cards

WA Health uses Purchasing Cards for purchasing goods and services to achieve savings through improved administrative efficiency and more effective cash management. The Purchasing Card is a personalised credit card that provides a clear audit trail for management.

WA Health credit cards are provided to employees who require it as part of their role. Credit cards are not for personal use by the cardholder. Should a cardholder use a credit card for a personal purpose, they must give written notice to the accountable authority within five working days and refund the total amount of expenditure.

Despite being made aware of obligations pertaining to the use of credit cards, one Metropolitan Health Service cardholder used their card for personal purposes. The full amount ($539.91) was refunded before the end of the reporting period.

Table 37: **Personal use expenditure by Metropolitan Health Service cardholders, January to June 2016**

Credit card personal use expenditure	January to June 2016
Aggregate amount of personal use expenditure for the reporting period	$539.91
Aggregate amount of personal use expenditure settled by the due date (within 5 working days)	$0
Aggregate amount of personal use expenditure settled after the period (after 5 working days)	$539.91
Aggregate amount of personal use expenditure outstanding at the end of the reporting period	$0

Government Building Contracts

The Government Building Training Policy applies to State Government building, construction and maintenance contracts that have a labour component of $2 million and over. All tenders issued from 1 October 2015 are in scope of this policy.

The Metropolitan Health Service supports the Government Building Training Policy and is committed to developing a strong training culture and sustained commitment to training through employment of apprentices and trainees within the building and construction industry.

As at 30 June 2016, no contracts subject to the Government Building Training Policy were awarded.

Governance requirements

Pecuniary interests

Senior officers of government are required to declare any interest in an existing or proposed contract that has, or could result in, the member receiving financial benefits.

In 2015–16, the Executive Director for the Contract Management and Procurement, North Metropolitan Health Service, Phillip Aylward, declared that he is the Director of the Princess Margaret Hospital Foundation. The Princess Margaret Hospital Foundation is a not-for-profit organisation that provides grants and activities to the Child and Adolescent Health Service. Administrative arrangements are in place within WA Health to ensure that Mr Aylward's directorship does not result in a conflict of interest.

Other legal disclosures

Advertising

In accordance with section 175Z of the *Electoral Act 1907*, the Metropolitan Health Service incurred a total advertising expenditure of $1,009,034 in 2015–16 (see Table 38). There was no expenditure in relation to polling organisations.

Table 38: **Summary of Metropolitan Health Service advertising for 2015–16**

Summary of advertising	Amount ($)
Advertising agencies	2,236
Market research organisations	783,794
Polling organisations	0
Direct mail organisations	5,152
Media advertising organisations	217,852
Total advertising expenditure	**1,009,034**

The organisations from which advertising services were procured and the amount paid to each organisation are detailed in Table 39.

Table 39: **Metropolitan Health Service advertising, by class of expenditure, 2015–16**

Recipient/organisations	Amount ($)
Advertising agencies	
The Brand Agency	2,236
Total	**2,236**
Market research organisations	
Press Ganey Associates	783,794
Total	**783,794**
Polling organisations	
	0
Total	**0**
Direct mail organisations	
Australasian Medical Publishing Company	5,152
Total	**5,152**
Media advertising organisations	
Adcorp	5,864
Cambridge Media	5,950
Carat Australia Media Services Pty Limited	7,068
Community Newspaper Group	3,956
Global Health Source	30,259
Government Education & Business Directories	772

Recipient/organisations	Amount ($)
Optimum Media Decisions (OMD)	112,634
Perth Recruitment Services	15,202
Seek	313
Sensis Pty Ltd	4,172
Telstra	30,312
The Scene Team	800
Xpress Magazine	550
Total	**217,852**

Disability access and inclusion plan

The Disability Services Act 1993 was introduced to ensure that people with disability have the same opportunities to fully access the range of health services, facilities and information available in the public health system, and to participate in public consultation regarding WA Health services. From June 2014, amendments to the Act require public authorities to ensure that people with disability have equal employment opportunities.

WA Health ensures compliance with the Act and all other principles through the implementation of *WA Health Disability Access and Inclusion Plan 2010–15*. Current initiatives and programs implemented by the Metropolitan Health Service in accordance with the Plan are outlined below.

North Metropolitan Health Service

Within the North Metropolitan Health Service, the *WA Health Disability Access and Inclusion Plan 2010–15* continues to inform health service planning. Individual areas within the Service have developed Disability Access and Inclusion Plan implementation strategies to ensure compliance with and to provide opportunity for all service users to comment on access to North Metropolitan Health Service events and facilities.

Access to service

To ensure services and events are accessible, Disability Access and Inclusion Plan intranet sites throughout the North Metropolitan Health Service are regularly updated so that staff can access and review information during planning. Additionally, global reminders are sent regarding printed information accessibility guidelines. To facilitate accessible event planning, Accessible Events Checklists were developed by Sir Charles Gairdner Hospital, Public Health and Ambulatory Care and Women and Newborn Health Service so that events and functions were planned to be accessible to people of all ages and abilities.

Access to buildings

Adjustments have been made across North Metropolitan Health Service sites to improve disability access and inclusion. These include modifications to staff equipment to facilitate wheelchair access, ward and bathroom renovations, modifications that enhance wheelchair accessibility and cater for a wider range of patients, replacing doors with automatic opening doors, and upgrading fire warning systems to ensure they are accessible to the visually and hearing impaired. Construction and redevelopments across North Metropolitan Health Service sites are planned to ensure the provision of access to people with disability.

Access to information

The services provided by North Metropolitan Health Service promote the availability of information in alternative formats upon request. Examples include the provision of Disability Access Maps both online and at sites, information that is available in alternative formats including disc, braille and audio tape, and the availability of the Disability Access and Inclusion Plan in accessible formats online. A link to the Disability Service Commission's Accessible Information guidelines is also available on the North Metropolitan Health Service Intranet as a staff resource.

Quality of service by staff

To ensure quality of service, the Disability Access and Inclusion Plan and disability awareness training has continued to be provided to all staff at orientation, with in-service education and information available on websites, including access to the Disability Access and Inclusion Plan. Additionally, participation in the North Metropolitan Health Service Disability Liaison Project assisted services to improve clinical practices. This was achieved through improved disability assessment, screening, and clinical practice that assisted in early identification of the disability patient cohort and better managed their inpatient admission. Further to this, the Disability Liaison Officer Project and North Metropolitan Health Service areas have improved disability awareness education through initiatives such as revising the Disability Access and Inclusion Plan e-learning package. This includes information about the Disability Access and Inclusion Plan and highlights key barriers that patients with disability may experience.

Another quality improvement initiative implemented by the North Metropolitan Health Service was the Interpreting and Translating Guidelines V1.2. These were developed in 2016 as a means of supporting a consistent approach to the provision of language services by packaging together the minimum set of resources expected to be implemented in all front-line services, as well as recommending training for staff working directly with consumers.

Opportunity to provide feedback

The North Metropolitan Health Service has continued facilitating the receipt of comments and complaints, ensuring information on the complaint management process was accessible for people with disability as well as training staff to appropriately manage with complaints from people with disability. It also worked with the Patient Liaison department to refine feedback processes, improving the visibility and accessibility of feedback drop points, and the online Customer Service Unit feedback form. Feedback received is tabled with the relevant Disability Access and Inclusion Plan Management Committee and actioned as appropriate.

Participation in public consultation

Mechanisms for engaging in public consultation included the presence of a disability representative and a carer representative on the Community Advisory Council, on-site Disability Access and Inclusion Plan Management Committees, and a community survey to ascertain public opinion regarding experiences in terms of access to a hospital and its services. Public consultation was also sought during the development of the Disability Access and Inclusion Plan.

Opportunities to obtain and maintain employment

The North Metropolitan Health Service is committed to assisting people with disability to obtain and maintain employment within the Health Service. This was reflected through the recruitment process and monitored through ongoing statistical analysis. In addition, sites provided education on equal opportunity including in staff induction processes, providing information to improve awareness and the achievement of objectives outlined in the *WA Health Equity and Diversity Plan 2012–2015*, and the review of recruitment process training.

South Metropolitan Health Service

South Metropolitan Health Service is committed to implementing initiatives that support the Disability and Access Inclusion Plan. Specific initiatives addressed in 2015–16 include the development of a training program for Patient Centred Care, staff membership on the Disability Health Networks Core Capabilities Project, and ongoing promotion of the International Day of People with Disabilities with interactive displays, presentations and competition prizes.

Access to service

The South Metropolitan Health Service worked towards improving access to services for people with disability through the use of admission and discharge checklists. This included questions specifically related to the needs of people with disability. These checklists facilitated effective discharge planning by assisting with transition back into the community through the organisation of community services; and providing loan of equipment and aids.

Access to buildings

All South Metropolitan Health Service sites and services regularly review external and internal access to facilities and make improvements as necessary. During 2015–16 the South Metropolitan Health Service worked towards enhancing access to buildings and other facilities for people with a disability, including increased availability of bariatric seating in public areas, review of signage, upgrade to some toilets to include an automated door to facilitate wheelchair access and the introduction of a concierge service and mobility equipment to assist visitors with a disability. Specifically, Royal Perth Hospital's Way-finding Working Group installed additional electronic way-finding terminals and voice-recorded floor messages on lifts throughout the hospital. To continually improve access, a survey to identify how to improve access to hospital facilities and services was also conducted.

Access to information

The South Metropolitan Health Service Intranet and Internet continue to meet the relevant accessibility requirements. Documents are available in different formats upon request, with random internal audits undertaken to monitor compliance. In addition, publications are now created in MPS Audio File format for visually impaired consumers. 'Carers Corners' have been incorporated into some wards and key areas to ensure patients and visitors are aware of programs and support made available to carers and people with disability. Hospital Consumer Advisory Councils and public relations teams also review patient information brochures and booklets to ensure they comply with the relevant accessibility requirements.

Quality of service by staff

All South Metropolitan Health Service sites and services continue to provide information regarding disability access and inclusion to all staff at induction and orientation as means of ensuring service quality is maintained for people with disabilities. All sites monitor and report on comments and complaints related to service provision for consumers with disabilities in order to identify learning and development opportunities. Hospital Consumer Advisory Committees, Disability Access Committees and/or site and health service governance committees also monitor complaints related to disability access and make recommendations for change as required.

Opportunity to provide feedback

South Metropolitan Health Service ensures people with a disability have the same opportunities as other people to make comments and complaints, which is included as part of WA Health's Complaint Management Policy. The complaint process is available to all individuals, and brochures are available in hardcopy and on the internet advising of this process. Feedback forms are available in multiple formats and languages. All feedback can be made verbally or in writing. Carers may also make complaints on behalf of consumers. Hospital Customer Liaison Services provide advocacy for people as required.

Participation in public consultation

South Metropolitan Health Service Consumer Advisory Councils and Disability Advisory Committees play a pivotal role in engaging with patients and carers and include a diverse range of health consumer representatives such as the elderly and people with a disability. All South Metropolitan Health Service sites and services have well-developed processes for Consumer Advisory Councils and equivalent groups to review hospital and South Metropolitan Health Service policies and publications. All public forums are held in accessible venues and planned using the Disability Services Commission's 'Creating Accessible Events' checklist, or a site specific variation. In 2015, Royal Perth Hospital held a widely advertised recruitment campaign for a new Consumer Advisory Council and subsidiary working group, including the Disability and Carers Working Group, to ensure appropriate representation at all levels of hospital governance and on all committees.

Opportunities to obtain and maintain employment

South Metropolitan Health Service sites and services adhere to the WA Health Substantive Equality Policy as part of their employment process. This includes ensuring the standard Job Description Form is inclusive for people with disability, as well as having policies and processes in place to modify work environments and identify occupational health and safety issues for staff members with disability. Site Disability Access and Inclusion Plans now include actions specific to this outcome.

Child and Adolescent Health Service

Access to service and events

A range of equipment is provided by the Child and Adolescent Health Service to assist people with disabilities to access services. All relevant policies consider the access requirements of people with disabilities. Within Princess Margaret Hospital, events are held in venues that are accessible by people with disabilities.

Access to buildings and other facilities

Access to buildings and facilities for people with disabilities is ensured through ongoing management and maintenance. Additionally, the *Child and Adolescent Health Service Disability Access and Inclusion Plan (2016–2021)* is being developed as part of the transition to the new Perth Children's Hospital.

Access to information

All Child and Adolescent Health Service consumer publications are available in alternative formats and languages on request, including large print and audio formats for patients with literacy or vision difficulties. The Child and Adolescent Health Service website has capability to assist people who are hearing impaired, as well as providing details on where people can find information and make contact with services. Website accessibility is maintained for both internal organisation and public sites, and is incorporated in e-learning modules and the development of online platforms, with clear guidelines around writing for the web.

Quality of service by staff

An e-learning package is available on the Child and Adolescent Health Service intranet for staff education on Disability Access and Inclusion. New staff are advised of the importance of disability access and inclusion during Child and Adolescent Health Service-wide corporate induction. Regular staff presentations continue in collaboration with the Disability Services Commission. An example of the improved quality of service includes the recent incorporation of an adult change table to cater to the toileting requirements of older children and adolescents.

Opportunity to provide feedback

All staff are available to assist people with disabilities to provide feedback. A dedicated Customer Liaison Service is also available during office hours. Easily accessible comments, complaints, and suggestion boxes are available throughout Child and Adolescent Health Service facilities. The Child and Adolescent Health Service website provides for comments, complaints, and suggestions to be sent via an email. Feedback is then processed and managed through Customer Liaison Service and discussed at the Consumer Advisory Council and the Disability Access Committee to ensure that any changes to policy or updates to services are considered.

Participation in public consultation

The Child and Adolescent Health Service Disability Advisory Committee has recently been expanded to include a wider range of Child and Adolescent Health Service staff and consumer representation. Additionally, all venues for public consultation are required to meet the needs of people with disabilities.

Opportunities to obtain and maintain employment

The Child and Adolescent Health Service uses inclusive recruitment practices and encourages people with disability to apply for positions advertised across the organisation. In the transition to the Perth Children's Hospital, the Child and Adolescent Health Service will be working with disability employment providers to actively recruit and employ people with disabilities, and ensure that workplaces are tailored to employee needs.

Compliance with public sector standards

Details of the WA Health compliance with the Public Sector Code of Ethics, Public Sector Standards in Human Resource Management and the WA Health Code of Conduct can be found in the *Department of Health Annual Report 2015–16*.

Recordkeeping plans

The *State Records Act 2000* was established to mandate the standardisation of statutory recordkeeping practices for every State Government agency. Government agency practice is subject to the provision of the Act, the standards and policies. Government agencies are also subject to scrutiny by the State Records Commission.

North Metropolitan Health Service

In August 2015, the North Metropolitan Health Service Recordkeeping Plan was approved by the State Records Commission. Implementation of the Plan included the creation of a Records Manager position, who is responsible for the implementation of a Recordkeeping Framework for North Metropolitan Health Service. Since filling this position in January 2016, planning for framework development has begun, and includes implementation of an Electronic Document and Records Management System.

To ensure compliance with recordkeeping policies, all new North Metropolitan Health Service staff are required to complete the Recordkeeping Awareness Training. The Records Manager has also developed and provided staff with up-to-date guidelines on recordkeeping practices, as well as a records management intranet site. Additionally, the North Metropolitan Health Service Interim Board Members have been provided with guidelines for recordkeeping responsibilities. To ensure continuing improvement of the Framework, the training program will be reviewed regularly, including staff surveys and monitoring progress against performance indicators.

South Metropolitan Health Service

In May 2015, the South Metropolitan Health Service Recordkeeping Plan was approved by the State Records Office, which identified 15 improvements to recordkeeping. Since July 2015, there has been significant progress in implementing this plan, including piloting of an Electronic Document and Records Management System, and upgrade of records management software. Policies and procedures have also been established for records management and digitalisation, with improvements made to the records retention and disposal schedule. The new Recordkeeping Plan will be reviewed in 2016–17.

Undertaking Recordkeeping Awareness Training continues to be mandatory throughout South Metropolitan Health Service and was included in the revised South Metropolitan Health Service Mandatory Training Framework (December 2015). Additional strategies to ensure employee compliance involve further embedding record keeping requirements into policy. This includes the new Code of Conduct, as well as regular inclusion of retention and disposal information in staff communication initiatives such as e-bulletins, intranets and newsletters.

Child and Adolescent Health Service

The Child and Adolescent Health Service Recordkeeping Plan was approved by the State Records Commission in November 2015 and from this a Child and Adolescent Health Service Recordkeeping Policy was developed and is scheduled for release in July 2016. The approved plan includes recordkeeping and record disposal policies, practices and processes, and a staged roll-out of an Electronic Document and Records Management System, which is currently underway. The Plan ensures the Child and Adolescent Health Service complies with the *State Records Act 2000* and progress is made toward better practice recordkeeping.

Compliance with recordkeeping policies within the Child and Adolescent Health Service begins at induction, with all new employees completing Records Awareness Training. An online end-user training module for the Electronic Document and Records Management System has also been established as, well as additional training for high priority users. The Child and Adolescent Health Service Managing Your Records Intranet page has also been developed and contains resources on management of hardcopy and electronic records, as well as links to further information and support contacts. Further resources are being added to this page as processes and policies are developed. A communications plan has been developed for the promotion of the Child and Adolescent Health Service Recordkeeping Plan, policy and various processes and resources, to all employees across the health starting in July 2016.

The Child and Adolescent Health Service Recordkeeping Plan will be evaluated using specifically developed performance indicators. The effectiveness of procedures and systems, as well as training and implementation of the Recordkeeping Plan will be evaluated and reported according to the schedule in the Child and Adolescent Health Service Recordkeeping Plan. It will be reviewed in five years

Substantive equality

WA Health continues to contribute towards substantive equality for all Western Australians through the implementation of the Policy Framework for Substantive Equality. The Framework provides a clear direction for all persons employed in WA Health by addressing the diverse needs and sensitivities of the communities in which it operates.

The South Metropolitan Health Service ensures that the Aboriginal community is engaged and has the opportunity to contribute to health care and service planning, development and evaluation. The South Metropolitan Health Service Substantive Equality Aboriginal Advisory Group is one partnership which is working towards the development of new ways of working, by enabling input in the planning and development of policy, programs and strategies to improve Aboriginal health and wellbeing. Five South Metropolitan Health Service District Aboriginal Health Action Groups are currently consulting the transition to Health Service Boards.

Guided by the North Metropolitan Health Service Policy Coordination Committee, the North Metropolitan Health Service continues to address and prevent systemic discrimination by adjusting policies, procedures and practices to meet the specific needs of certain groups in the community. The North Metropolitan Health Service Policy and Procedures Framework aids in the screening of new policies to ensure relevance and appropriateness for all clients.

In partnership with the WA Chamber of Commerce and Industry, the North Metropolitan Health Service established a Vocational Training and Employment Program. The program has employed 19 long-term unemployed and disadvantaged Aboriginal job seekers to patient support service roles. This supports the development of a workplace environment that values the employment of an Aboriginal workforce and incorporates Aboriginal cultural perspectives into the health service system.

The Child and Adolescent Health Service *Aboriginal Cultural Learning Plan 2015–2018* is being developed in consultation with the Aboriginal community. This collaboration will support improvement in the health outcomes of Aboriginal infants, children, young people and their families by embedding cultural learning in the delivery of health services. Also, the Child and Adolescent Health Service Aboriginal Health Leadership Advisory Committee are currently involved in consultation concerning the new Perth Children's Hospital.

The Child and Adolescent Health Service continues to focus on providing more culturally appropriate, competent and responsive health care via hospital and community health services. A range of culturally appropriate services are provided to:

- new refugee and asylum-seeker patients
- families who are socially and economically disadvantaged
- culturally and linguistically diverse groups
- youth with mental health conditions
- Aboriginal people.

Services are tailored to meet the unique needs of these groups via a skilled workforce from a range of cultural backgrounds.

Occupational safety and health and injury

The Metropolitan Health Service is committed to the provision of a safe environment for its employees, patients, visitors, agency staff, contractors, volunteers and students. This includes providing and maintaining a safe workplace and systems of work, and consultation with employees and their representatives. Staff are provided with information, training, instruction and supervision to enable them to work safely.

Commitment to occupational safety, health and injury management

The Metropolitan Health Service takes a proactive approach to occupational health and safety, in accordance with the *Occupational Safety & Health Act, 1984*. This is realised through establishing clear goals and strategies to implement and monitor systems, responsibilities and preventative programs. An effective injury management system for rehabilitating injured employees and returning them to work is maintained in accordance with the *Workers' Compensation and Injury Management Act 1981*.

Compliance with occupational safety, health and injury management

The Metropolitan Health Service complies with relevant occupational safety, health and injury management legislation, regulations, policies and procedures. This is achieved by:

- enhancing effectiveness of the Occupational Safety and Health management system by consulting with employees and contractors on issues of health and safety
- improving performance by establishing measurable objectives and targets
- undertaking risk management activities
- providing adequate facilities to protect the health, safety and welfare of all employees
- communicating with staff to enable safe work practices
- promoting, training and supporting safety and health representatives to be a key safety resource, and provide sufficient time to undertake their legislative responsibilities and duties.

Employee consultation

The Metropolitan Health Service has established relevant committees to support and promote consultation with all employees in occupational safety and health issues.

The consultation system includes:

- line management
- Occupational Safety and Health Representatives
- committees and local occupational safety and health groups
- hazard/incident reporting and investigation systems
- routine workplace hazard inspections
- processes for resolution of issues
- implementation of control measures to prevent incidents occurring
- regular meetings for review of issues and trends
- direct employee communication to provide information and for early identification, discussion and resolution of issues
- communicating recommendations and issues to management.

Employee rehabilitation

The Metropolitan Health Service has established a systematic approach to workplace-based injury management services for all employees following work-related injury, illness or disability. Best practice injury management strategies implemented include allocation of an Injury Management Consultant, return to work programs and counselling through the Employee Assistance Program. The Service provides injury management referrals to specialist doctors to facilitate diagnosis and treatment, and exercise programs to facilitate recovery and return to work. Vocational rehabilitation practices are monitored and reviewed to ensure they meet with medical evidence and best practice, and are fully compliant under the WA Workers Compensation and Injury Management code of practice.

Occupational safety and health assessment and performance indicators

The Metropolitan Health Service regularly audits the Occupation Safety and Health Management Systems to identify changes to strengthen and improve the system. A chemical substances and compliance audit is also undertaken regularly to maintain an up-to-date database of all chemicals and dangerous goods used.

The annual performance reported for the Metropolitan Health Service in relation to occupational safety, health and injury for 2015–16 is summarised in Table 40.

Table 40: **Occupational safety, health and injury performance, 2013–14 to 2015–16**

	Measure					
	Fatalities (number of deaths)	Lost time injury/ diseases (LTI/D) incidence rate (rate per 100)	Lost time injury severity rate (rate per 100)	Percentage of injured workers returned to work within 13 weeks	Percentage of injured workers returned to work within 26 weeks	Percentage of managers trained in occupational safety, health and injury management responsibilities
Target	**0**	**0 or 10% reduction**	**0 or 10% reduction**	**N/A**	**Greater than or equal to 80%**	**Greater than or equal to 80%**
Results						
NMHS						
2013–14	0	2.58	27.20	N/A	77.1%	67.3%
2015–16	**0**	**2.81**	**31.02**	**71.3%**	**82.3%**	**78.7%**
Comment	**Target achieved**	9% increase **Target not achieved**	14% increase **Target not achieved**	N/A	**Target achieved**	**Target not achieved**
SMHS						
2013–14	0	3.18	39.84	N/A	71.3%	44.2%
2015–16	**0**	**2.51**	**43.38**	**57.5%**	**69.6%**	**47.9%**
Comment	**Target achieved**	21% reduction **Target achieved**	9% increase **Target not achieved**		**Target not achieved**	**Target not achieved**
CAHS						
2013–14	0	1.86	35.09	N/A	93.0%	61.5%
2015–16	**0**	**2.19**	**52.86**	**88.3%**	**91.7%**	**67.2%**
Comment	**Target achieved**	18% increase **Target not achieved**	51% increase **Target not achieved**	N/A	**Target achieved**	**Target not achieved**
DHS						
2013–14	0	2.18	13.33	N/A	78.6%	67.5%
2015–16	**0**	**1.13**	**0.00**	**75.0%**	**87.5%**	**91.3%**
Comment	**Target achieved**	48% decrease **Target achieved**	100% decrease **Target achieved**	N/A	**Target achieved**	**Target achieved**
Pathwest						
2013–14	1	1.40	30.43	N/A	92.3%	67.2%
2015–16	**0**	**1.03**	**35.29**	**71.4%**	**100.0%**	**61.2%**
Comment	**Target achieved**	26% decrease **Target achieved**	16% increase **Target not achieved**	N/A	**Target achieved**	**Target not achieved**

Note: Performance is based on a three-year trend and so the comparison base year is two years prior to the current reporting year.

Government of **Western Australia**
Department of **Treasury**

Your ref : FAA27944 Mental Health Commission SPAs
Our ref : 00349043
Enquiries : Christine Crasto-Carvalho
Telephone : 6551 2580

Dr D J Russell-Weisz
Director General
Department of Health
PO Box 817
PERTH BUSINESS CENTRE WA 6849

Dear Dr Russell-Weisz

MENTAL HEALTH COMMISSION SPECIAL PURPOSE ACCOUNTS

Further to your letters of 16 March and 28 May 2016, I am pleased to advise that acting under delegated authority from the Treasurer, I have:

- determined and approved, pursuant to section 16(1)(d) of the Financial Management Act 2006 (the Act), the Mental Health Commission Fund (East Metropolitan Health Service) Account as an agency special purpose account (SPA) for the purposes set out in the associated special purpose statement;. It is noted that your letter does not seek approval to the SPA but this has since been confirmed by Mr Graeme Jones, Chief Finance Officer of the Department of Health.
- approved under section 17 of the Act, the special purpose statement for the Mental Health Commission Fund (East Metropolitan Health Service) Account as attached; and
- approved, under section 17(3) and (4) of the Act, the amended special purpose statements for the:
  - Mental Health Commission Fund (North Metropolitan Health Service) Account;
  - Mental Health Commission Fund (South Metropolitan Health Service) Account;
  - Mental Health Commission Fund (Children and Adolescent Health Service) Account;
  - Mental Health Commission Fund (WA Country Health Service) Account and
- approved closure of the Mental Health Commission Fund (Fiona Stanley Hospital) Account under section 21(1) of the Act.

The original statements are enclosed for your records. A copy of the approved special purpose statements is required to be sent to the Auditor General under section 17(4) of the Act.

The approved statements are required to be published in the Metropolitan Health Service (MHS) and WA Country Health Service (WACHS) 2015–16 annual reports under Treasurer's instruction (TI) 950 'Publication of special purpose statements and trust statements'.

It is noted that despite an error in the previously approved statements, the MHS and WACHS have properly disclosed the SPAs in notes to their annual financial statements as required by TI 1103(15)(ii) 'Statements of Financial Position'.

I am aware that the WACHS and four health service areas within MHS will become health service providers (HSPs) under the *Health Services Act 2016* when it is proclaimed on 1 July 2016. It is understood that the SPAs and associated statements will continue under transitional provisions (section 237 transfer orders) as an interim arrangement until the HSPs are ready to sign the special purpose statements in their own right. It would be appreciated if this could be actioned as soon as practicable.

Yours sincerely

Michael Barnes
UNDER TREASURER
20 JUN 2016
Enc.

Gordon Stephenson House, 140 William Street, Perth, Western Australia 6000
Locked Bag 11, Cloisters Square, Western Australia 6850
Telephone (08) 6551 2777
www.treasury.wa.gov.au

Department of Health

GOVERNMENT OF WESTERN AUSTRALIA

Special Purpose Statement
for s16(1)(d) FMA Special Purpose Accounts

MENTAL HEALTH COMMISSION FUND (NORTH METROPOLITAN HEALTH SERVICE) ACCOUNT

Title and Responsibility: A special purpose account, entitled the Mental Health Commission Fund (North Metropolitan Health Service) Account (the "Account") is to be established pursuant to s16(1)(d) of the *Financial Management Act 2006*. and maintained by the Minister for Health incorporated as the board of the Hospitals formerly comprised in the Metropolitan Health Service Board under s7 *Hospitals and Health Services Act 1927*, who has delegated all the powers and duties as such to the Director General of the Department of Health.

Purpose: 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 North Metropolitan Health Service. in accordance with the annual Service Agreement and subsequent agreements.

Commencement Date: 1 June 2016

Receipts: There shall be credited to the Account such moneys payable by the Mental Health Commission in respect of the stated purpose of the Account.

Payments: Moneys standing to the credit of the Account are to be expended for the purposes detailed:

- in the Service Agreement between the Mental Health Commission and the Department of Health
- in subsequent agreements between the Mental Health Commission and the North Metropolitan Health Service, or the Department of Health and the Mental Health Commission on behalf of the North Metropolitan Health Service.

Administration, Accounting and Reporting:

Money in the Account is to be administered, accounted for and reported on by the Accountable Authority of the Metropolitan Health Service, in accordance with the *Financial Management Act 2006, Financial Management Regulations 2007, Treasurer's Instructions*. the agency's *Financial Management Manual*, and any other legal requirements and agreements.

Disposal of Funds on Cessation:

Any balance standing to the credit of the Account upon cessation of operations for which the Account was created shall be disposed via agreement between the Director General of the Department of Health and the Mental Health Commissioner.

I have examined and agree to the provisions of this Special Purpose Statement.

Dr D J Russell-Weisz
Director General

Department of Health
(as delegate of the Minister for Health)

Date: 28 May 2016

I approve the establishment of a s16(1)(d) Special Purpose Account for the purposes specified in this Statement.

Michael Barnes
Under Treasurer

Department of Treasury
(as delegate of the Treasurer)

Date: 20/6/16

Department of Health

GOVERNMENT OF WESTERN AUSTRALIA

Special Purpose Statement
for s16(1)(d) FMA Special Purpose Accounts

MENTAL HEALTH COMMISSION FUND (SOUTH METROPOLITAN HEALTH SERVICE) ACCOUNT

Title and Responsibility: A special purpose account, entitled the Mental Health Commission Fund (South Metropolitan Health Service) Account (the "Account") is to be established pursuant to s16(1)(d) of the *Financial Management Act 2006*, and maintained by the Minister for Health incorporated as the board of the Hospitals formerly comprised in the Metropolitan Health Service Board under s7 *Hospitals and Health Services Act 1927*, who has delegated all the powers and duties as such to the Director General of the Department of Health.

Purpose: 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 South Metropolitan Health Service. in accordance with the annual Service Agreement and subsequent agreements.

Commencement Date: 1 June 2016

Receipts: There shall be credited to the Account such moneys payable by the Mental Health Commission in respect of the stated purpose of the Account.

Payments: Moneys standing to the credit of the Account are to be expended for the purposes detailed:

- in the Service Agreement between the Mental Health Commission and the Department of Health
- in subsequent agreements between the Mental Health Commission and the South Metropolitan Health Service, or the Department of Health and the Mental Health Commission on behalf of the South Metropolitan Health Service.

Administration, Accounting and Reporting:

Money in the Account is to be administered, accounted for and reported on by the Accountable Authority of the Metropolitan Health Service. in accordance with the *Financial Management Act 2006, Financial Management Regulations 2007, Treasurer's Instructions*, the agency's *Financial Management Manual*, and any other legal requirements and agreements.

Disposal of Funds on Cessation:

Any balance standing to the credit of the Account upon cessation of operations for which the Account was created shall be disposed via agreement between the Director General of the Department of Health and the Mental Health Commissioner.

I have examined and agree to the provisions of this Special Purpose Statement.

Dr D J Russell-Weisz
Director General

Department of Health
(as delegate of the Minister for Health)

Date: 28 May 2016

I approve the establishment of a s16(1)(d) Special Purpose Account for the purposes specified in this Statement.

Michael Barnes
Under Treasurer

Department of Treasury
(as delegate of the Treasurer)

Date: 20/6/16

Department of Health

GOVERNMENT OF WESTERN AUSTRALIA

Special Purpose Statement
for s16(1)(d) FMA Special Purpose Accounts

MENTAL HEALTH COMMISSION FUND (EAST METROPOLITAN HEALTH SERVICE) ACCOUNT

Title and Responsibility: A special purpose account, entitled the Mental Health Commission Fund (East Metropolitan Health Service) Account (the "Account") is to be established pursuant to s16(1)(d) of the *Financial Management Act 2006*, and maintained by the Minister for Health incorporated as the board of the Hospitals formerly comprised in the Metropolitan Health Service Board under s7 *Hospitals and Health Services Act 1927*, who has delegated all the powers and duties as such to the Director General of the Department of Health.

Purpose: 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 East Metropolitan Health Service, in accordance with the annual Service Agreement and subsequent agreements.

Commencement Date: 1 June 2016

Receipts: There shall be credited to the Account such moneys payable by the Mental Health Commission in respect of the stated purpose of the Account.

Payments: Moneys standing to the credit of the Account are to be expended for the purposes detailed:

- in the Service Agreement between the Mental Health Commission and the Department of Health
- in subsequent agreements between the Mental Health Commission and the East Metropolitan Health Service, or the Department of Health and the Mental Health Commission on behalf of the East Metropolitan Health Service.

Administration, Accounting and Reporting:

Money in the Account is to be administered, accounted for and reported on by the Accountable Authority of the Metropolitan Health Service, in accordance with the *Financial Management Act 2006, Financial Management Regulations 2007, Treasurer's Instructions*, the agency's *Financial Management Manual*, and any other legal requirements and agreements.

Disposal of Funds on Cessation:

Any balance standing to the credit of the Account upon cessation of operations for which the Account was created shall be disposed via agreement between the Director General of the Department of Health and the Mental Health Commissioner.

I have examined and agree to the provisions of this Special Purpose Statement.

Dr D J Russell-Weisz
Director General

Department of Health
(as delegate of the Minister for Health)

Date: 28 May 2016

I approve the establishment of a s16(1)(d) Special Purpose Account for the purposes specified in this Statement.

Michael Barnes
Under Treasurer

Department of Treasury
(as delegate of the Treasurer)

Date: 20/6/16

Department of Health

GOVERNMENT OF WESTERN AUSTRALIA

Special Purpose Statement
for s16(1)(d) FMA Special Purpose Accounts

MENTAL HEALTH COMMISSION FUND (CHILD AND ADOLESCENT HEALTH SERVICE) ACCOUNT

Title and Responsibility: A special purpose account. entitled the Mental Health Commission Fund (Child and Adolescent Health Service) Account (the "Account") is to be established pursuant to s16(1)(d) of the *Financial Management Act 2006*, and maintained by the Minister for Health incorporated as the board of the Hospitals formerly comprised in the Metropolitan Health Service Board under s7 *Hospitals and Health Services Act 1927*, who has delegated all the powers and duties as such to the Director General of the Department of Health.

Purpose: 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 Child and Adolescent Health Service, in accordance with the annual Service Agreement and subsequent agreements.

Commencement Date: 1 June 2016

Receipts: There shall be credited to the Account such moneys payable by the Mental Health Commission in respect of the stated purpose of the Account.

Payments: Moneys standing to the credit of the Account are to be expended for the purposes detailed:

- in the Service Agreement between the Mental Health Commission and the Department of Health
- in subsequent agreements between the Mental Health Commission and the Child and Adolescent Metropolitan Health Service, or the Department of Health and the Mental Health Commission on behalf of the Child and Adolescent Metropolitan Health Service.

Administration, Accounting and Reporting:

Money in the Account is to be administered, accounted for and reported on by the Accountable Authority of the Metropolitan Health Service, in accordance with the *Financial Management Act 2006, Financial Management Regulations 2007. Treasurer's Instructions*, the agency's *Financial Management Manual*, and any other legal requirements and agreements.

Disposal of Funds on Cessation:

Any balance standing to the credit of the Account upon cessation of operations for which the Account was created shall be disposed via agreement between the Director General of the Department of Health and the Mental Health Commissioner.

I have examined and agree to the provisions of this Special Purpose Statement.

Dr D J Russell-Weisz
Director General

Department of Health
(as delegate of the Minister for Health)

Date: 28 May 2016

I approve the establishment of a s16(1)(d) Special Purpose Account for the purposes specified in this Statement.

Michael Barnes
Under Treasurer

Department of Treasury
(as delegate of the Treasurer)

Date: 20/6/16

Department of Health

GOVERNMENT OF WESTERN AUSTRALIA

Trust Statement
for s16(1)(c) FMA Special Purpose Accounts

NORTH METROPOLITAN HEALTH SERVICE PATIENTS' PRIVATE MONEY TRUST ACCOUNT

Title and Responsibility: A special purpose account, entitled the North Metropolitan Health Service Patients' Private Money Trust Account (the "Account") is to be established pursuant to s16(1)(c) of the *Financial Management Act 2006*, and maintained by the Minister for Health incorporated as the board of the Hospitals formerly comprised in the Metropolitan Health Service Board under s7 *Hospitals and Health Services Act 1927*, who has delegated all the powers and duties as such to the Director General of the Department of Health.

Purpose: To hold funds in trust on behalf of patients at public hospitals in the North Metropolitan Health Service, which can only be spent in accordance with their instructions and/or returned to them upon discharge.

Commencement Date: 1 July 2016

Receipts: There shall be credited to the Account moneys held in trust on behalf of patients at public hospitals in the North Metropolitan Health Service.

Payments: Moneys standing to the credit of the Account are to be:

- expended in accordance with patients' instructions; and/or
- returned to the patients upon their discharge from a public hospital in the North Metropolitan Health Service.

Administration, Accounting and Reporting:

Money in the Account is to be administered, accounted for and reported on by the Accountable Authority of the Metropolitan Health Service, in accordance with the *Financial Management Act 2006, Financial Management Regulations 2007, Treasurer's Instructions*, the agency's Financial Management Manual, and any other legal requirements and agreements (including the relevant provisions in the *Health Services Act 2016*).

Disposal of Funds on Cessation:

Any balance standing to the credit of the Account upon cessation of operations for which the Account was created shall returned to the relevant patients, or dealt with in accordance with the *Unclaimed Money Act 1990* or any other relevant written law.

I have examined and agree to the provisions of this Trust Statement.

Dr David J Russell-Weisz
Director General

Department of Health
(as delegate of the Minister for Health)

Date: 23/6/16

I approve the establishment of a s16(1)(c) Special Purpose Account for the purposes specified in this Statement.

Michael Barnes
Under Treasurer

Department of Treasury
(as delegate of the Treasurer)

Date: 28/6/16

Department of Health

GOVERNMENT OF WESTERN AUSTRALIA

Trust Statement
for s16(1)(c) FMA Special Purpose Accounts

SOUTH METROPOLITAN HEALTH SERVICE PATIENTS' PRIVATE MONEY TRUST ACCOUNT

Title and Responsibility: A special purpose account, entitled the South Metropolitan Health Service Patients' Private Money Trust Account (the "Account") is to be established pursuant to s16(1)(c) of the *Financial Management Act 2006*, and maintained by the Minister for Health incorporated as the board of the Hospitals formerly comprised in the Metropolitan Health Service Board under s7 *Hospitals and Health Services Act 1927*, who has delegated all the powers and duties as such to the Director General of the Department of Health.

Purpose: To hold funds in trust on behalf of patients at public hospitals in the South Metropolitan Health Service, which can only be spent in accordance with their instructions and/or returned to them upon discharge.

Commencement Date: 1 July 2016

Receipts: There shall be credited to the Account moneys held in trust on behalf of patients at public hospitals in the South Metropolitan Health Service.

Payments: Moneys standing to the credit of the Account are to be:

- expended in accordance with patients' instructions; and/or
- returned to the patients upon their discharge from a public hospital in the South Metropolitan Health Service.

Administration, Accounting and Reporting:

Money in the Account is to be administered, accounted for and reported on by the Accountable Authority of the Metropolitan Health Service, in accordance with the *Financial Management Act 2006*, Financial Management Regulations 2007*, Treasurer's Instructions*, the agency's Financial Management Manual, and any other legal requirements and agreements (including the relevant provisions in the *Health Services Act 2016*).

Disposal of Funds on Cessation:

Any balance standing to the credit of the Account upon cessation of operations for which the Account was created shall returned to the relevant patients, or dealt with in accordance with the *Unclaimed Money Act 1990* or any other relevant written law.

I have examined and agree to the provisions of this Trust Statement.

Dr David J Russell-Weisz
Director General

Department of Health
(as delegate of the Minister for Health)

Date: 23/6/16

I approve the establishment of a s16(1)(c) Special Purpose Account for the purposes specified in this Statement.

Michael Barnes
Under Treasurer

Department of Treasury
(as delegate of the Treasurer)

Date: 28/6/16

Department of Health

GOVERNMENT OF WESTERN AUSTRALIA

Trust Statement
for s16(1)(c) FMA Special Purpose Accounts

EAST METROPOLITAN HEALTH SERVICE
PATIENTS' PRIVATE MONEY TRUST ACCOUNT

Title and Responsibility: A special purpose account, entitled the East Metropolitan Health Service Patients' Private Money Trust Account (the "Account") is to be established pursuant to s16(1)(c) of the *Financial Management Act 2006*, and maintained by the Minister for Health incorporated as the board of the Hospitals formerly comprised in the Metropolitan Health Service Board under s7 *Hospitals and Health Services Act 1927*, who has delegated all the powers and duties as such to the Director General of the Department of Health.

Purpose: To hold funds in trust on behalf of patients at public hospitals in the East Metropolitan Health Service, which can only be spent in accordance with their instructions and/or returned to them upon discharge.

Commencement Date: 1 July 2016

Receipts: There shall be credited to the Account moneys held in trust on behalf of patients at public hospitals in the East Metropolitan Health Service.

Payments: Moneys standing to the credit of the Account are to be:

- expended in accordance with patients' instructions; and/or
- returned to the patients upon their discharge from a public hospital in the East Metropolitan Health Service.

Administration, Accounting and Reporting:

Money in the Account is to be administered, accounted for and reported on by the Accountable Authority of the Metropolitan Health Service, in accordance with the *Financial Management Act 2006*, *Financial Management Regulations 2007, Treasurer's Instructions*, the agency's Financial Management Manual, and any other legal requirements and agreements (including the relevant provisions in the *Health Services Act 2016*).

Disposal of Funds on Cessation:

Any balance standing to the credit of the Account upon cessation of operations for which the Account was created shall returned to the relevant patients, or dealt with in accordance with the *Unclaimed Money Act 1990* or any other relevant written law.

I have examined and agree to the provisions of this Trust Statement.

Dr David J Russell-Weisz
Director General

Department of Health
(as delegate of the Minister for Health)

Date: 23/6/16

I approve the establishment of a s16(1)(c) Special Purpose Account for the purposes specified in this Statement.

Michael Barnes
Under Treasurer

Department of Treasury
(as delegate of the Treasurer)

Date: 28/6/16

Department of Health

GOVERNMENT OF WESTERN AUSTRALIA

Trust Statement
for s16(1)(c) FMA Special Purpose Accounts

CHILD AND ADOLESCENT HEALTH SERVICE PATIENTS' PRIVATE MONEY TRUST ACCOUNT

Title and Responsibility: A special purpose account, entitled the Child and Adolescent Health Service Patients' Private Money Trust Account (the "Account") is to be established pursuant to s16(1)(c) of the *Financial Management Act 2006*, and maintained by the Minister for Health incorporated as the board of the Hospitals formerly comprised in the Metropolitan Health Service Board under s7 *Hospitals and Health Services Act 1927*, who has delegated all the powers and duties as such to the Director General of the Department of Health.

Purpose: To hold funds in trust on behalf of patients at public hospitals in the Child and Adolescent Health Service, which can only be spent in accordance with their instructions and/or returned to them upon discharge.

Commencement Date: 1 July 2016

Receipts: There shall be credited to the Account moneys held in trust on behalf of patients at public hospitals in the Child and Adolescent Health Service.

Payments: Moneys standing to the credit of the Account are to be:

- expended in accordance with patients' instructions; and/or
- returned to the patients upon their discharge from a public hospital in the Child and Adolescent Health Service.

Administration, Accounting and Reporting:

Money in the Account is to be administered, accounted for and reported on by the Accountable Authority of the Metropolitan Health Service, in accordance with the *Financial Management Act 2006, Financial Management Regulations 2007, Treasurer's Instructions*, the agency's Financial Management Manual, and any other legal requirements and agreements (including the relevant provisions in the *Health Services Act 2016*).

Disposal of Funds on Cessation:

Any balance standing to the credit of the Account upon cessation of operations for which the Account was created shall returned to the relevant patients, or dealt with in accordance with the *Unclaimed Money Act 1990* or any other relevant written law.

I have examined and agree to the provisions of this Trust Statement.

Dr David J Russell-Weisz
Director General

Department of Health
(as delegate of the Minister for Health)

Date: 23/6/16

I approve the establishment of a s16(1)(c) Special Purpose Account for the purposes specified in this Statement.

Michael Barnes
Under Treasurer

Department of Treasury
(as delegate of the Treasurer)

Date: 28/6/16

This page is left blank intentionally.

Appendices

Appendix 1: Metropolitan Health Service contact details

North Metropolitan Health Service

Street address:
Queen Elizabeth II Medical Centre,
Hospital Avenue, Nedlands WA 6009
Postal address:
Locked Bag 2012, Nedlands WA 6909
Phone: (08) 9346 3333
Fax: (08) 9346 3759
Web: www.nmahs.health.wa.gov.au

Sir Charles Gairdner Hospital

Street address:
Queen Elizabeth II Medical Centre
Hospital Avenue, Nedlands WA 6009
Postal address:
Locked Bag 2012, Nedlands WA 6909
Phone: (08) 9346 3333
Fax: (08) 9346 3759
Email: NMHS.MHExecOffice@health.wa.gov.au
SCGHpatientliaisonservice@health.wa.gov.au
Web: www.scgh.health.wa.gov.au

North Metropolitan Health Service Public Health and Ambulatory Care

Street and postal address:
54 Salvado Road, Wembley WA 6014
Phone: (08) 9380 7700
Fax: (08) 9380 7719
Web: www.scgh.health.wa.gov.au

North Metropolitan Health Service Mental Health

Street address:
83 Fairfield Street, Mt Hawthorn WA 6016
Postal address:
Private Bag 1, Claremont WA 6910
Phone: (08) 9242 9642
Fax: (08) 9242 9644
Email: NMHS.MHExecOffice@health.wa.gov.au
Web: www.nmahsmh.health.wa.gov.au

Swan District Hospital Campus

(closed November 2015)
Street address:
Eveline Road, Middle Swan WA 6056
Postal address:
PO Box 195, Midland WA 6936
Phone: (08) 9347 5400
Fax: (08) 9347 5410
Web: www.nmahs.health.wa.gov.au

Osborne Park Hospital

Street and postal address:
Osborne Place, Stirling WA 6021
Phone: (08) 9346 8000
Fax: (08) 9346 8008
Email: OPHCAC@health.wa.gov.au
Web: www.oph.health.wa.gov.au

Women and Newborn Health Service

Street address:
King Edward Memorial Hospital for Women
374 Bagot Road, Subiaco WA 6008
Postal address:
PO Box 134, Subiaco WA 6904
Phone: (08) 9340 2222
Fax: (08) 9381 7802
Email: kemhcsu@health.wa.gov.au
Web: www.wnhs.health.wa.gov.au

PathWest Laboratory Medicine

Street address:
J Block, QEII Medical Centre
Hospital Avenue, Nedlands WA 6009
Postal address:
Locked Bag 2009, Nedlands WA 6909
Phone: (08) 9346 3000
Fax: (08) 9381 7594
Email: pathwest@health.wa.gov.au
Web: www.pathwest.com.au

Dental Health Services

Street address:
43 Mount Henry Road, Como WA 6152
Postal address:
Locked Bag 15,
Bentley Delivery Centre WA 6983
Phone: (08) 9313 0555
Fax: (08) 9313 1302
Email: enquiries@dental.health.wa.gov.au
Web: www.dental.wa.gov.au

BreastScreen WA

Street and postal address:
9th Floor, Eastpoint Plaza
233 Adelaide Terrace, Perth WA 6000
Phone: (08) 9323 6700
Fax: (08) 9323 6799
Email: breastscreenwa@health.wa.gov.au
Web: www.breastscreen.health.wa.gov.au

Joondalup Health Campus (Public)*

Street and postal address:
Shenton Avenue, Joondalup WA 6027
Phone: (08) 9400 9400
Web: www.joondaluphealthcampus.com.au

*Operated on behalf of the State Government by Joondalup Hospital Pty Ltd, a subsidiary of Ramsay Health Care

Graylands Hospital Campus

Street address:
Brockway Road,
Mount Claremont WA 6010
Postal address:
PO Private Bag No. 1,
Claremont WA 6910
Phone: (08) 9347 6600
Fax: (08) 9385 2701
Email: Feedback.NMHSMH@health.wa.gov.au

Kalamunda Hospital Campus

Street address:
Elizabeth Street, Kalamunda WA 6076
Postal address:
PO Box 243, Kalamunda WA 6926
Phone: (08) 08 9257 8100
Fax: (08) 9293 2488
Email: KDCH.administration@health.wa.gov.au

St John of God Midland Public Hospital*

Street address:
1 Clayton St, Midland WA 6056
Postal address:
PO Box 1254, Midland WA 6936
Phone: (08) 9462 4000
Fax: (08) 9385 2701
Email: info.midland@sjog.org.au
Web: www.midlandhospitals.org.au

*Operated on behalf of the State Government by St John of God Health Care.

South Metropolitan Health Service

Street address:
14 Barry Marshall Parade,
Murdoch WA 6150
Postal address:
Locked Bag 100, Palmyra DC WA 6961
Phone: (08) 6152 2222
Email: SMHS.generalenquiries@health.wa.gov.au
Web: www.southmetropolitan.health.wa.gov.au

Royal Perth Hospital – Wellington Street Campus

Street address:
197 Wellington Street, Perth WA 6000
Postal address:
GPO Box X2213, Perth WA 6847
Phone: (08) 9224 2244
Fax: (08) 9224 3511
Email: rph.general.enquiries@health.wa.gov.au
Web: www.rph.wa.gov.au

South Metropolitan Population Health

Street address:
D5 Fremantle Hospital, Alma Street,
Fremantle WA 6160
Postal address:
PO Box 480, Fremantle WA 6959
Phone: (08) 9431 0200
Fax: (08) 9431 0227
Web: www.southmetropolitan.health.wa.gov.au

Bentley Hospital

Street address:
18-56 Mills Street, Bentley WA 6102
Postal address:
PO Box 158, Bentley WA 6982
Phone: (08) 9416 3666
Fax: (08) 9416 3711
Email: bl.enquires@health.wa.gov.au
Web: www.bhs.wa.gov.au

Fremantle Hospital and Health Service

Street address:
South Terrace (near Alma Street),
Fremantle WA 6160
Postal address:
PO Box 480, Fremantle WA 6959
Phone: (08) 9431 3333
Fax: (08) 9431 2921
Email: FHHS.publicrelations@health.wa.gov.au
Web: www.fhhs.health.wa.gov.au

Fiona Stanley Hospital

Street address:
11 Robin Warren Drive,
Murdoch WA 6150
Postal address:
Locked Bag 100, Palmyra DC WA 6961
Phone: (08) 6152 2222
Email: fsh@health.wa.gov.au
Web: www.fsh.health.wa.gov.au

Rottnest Island Nursing Post

Street address:
2 Abbott Street, Rottnest WA 6161
Postal address:
RINP, c/o Fiona Stanley Hospital
PO Box 100, Palmyra DC WA 6961
Phone: (08) 9292 5030
Fax: (08) 9292 5121
Email:
rottnestisland.nursingpost@health.wa.gov.au
Web: www.fsh.health.wa.gov.au

Armadale Health Service

Street address:
3056 Albany Highway,
Armadale WA 6112
Postal address:
PO Box 460, Armadale WA 6992
Phone: (08) 9391 2000
Fax: (08) 9391 2129
Email: ahs@health.wa.gov.au
Web: www.ahs.health.wa.gov.au

Rockingham General Hospital

Street address:
Elanora Drive, Cooloongup WA 6168
Postal address:
PO Box 2033, Rockingham WA 6968
Phone: (08) 9599 4000
Fax: (08) 9599 4619
Email: rkpg@health.wa.gov.au
Web: www.rkpg.health.wa.gov.au

Murray District Hospital

Street address:
McKay Street, Pinjarra WA 6208
Postal address:
PO Box 243, Pinjarra WA 6208
Phone: (08) 9531 7222
Fax: (08) 9531 7241
Email: rkpg@health.wa.gov.au
Web: www.rkpg.health.wa.gov.au

Peel Health Campus (Public)*

Street and postal address:
110 Lakes Road, Mandurah WA 6210
Phone: (08) 9531 8000
Fax: (08) 9531 8578
Email: Enquiries.PHC@ramsayhealth.com.au
Web: www.ramsayhealth.com.au

*Operated on behalf of the State Government by Ramsay Health Care.

Child and Adolescent Health Service

Street address:
Roberts Road, Subiaco WA 6008
Postal address:
GPO Box D184, Perth WA 6840
Phone: (08) 9340 8222
Fax: (08) 9340 7000
Email: pmh@health.wa.gov.au
Web: www.cahs.health.wa.gov.au

Princess Margaret Hospital for Children

Street address:
Roberts Road, Subiaco WA 6008
Postal address:
GPO Box D184, Perth WA 6840
Phone: (08) 9340 8222
Fax: (08) 9340 7000
Email: pmh@health.wa.gov.au
Web: www.pmh.health.wa.gov.au

Child and Adolescent Community Health

Street address:
233 Adelaide Terrace, Perth WA 6000
Postal address:
GPO Box S1296, Perth WA 6845
Phone: (08) 9323 6666
Fax: (08) 9323 6699
Email: childcommunity@health.wa.gov.au
Web: www.cahs.health.wa.gov.au

Child and Adolescent Mental Health Service

Street address:
70 Hay Street, Subiaco WA 6008
Postal address:
GPO Box D184, Perth WA 6840
Phone: (08) 6389 5800
Fax: (08) 6389 5848
Email:
cahscamhs.businesssupport@health.wa.gov.au
Web: www.cahs.health.wa.gov.au

Appendix 2: Board and committee remuneration

Position	Name	Type of remuneration	2015–16 period of membership	Gross/actual remuneration
Armadale District Aboriginal Health Action Group				
Chair	Eric Wynne	Per meeting	12 months	$720
Vice Chair	Leon Hayward	Per meeting	12 months	$660
Member	Madge Hill	Per meeting	12 months	$510
Member	Edna Riley	Per meeting	12 months	$150
Member	Glenys Yarran	Per meeting	12 months	$300
Member	Raelene Hayward	Per meeting	12 months	$510
Member	Desma Collard	Per meeting	12 months	$0
Member	Chris Stack	Per meeting	12 months	$240
Member	Eunice Bynder	Per meeting	12 months	$810
Member	Dianne Wynne	Per meeting	12 months	$390
Member	Cheryl French	Per meeting	12 months	$540
Member	Loretta Hill	Per meeting	12 months	$360
Member	Gary Bennell	Per meeting	6 months	$330
Member	Gloria Bennell	Per meeting	6 months	$540
Member	Patricia Bennell	Per meeting	6 months	$480
Member	Margaret Milly Milly	Per meeting	5 months	$90
Member	Tracey Thorne	Per meeting	5 months	$90
			Total:	**$6,720**

Position	Name	Type of remuneration	2015–16 period of membership	Gross/actual remuneration
Armadale Health Service (AHS) Community Advisory Council				
Chair	Councillor Julie Brown	Per meeting	12 months	$1,345
Deputy Chair	Dorothy Harrison	Per meeting	12 months	$2,745
Member	Julie Hoey	Per meeting	12 months	$2,375
Member	Sherrin Roberts	Per meeting	1 months	$680
Member	Eric Wynne	Per meeting	12 months	$600
Member	John Hancock	Per meeting	12 months	$0
Member	Councillor Kerry Busby	Per meeting	12 months	$150
Member	Diane Peirce	Per meeting	12 months	$600
Member	Jan Stone	Per meeting	12 months	$870
Member	Councillor John Kirkpatrick	Per meeting	4 months	$0
Member	Sheryl Little	Per meeting	12 months	$1,155
Member	Councillor Sandra Hawkins	Per meeting	5 months	$540
			Total:	**$11,060**
Bentley District Aboriginal Health Action Group				
Chair	Doreen Nelson	Per meeting	12 months	$810
Deputy Chair	Albert Knapp	Per meeting	12 months	$900
Member	Jenny McEwan	Per meeting	12 months	$810
Member	Shirley Voss	Per meeting	12 months	$810
Member	Joanne Hayward	Per meeting	12 months	$1,050
Member	Shirley Thorne	Per meeting	12 months	$540

Position	Name	Type of remuneration	2015–16 period of membership	Gross/actual remuneration
Member	Bradley Hayward	Per meeting	12 months	$630
Member	Ada Bolton	Per meeting	12 months	$510
Member	Dorothy Winmar	Per meeting	12 months	$660
Member	Herman Eades	Per meeting	12 months	$900
Member	Marlene Hansen	Per meeting	12 months	$390
Member	Aileen Eades	Per meeting	12 months	$420
			Total:	**$8,430**
Bentley Health Service Community Advisory Council				
Chair	John Bartlett	Annual	3 months	$180
Member	Bethwyn Jarves	Annual	3 months	$180
Member	Ivor Edwards	Annual	3 months	$180
Member	Ambreen Munir	Annual	3 months	$180
			Total:	**$720**
BreastScreen WA General Practitioner Advisory Committee				
Chair	Dr Eric Khong	Not eligible	12 months	$0
Member	Dr Karen Moller	Per meeting	12 months	$480
Member	Dr Angela Cooney	Per meeting	12 months	$960
Member	Dr Judy Galloway	Per meeting	12 months	$720
Member	Dr Alison Stubbs	Per meeting	12 months	$960
Member	Dr Jacquie Garton-Smith	Per meeting	12 months	$960
Member	Dr Vicki Westoby	Per meeting	12 months	$480
Member	Dr Crystal Cree	Per meeting	12 months	$480
			Total:	**$5,040**

Position	Name	Type of remuneration	2015–16 period of membership	Gross/actual remuneration
Eating Disorders Program Consumer Advisory Groups				
Member	Asha McAlister	Per meeting	12 months	$240
Member	Emily Wheeler	Per meeting	12 months	$240
Member	Ashleigh Hardcastle	Per meeting	12 months	$300
Member	Lynelle Fields	Per meeting	12 months	$300
			Total:	**$1,080**
Fremantle District Aboriginal Health Action Group				
Chair	Diane May	Per meeting	12 months	$1,080
Deputy Chair	Hayden Howard	Per meeting	12 months	$1,020
Member	Tenika Calgaret	Per meeting	12 months	$990
Member	Sharon Calgaret	Per meeting	12 months	$1,080
Member	Howard Riley	Per meeting	12 months	$870
Member	Tina Francis	Per meeting	12 months	$840
Member	Connie Moses	Per meeting	12 months	$750
Member	Susan Pickett	Per meeting	10 months	$420
Member	Corina Abraham	Per meeting	12 months	$1,020
Member	Marjorie Newell	Per meeting	12 months	$600
Member	Betty Ugle	Per meeting	12 months	$150
Member	Sealan Garlett	Per meeting	5 months	$60
Member	Francis Edney	Per meeting	5 months	$330
Member	Rosemary May	Per meeting	5 months	$180
Member	Laura Cound	Per meeting	1 month	$90
			Total:	**$9,480**

Position	Name	Type of remuneration	2015–16 period of membership	Gross/actual remuneration
King Edward Memorial Hospital Community Advisory Committee (Name changed to Womens and Newborns Health Service Community Advisory Council)				
Chair	Jody Blake	Per meeting	7 months	$0
Member	Maureen Helen	Per meeting	12 months	$0
Member	Amanda Hocking	Not eligible	Not applicable	$0
Member	Wendy Hunt	Not eligible	12 months	$0
Member	Briony McKenzie	Per meeting	12 months	$0
Member	Ann McRae	Per meeting	12 months	$0
Member	Sonja Whimp	Per meeting	12 months	$0
Member	Nicole Woods	Per meeting	12 months	$0
Member	Jamie Yallup-Farrant	Per meeting	12 months	$0
Member	Gail Yarran	Per meeting	12 months	$0
Member	Jane Jones	Per meeting	12 months	$0
Member	Gemma Cadby	Per meeting	12 months	$0
Member	Sarah Sibson	Per meeting	12 months	$0
Member	Maryam Aghamohammadi	Per meeting	12 months	$0
			Total:	**$1,860**
North Metropolitan Health Service Community Advisory Council				
Chair	Tim Benson	Per meeting	12 months	$240
Deputy Chair	Alan Alford	Per meeting	12 months	$300
Member	Joan Varian	Per meeting	12 months	$240
Member	Jacqueline Carter	Per meeting	12 months	$180
Member	Theresa Ann McRae	Per meeting	12 months	$300
Member	Margaret Ryan	Per meeting	12 months	$300
Member	Ian Wright	Per meeting	12 months	$300
Member	John Brian Stafford	Per meeting	12 months	$0
Member	Jane Whiddon	Per meeting	12 months	$0
			Total:	**$1,860**
Osborne Park Hospital Community Advisory Council				
Chair	Joan Varian	Per meeting	12 months	$300
Member	Peter Merralls	Per meeting	12 months	$360
Member	Sharon Cooke	Per meeting	1 months	$60
Member	Pam Van Omme	Per meeting	12 months	$300
Member	Tom Benson	Per meeting	12 months	$360
Member	Suresh Rajan	Per meeting	12 months	$360
Member	Joey Cookman	Per meeting	12 months	$360
Member	Lesley Shore	Per meeting	12 months	$180
Member	Elizabeth Taylor	Per meeting	6 months	$180
			Total:	**$2,460**
Peel District Aboriginal Health Action Group (Name changed to Mandurah District Aboriginal Health Action Group)				
Chair	Kylie Gliddon	Per meeting	12 months	$600
Deputy Chair	Ross Pickett	Per meeting	12 months	$870
Member	Ivy Bennell	Per meeting	12 months	$570
Member	Leslie Jacobs	Per meeting	12 months	$870
Member	Nathaniel Pickett	Per meeting	12 months	$840
Member	Linda Quartermaine	Per meeting	12 months	$660

Position	Name	Type of remuneration	2015–16 period of membership	Gross/actual remuneration
Member	Lorraine Woods	Per meeting	12 months	$660
Member	Sasha Morrison	Per meeting	12 months	$660
Member	Peter Woods	Per meeting	12 months	$240
Member	Elsie Ugle	Per meeting	12 months	$750
Member	Peta Ugle	Per meeting	2 months	$120
Member	Janice Cockie	Per meeting	2 months	$150
Member	Phyllis Ugle	Per meeting	12 months	$150
Member	Steven Jacobs	Per meeting	12 months	$150
Member	Harry Nannup	Per meeting	12 months	$150
Member	Barbara Pickett	Per meeting	8 month	$300
			Total:	**$7,740**
Queen Elizabeth II Medical Centre Trust				
Chair	Steven Cole	Annual	12 months	$48,650
Deputy Chair (retired March 2016)	Gaye McMath	Not eligible	Not applicable	$0
Member	Wayne Salvage	Not eligible	Not applicable	$0
Member	Angela Kelly	Not eligible	Not applicable	$0
Member	Professor John Newnham	Not eligible	Not applicable	$0
Member	Professor Wendy Erber	Not eligible	Not applicable	$
Member	Professor Peter Davies	Not eligible	Not applicable	$0
			Total:	**$48,650**

Position	Name	Type of remuneration	2015–16 period of membership	Gross/actual remuneration
Rockingham General Hospital Community Advisory Council (Name changed to Rockingham Peel Group Community Advisory Council)				
Chair	Jan Thair	Per meeting	12 months	$780
Member	Jordon Steele-John	Per meeting	12 months	$150
Member	Sally Whyte	Not eligible	Not applicable	$0
Member	Jane Churchill	Not eligible	Not applicable	$0
Member	Collin Pitson	Not eligible	Not applicable	$0
Member	Betty McNeil	Not eligible	Not applicable	$0
Member	Joy Stewart	Not eligible	Not applicable	$0
Member	Wendy Cooper	Not eligible	Not applicable	$0
Member	Renate Charban	Per meeting	12 months	$615
Member	John Dalgleish	Per meeting	12 months	$660
Member	Glenice Garvie	Per meeting	12 months	$720
Member	Beth Philipps	Per meeting	12 months	$420
Member	Joy Jeffes	Per meeting	12 months	$645
Member	Debra Letica	Per meeting	12 months	$960
			Total:	**$4,950**
Rockingham General Hospital Medical Advisory Committee				
Chair	Dr Gordon Shymko	Not eligible	Not applicable	$0
Member	Lindsay Adams	Not eligible	Not applicable	$0
Member	Hari Adoni	Not eligible	Not applicable	$0
Member	James Alonzo	Not eligible	Not applicable	$0
Member	Astrid Arellano	Not eligible	Not applicable	$0
Member	Kartik Atre	Not eligible	Not applicable	$0

Position	Name	Type of remuneration	2015–16 period of membership	Gross/actual remuneration
Member	Andrew Barker	Not eligible	Not applicable	$0
Member	David Bartolo	Not eligible	Not applicable	$0
Member	Edward Bouverie	Not eligible	Not applicable	$0
Member	Boris Brankov	Not eligible	Not applicable	$0
Member	Douglas Bridge	Not eligible	Not applicable	$0
Member	Matthew Brown	Not eligible	Not applicable	$0
Member	Guy Buters	Not eligible	Not applicable	$0
Member	Tony Calogero	Not eligible	Not applicable	$0
Member	Krish Chikkaveerappa	Not eligible	Not applicable	$0
Member	Theresa Chow	Not eligible	Not applicable	$0
Member	Andrew Christophers	Not eligible	Not applicable	$0
Member	Ben Clark	Not eligible	Not applicable	$0
Member	Huw Clark	Not eligible	Not applicable	$0
Member	Tim Clay	Not eligible	Not applicable	$0
Member	Kirsty Crocker	Not eligible	Not applicable	$0
Member	Dawn Dawson	Not eligible	Not applicable	$0
Member	Raghu Dharmapuri	Not eligible	Not applicable	$0
Member	Peter Dias	Not eligible	Not applicable	$0
Member	John Dyer	Not eligible	Not applicable	$0
Member	Rod Ellis	Not eligible	Not applicable	$0
Member	Jim Filby	Not eligible	Not applicable	$0
Member	Eve Foreman	Not eligible	Not applicable	$0
Member	Shane Gangatharan	Not eligible	Not applicable	$0

Position	Name	Type of remuneration	2015–16 period of membership	Gross/actual remuneration
Member	Wouter Gerryts	Not eligible	Not applicable	$0
Member	Stephen Grainger	Not eligible	Not applicable	$0
Member	Robin Guttinger	Not eligible	Not applicable	$0
Member	Rachel Hall	Not eligible	Not applicable	$0
Member	Genevieve Hankey	Not eligible	Not applicable	$0
Member	Dickon Hayne	Not eligible	Not applicable	$0
Member	Sam Hillyard	Not eligible	Not applicable	$0
Member	Yan Kit Charles Ho	Not eligible	Not applicable	$0
Member	Siong Hou Hui	Not eligible	Not applicable	$0
Member	Benedicta Itotoh	Not eligible	Not applicable	$0
Member	Ross Jose	Not eligible	Not applicable	$0
Member	Shelley Campos	Not eligible	Not applicable	$0
Member	Li-on Lam	Not eligible	Not applicable	$0
Member	Heather Lane	Not eligible	Not applicable	$0
Member	Matthew Lawson-Smith	Not eligible	Not applicable	$0
Member	Tom Lee	Not eligible	Not applicable	$0
Member	Mikhail Lozinskiy	Not eligible	Not applicable	$0
Member	Alastair Mackendrick	Not eligible	Not applicable	$0
Member	Tania Martin	Not eligible	Not applicable	$0
Member	Thomas Matthews	Not eligible	Not applicable	$0
Member	Andrew Mattin	Not eligible	Not applicable	$0
Member	Barry McKeown	Not eligible	Not applicable	$0
Member	Tulsi Menon	Not eligible	Not applicable	$0

Position	Name	Type of remuneration	2015–16 period of membership	Gross/actual remuneration
Member	Pauline Morrow	Not eligible	Not applicable	$0
Member	Nitin Nair	Not eligible	Not applicable	$0
Member	Mark Nicholas	Not eligible	Not applicable	$0
Member	Alfredo Noches-Garcia	Not eligible	Not applicable	$0
Member	Hiten Patel	Not eligible	Not applicable	$0
Member	William Patton	Not eligible	Not applicable	$0
Member	Rebecca Pogson	Not eligible	Not applicable	$0
Member	Rajini Rajanayagam	Not eligible	Not applicable	$0
Member	Essa (Mohamed) Rasool	Not eligible	Not applicable	$0
Member	Nooshin Rasool	Not eligible	Not applicable	$0
Member	Simone Cooper	Not eligible	Not applicable	$0
Member	Peta Sadler	Not eligible	Not applicable	$0
Member	Ajay Sharma	Not eligible	Not applicable	$0
Member	Kelvin Siew	Not eligible	Not applicable	$0
Member	Brett Sillars	Not eligible	Not applicable	$0
Member	Abhey Singh	Not eligible	Not applicable	$0
Member	Nathan Smalley	Not eligible	Not applicable	$0
Member	Ben Smedley	Not eligible	Not applicable	$0
Member	Kavipriya Soma	Not eligible	Not applicable	$0
Member	Katja Stehr	Not eligible	Not applicable	$0
Member	Joel Stein	Not eligible	Not applicable	$0
Member	Karthikeyan Thanigaimani	Not eligible	Not applicable	$0

Position	Name	Type of remuneration	2015–16 period of membership	Gross/actual remuneration
Member	Andrew Thompson	Not eligible	Not applicable	$0
Member	Ai Tran	Not eligible	Not applicable	$0
Member	Anthony Tzannes	Not eligible	Not applicable	$0
Member	Simon Wall	Not eligible	Not applicable	$0
Member	Benjamin Witte	Not eligible	Not applicable	$0
Member	David De la Hunty	Not eligible	Not applicable	$0
Member	Geraldine Carlton	Not eligible	Not applicable	$0
Member	Abayomi Adeniyi	Not eligible	Not applicable	$0
Member	Thinh Nguyen	Not eligible	Not applicable	$0
Member	Amol Pargaonkar	Not eligible	Not applicable	$0
Member	Matthew Sewell	Not eligible	Not applicable	$0
Member	Biju Thomas	Not eligible	Not applicable	$0
Member	Darshan Trivedi	Not eligible	Not applicable	$0
Member	Sunny Varghese	Not eligible	Not applicable	$0
Member	Daniela Vecchio	Not eligible	Not applicable	$0
Member	Huw Williams	Not eligible	Not applicable	$0
Member	Lakshmi Fernandes	Not eligible	Not applicable	$0
Member	Shelbin Neelankavil	Not eligible	Not applicable	$0
Member	Neil Banham	Not eligible	Not applicable	$0
Member	Helen Thomas	Not eligible	Not applicable	$0
Member	Nicolas Fernandes	Not eligible	Not applicable	$0
Member	Murali Narayanan	Not eligible	Not applicable	$0
Member	Angela Graves	Not eligible	Not applicable	$0

Position	Name	Type of remuneration	2015–16 period of membership	Gross/actual remuneration
Member	Nicholas Prophet	Not eligible	Not applicable	$0
Member	Samantha Bowyer	Not eligible	Not applicable	$0
Member	Francis Loutsky	Not eligible	Not applicable	$0
Member	Lubna Azhar	Not eligible	Not applicable	$0
Member	Ken Thong	Not eligible	Not applicable	$0
Member	Ravi Sonawane	Not eligible	Not applicable	$0
Member	Rishi Kotecha	Not eligible	Not applicable	$0
Member	Tim Patel	Not eligible	Not applicable	$0
Member	Rajasekar Malvathu	Not eligible	Not applicable	$0
Member	Flemming Nielsen	Not eligible	Not applicable	$0
Member	Arvind Sharma	Not eligible	Not applicable	$0
Member	Khalid Malik	Not eligible	Not applicable	$0
Member	Bheemasenachar Prasad	Not eligible	Not applicable	$0
Member	Margherita Nicoletti	Not eligible	Not applicable	$0
Member	Asheila Narang	Not eligible	Not applicable	$0
Member	Maria Soldini	Not eligible	Not applicable	$0
Member	De-Wet Van Riet	Not eligible	Not applicable	$0
Member	Tehal Kooner	Not eligible	Not applicable	$0
Member	Elizabeth Paterson	Not eligible	Not applicable	$0
Member	Adrian Mcelholm	Not eligible	Not applicable	$0
Member	Abhijit Basu	Not eligible	Not applicable	$0
			Total:	**$0**

Position	Name	Type of remuneration	2015–16 period of membership	Gross/actual remuneration
Rockingham Kwinana Aboriginal District Health Action Group				
Chair	Yvonne Winmar	Per meeting	12 months	$870
Deputy Chair	Janet Hansen	Per meeting	12 months	$540
Member	Doris Getta	Per meeting	12 months	$810
Member	Theresa Walley	Per meeting	12 months	$90
Member	Benita Indich	Per meeting	12 months	$480
Member	Lindsay Calyun	Per meeting	12 months	$480
Member	Helen Kickett	Per meeting	12 months	$330
Member	Vonita Walley	Per meeting	12 months	$870
Member	Marianne Mackay	Per meeting	12 months	$540
Member	Charles Kickett	Per meeting	12 months	$90
			Total:	**$5,100**
Royal Perth Hospital Animal Ethics Committee				
Chair	Prof. Kevin Croft	Per meeting	Sessional	$5,236
Executive Officer	Dr Linda Manning	Not eligible	Not applicable	$0
Category A Member	Assoc. Prof. Lenn Cullen	Per meeting	12 months	$1,200
Category A Member	Dr Tim Hyndman	Per meeting	12 months	$1,000
Category B Member	Dr Ann Barden	Per meeting	12 months	$1,200
Category B Member	Dr Jacky Bentel	Not eligible	Not applicable	$0
Category C Member	Noel Smith	Per meeting	12 months	$1,000

Position	Name	Type of remuneration	2015–16 period of membership	Gross/actual remuneration
Category C Member	Steve Vanstan	Per meeting	12 months	$1,200
Category D Member	Mike Field	Per meeting	12 months	$1,000
Category D Member	Dr Pam Garnett	Per meeting	12 months	$400
			Total:	**$12,236**
Royal Perth Hospital Community Advisory Council (Name changed to Royal Perth Hospital Consumer Advisory Committee)				
Chair	Petrina Lawrence	Per meeting	12 months	$660
Deputy Chair	Margaret Ryan	Per meeting	12 months	$660
Member	Patricia Dagg	Per meeting	12 months	$600
Member	Robert Matthews	Per meeting	12 months	$600
Member	Kenneth Quick	Per meeting	12 months	$660
Member	Mary Ward	Per meeting	12 months	$660
Member	Margaret Walsh	Per meeting	12 months	$600
Member	Darianne Zambotti	Per meeting	12 months	$480
Member	Deborah Gray	Per meeting	12 months	$480
Member	Margaret Flynn	Per meeting	12 months	$660
Member	Eric Wynne	Per meeting	12 months	$480
			Total:	**$6,540**
South Metropolitan Area Aboriginal Health Action Group				
Member	Doreen Nelson	Per meeting	12 months	$360
Member	Albert Knapp	Per meeting	12 months	$360
Member	Janet Hansen	Per meeting	12 months	$300
Member	Howard Riley	Per meeting	12 months	$120
Member	Connie Moses	Per meeting	12 months	$300
Member	Leslie Jacobs	Per meeting	12 months	$120
Member	Ivy Bennell	Per meeting	12 months	$300
Member	Eric Wynne	Per meeting	12 months	$240
Member	Leon Hayward	Per meeting	12 months	$450
Member	Kylie Gliddon	Per meeting	12 months	$330
Member	Yvonne Winmar	Per meeting	12 months	$330
Member	Hayden Howard	Per meeting	12 months	$330
Member	Ross Pickett	Per meeting	3 months	$150
Member	Diane May	Per meeting	3 months	$150
			Total:	**$3,840**
South Metropolitan Area Health Service Consumer Advisory Council				
Chair	Dr Robyn Lawrence	Not eligible	Not applicable	$0
Member	Dorothy Harrison	Per meeting	6 months	$104
Member	Lyn Williamson	Per meeting	6 months	$120
Member	Piper Marsh	Per meeting	6 months	$60
Member	Jan Thair	Per meeting	6 months	$60
Member	Petrina Lawrence	Per meeting	6 months	$120
Member	Marie Matthews	Per meeting	6 months	$60
Member	Jacqueline Matheron	Per meeting	6 months	$60
Member	Nancy Pierce	Per meeting	6 months	$120
Member	Sharon Kenny	Per meeting	6 months	$120
Member	Iren Hunyadi	Per meeting	9 months	$120

Position	Name	Type of remuneration	2015–16 period of membership	Gross/actual remuneration
Member	Marc Zen	Per meeting	9 months	$60
Member	Mary Ward	Per meeting	6 months	$120
Member	Colin Stephenson	Per meeting	6 months	$60
Member	Erin Wynne	Per meeting	9 months	$60
Member	Lesley Oliver	Not eligible	Not applicable	$0
Member	Stephanie Newell	Not eligible	Not applicable	$0
Member	Kerry Mace	Per meeting	6 months	$60
Member	Debra Leticia	Per meeting	6 months	$0
			Total:	**$1,304**

Notes:

1. The above list of Boards is as per the State Government Boards and Committees Register.
2. Remuneration is provided to private sector and consumer representative members of a board/committee. Individuals are ineligible for remuneration if their membership on the board/committee is considered to be an integral part of their organisational role.
3. Remuneration amounts can vary depending on the type of remuneration, the number of meetings attended, and whether a member submitted a remuneration claim.
4. 'Period of membership' is defined as the period (in months) that an individual was a member of a board/committee during the 2015–16 financial year. If a member was ineligible to receive remuneration, their period of membership is immaterial to the remuneration amount and has been defined as 'Not applicable'.

This document can be made available in alternative formats on request for a person with disability.

Produced by Purchasing and System Performance Division

PSP-013189 Metro SEP'16