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

Metropolitan Health Service
Annual Report





2013–14

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

Metropolitan Health Service
Annual Report

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

Statement of Compliance

HON DR KIM HAMES MLA
MINISTER FOR HEALTH

In accordance with Section 61 of the *Financial Management Act 2006*, I hereby submit for your information and presentation to Parliament, the Annual Report of the Metropolitan Health Service for the financial year ended 30 June 2014.

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

Professor Bryant Stokes
ACTING DIRECTOR GENERAL
DEPARTMENT OF HEALTH
ACCOUNTABLE AUTHORITY

16 September 2014

Contents

Overview of Agency

Vision statement

Our vision

Healthier, longer and better quality lives for all Western Australians.

Our mission

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

- caring for individuals and the community
- caring for those who need it most
- making the best use of funds and resources
- supporting our team.

Our values

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

Our values can be summarised as:

Executive summary

WA's public health system, WA Health, performed well for the community in 2013–14, despite strong demand for its services from a fast–growing population and the continuing challenge of delivering the Department of Health's biggest-ever infrastructure program.

The period was also my first full-year as Acting Director General after assuming the role in April 2013.

During 2013–14, an important committee – the Transition and Reconfiguration Committee – was formed to help facilitate the task of transferring services and resources to several new hospitals, including Fiona Stanley Hospital and Perth Children's Hospital, which are due to come on stream in the next few years.

The committee will also guide the future transformation of the Department of Health as it responds to changing demographic and economic conditions and, furthermore, to help devolve responsibility throughout the organisation.

The performance of WA Health in 2013–14 was underpinned by long–term planning, regular and ongoing monitoring and review, stronger governance guidelines, and innovative reform from a professional 43,000-strong workforce.

Delivering a healthy WA

Western Australians as a whole enjoy an excellent standard of health, reflected in life expectancy among the best in the world and infant mortality rates among the lowest in Australia.

The Australian Institute for Health and Welfare report, *The Australian Hospital Statistics 2012–13*, in early 2014 showed WA hospitals were treating more patients than ever before, while still meeting important national performance targets.

During 2013, the WA median wait time for elective surgery is the lowest for all urgency categories, compared to other States and Territories.

WA also continued to lead the country in the proportion of emergency department visits completed in four hours or less which, at 78 per cent, is higher than the national average of 71 per cent.

However, we recognise that sections of the community experience poorer health outcomes and we are resolute in our commitment to improve the health of those who are most in need.

The broad WA community benefits from effective public health programs, responsive health services and hospitals which, in the provision of patient care, meet high standards of safety and quality.

Work continued through the year on the $7 billion infrastructure overhaul that is expanding and transforming hospitals and health facilities across WA, including the construction of Fiona Stanley Hospital, the State's major new tertiary hospital, due to be opened in stages from October 2014.

Also announced in 2013–14 was the reconfiguration of South Metropolitan Health Service to ensure the workforce and resources were ready to operate Fiona Stanley Hospital when it opens.

Included in the reconfiguration was the transfer of the State Rehabilitation Centre from Shenton Park to Fiona Stanley Hospital, due in October 2014; the obstetrics, gynaecology and neonatal services at Kaleeya Hospital to Fiona Stanley Hospital by November 2014; and Fremantle Hospital's emergency department to Fiona Stanley Hospital in 2015.

Our challenge is to use this vast investment in infrastructure to boost productivity and efficiency in our health services. These services are costing more, but the State's revenue base is growing at a slower rate.

A particular focus has been information and communications technology governance and planning, and a professional and consistent approach to procurement.

With those priorities in mind, the Office of Deputy Director General and Office of Chief Procurement Officer were formed to support me in implementing key changes across the governance, performance and procurement processes in WA Health.

In 2013–14 WA Health also acted on the recommendations of the Corruption and Crime Commission's *Report on Fraud and Corruption in Procurement in WA Health: Dealing with the Risks.*

Since the report was tabled in June 2014, WA Health has conducted:

- a comprehensive risk assessment for fraud and corruption in procurement
- developed strategies to ensure compliance
- used risk assessment to inform internal audit and strategic planning and activity
- procurement staff training programs
- policy and procedure reviews to manage conflicts of interest, gifts and benefits, and outside employment.

Throughout these times of significant change, however, WA Health continues to improve its performance and align its efforts to the four key pillars of *WA Health Strategic Intent 2010–15*:

- caring for individuals and the community
- caring for those who need it most
- making the best use of funds and resources
- supporting our team.

Caring for individuals and the community

WA continues to be at the forefront of tobacco control, with well supported initiatives such as Quitline, the Make Smoking History campaign and WA's own Smoke Free WA Health System policy.

The Department of Health's tough stance on tobacco and related products was backed by a Supreme Court decision during 2013–14 that resulted in a fine for a retailer selling e–cigarettes.

Focus also continues on health conditions linked to excess body mass. A Department of Health report (*The Cost of Excess Body Mass to the Acute Hospital System in Western Australia 2011*) released during the year found more than $240 million a year, or 5.4 per cent of total hospital costs, was the cost attributed to excess body mass through health conditions such as osteoarthritis, type 2 diabetes, hypertensive disease and congestive heart failure. Initiatives continue to encourage people to "live lighter" to combat this problem.

There was also a free, statewide vaccination program offered to Year 8 students across WA, providing human papillomavirus vaccine, as well as booster doses of diphtheria, tetanus, pertussis and chicken pox vaccines.

Research, again, received strong support in 2013–14, with $8.71 million awarded from three State Government health research funds. Researchers will share $5.96 million of Medical and Health Research Infrastructure Fund grants; six projects will share $1.55 million in Targeted Research Fund grants; and six WA Health clinicians will share $1.2 million of Clinician Research Fellowship funding.

In addition, nearly $3 million was allocated for new initiatives to help Western Australian researchers access a greater share of national research funding and enhance the State's health and medical research capability.

Caring for those who need it most

WA Health renewed its commitment to closing the gap in life expectancy for Aboriginal people by announcing its new Footprints to Better Health strategy.

More than 100 dedicated Aboriginal health services will be delivered under the strategy, which combines the former Closing the Gap program and the Indigenous Early Childhood Development programs.

The strategy is supported by the allocation of more than $32.2 million to build on the work already undertaken to close the gap in life expectancy and $2 million for the implementation of the Footprints to Better Health strategy.

WA Health also contributed a team of professionals, including emergency department nurses, to the Typhoon Haiyan relief effort in the Philippines as part of the second Australian Medical Assistance Team (AusMAT) deployment to provide urgent medical assistance.

Sir Charles Gairdner Hospital became home to Australia's first CyberKnife – a $9 million, technologically advanced weapon in the fight against cancer – which uses high dose radiation to treat certain tumours.

BreastScreen WA launched an online booking system, which is expected to see more than 5,000 additional women screened for breast cancer each year.

There was record investment in school health, with the first of 155 new school health staff starting work in WA schools. There will be $38 million in funding over four years for additional school health staff across the State, most of whom will be based in regional teams servicing a number of schools in each area.

Making the best use of our funds and resources

This was the last year of Australian Government funding under the old system before the key national reform of Activity Based Funding takes hold from July 2014. This will benchmark our performance against other States and affect the amount of funding we receive from the Australian Government.

To be in the best position for this new funding regime, WA Health has focussed on improvements across the board, but especially in information and communication technology governance and planning, and adopting a professional and consistent approach to procurement.

As mentioned previously, more than $7 billion has been invested in 80 infrastructure projects, including the flagship Fiona Stanley Hospital and Perth Children's Hospital.

The metropolitan area also welcomed investment in a new $15 million 37–bed paediatric ward for the northern suburbs, based at Joondalup Health Campus.

In regional areas, major upgrades have been completed or are planned at 24 regional and remote facilities, including:

- construction of the $31.3 million redevelopment of the Esperance Health Campus
- expansion of the Albany Health Campus, which in its first year saw tens of thousands of people benefit from improved healthcare closer to home.
- the Emergency Telehealth System, which treated more than 4,500 people in regional WA in its first 18 months of operation. Further expansion of this initiative will help provide sustainable, efficient emergency services in regional WA.

Also the Southern Inland Health Initiative received an additional $1.9 million in grants to boost primary health services in the Wheatbelt and Central Great Southern.

Supporting our team

People are WA Health's greatest asset and attracting and retaining the best people into the workforce is vital to maintaining a quality health system.

The goal is to have the right doctors, nurses and allied health staff, in the right numbers, in the right places and at the right time to meet the challenging health needs of our State.

The WA Health workforce is facing significant challenges, including the transfer and reconfiguration of people and resources to new hospitals, most significantly Fiona Stanley Hospital and Perth Children's Hospital.

Several specialised transition management systems and databases were developed to help manage and streamline this staff transition process.

WA Health is also developing a 10–year strategic workforce plan, based on the *WA Health Clinical Services Framework 2010–2020*, which will ensure workforce planning is aligned with demand.

Staff retention is another important factor as it has a direct, costly and significant impact on the capacity of WA Health to deliver its quality services. Environmental factors such as the ageing population, the increase in competition in the labour market and the skills shortage in the health sector means that the need for WA Health to focus on improving retention levels is more critical than ever.

To advance greater Aboriginal employment and healthcare inclusion, the revitalised *WA Health Aboriginal Health Workforce Strategy 2014–2024* continues to fund and support leadership programs such as Aboriginal nursing cadetships, nurse mentors, and career and course transition pathways.

Significant workforce challenges are also being faced by the mental health sector. The current workforce is inadequate to meet the mental health needs of WA.

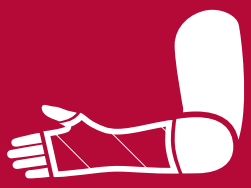
We also have to ensure the WA country community has adequate access to primary health care. WA Health has conducted a concerted and ongoing recruitment drive, resulting in 186 new permanent doctors who have commenced in WA Country Health Service hospitals since 2012.

Professor Bryant Stokes
Acting Director General
DEPARTMENT OF HEALTH

Metropolitan WA at a glance

In metropolitan WA a male is expected to live to **81.7** years of age and a female to **85.7** years of age

441,905
people were admitted to a metropolitan hospital in 2013



1,628
people on any one day will present to a metropolitan emergency department

1,372
deaths in metropolitan WA are caused by coronary heart disease each year

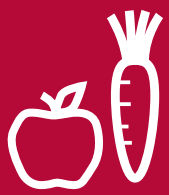
9,304
people in metropolitan WA are diagnosed with cancer each year

26%
16–24 year olds in WA experienced a mental health problem in 2013–14

54%
of all potentially preventable hospitalisations in WA were due to chronic conditions

52.2%
of WA children living in the metropolitan area do not undertake sufficient physical activity

26.8%
of adults living in the metropolitan area are obese



93.8%
of adults living in the metropolitan area do not eat two serves of fruit and five serves of vegetables daily

283,332
WA school children visited a school dental health service in 2013

108,000
WA women have a mammogram each year to screen for breast cancer

Operational structure

Enabling legislation

The Metropolitan Health Service is established under sections 15 and 16 of the *Hospitals and Health Services Act 1927*. The Minister for Health is incorporated as the 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 2013–14 for administered legislation.

Accountable authority

The Acting Director General of Health, Professor Bryant Stokes, is the accountable authority for the Metropolitan Health Service.

Responsible Minister

The Metropolitan Health Service is responsible to the Minister for Health, the Hon. Dr Kim Hames.

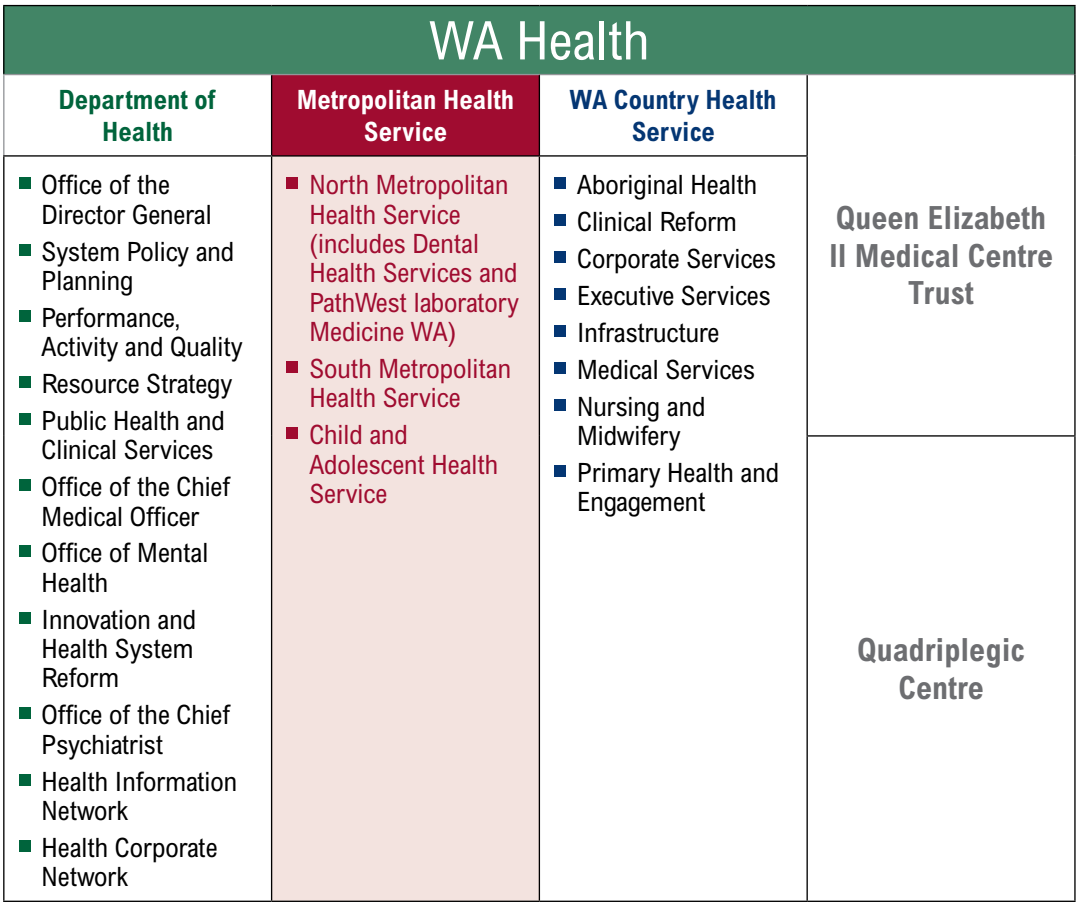
WA Health structure

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.

Figure 1: **WA Health structure**



Metropolitan Health Service management structures

The Metropolitan Health Service consists of three separate entities, the North Metropolitan Health Service, South Metropolitan Health Service, and 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 2013–14.

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

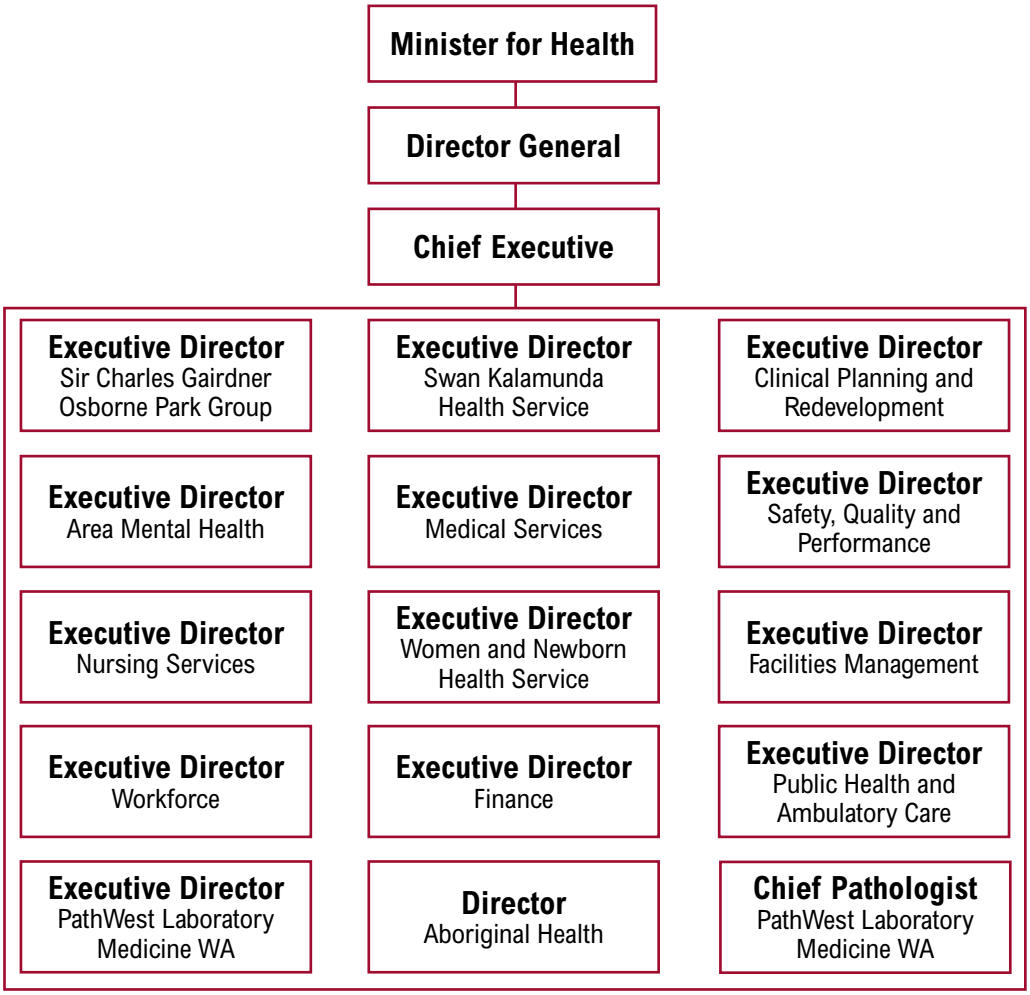


Figure 3: **South Metropolitan Health Service management structure**

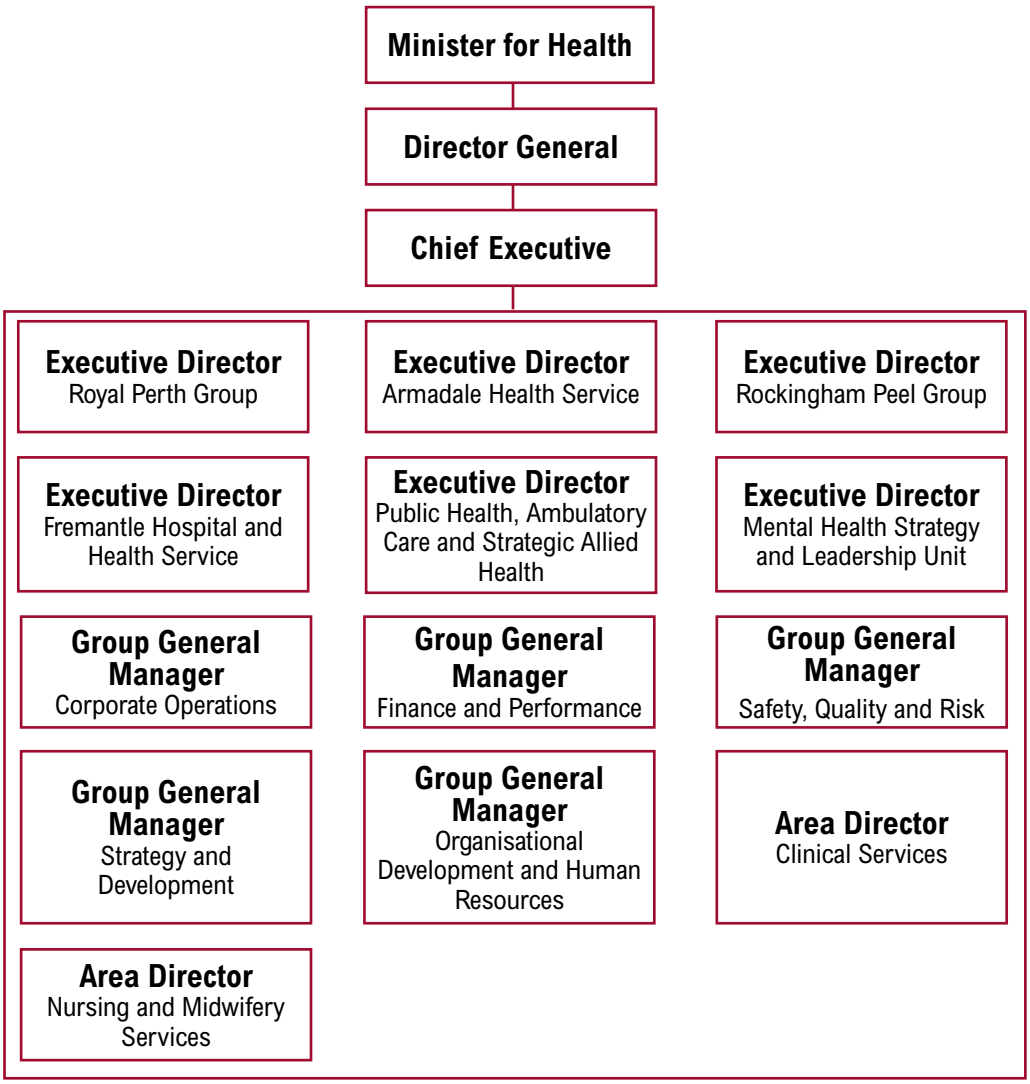
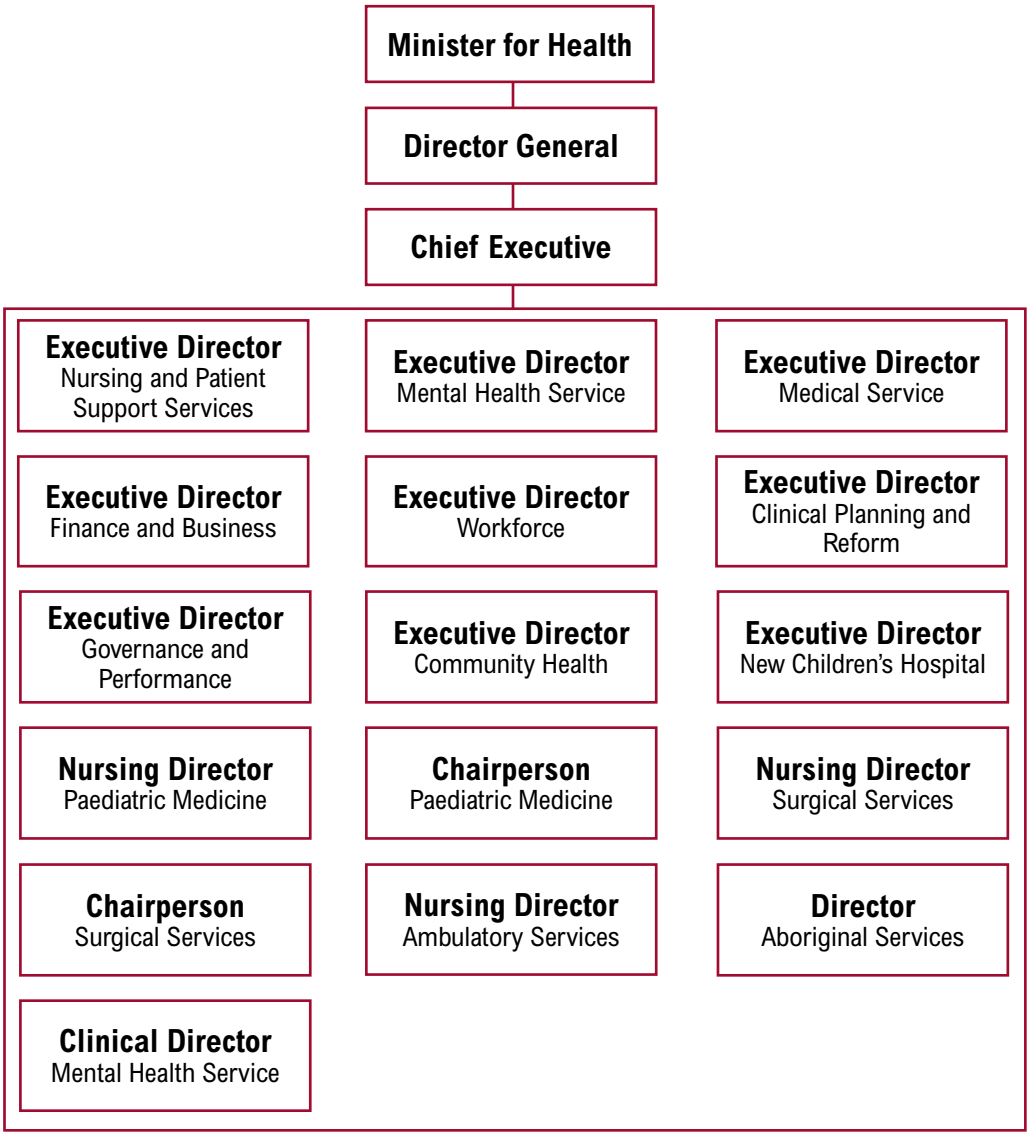


Figure 4: **Child and Adolescent Health Service management structure**



Senior officers

Senior officers and their area of responsibility for the Metropolitan Health Service as at 30 June 2014 are listed in Tables 1 to 3.

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

Area of responsibility	Title	Name	Basis of appointment
Aboriginal Health	Director	Cheryl Hayward	Substantive
Area Mental Health	Executive Director	Patrick Marwick	Acting
Clinical Planning and Redevelopment	Executive Director	David Mulligan	Term contract
Facilities Management	Executive Director	John Fullerton	Term contract
Finance	Executive Director	Alain St Flour	Term contract
Medical Services	Executive Director	Dr Tim Williams	Term contract
North Metropolitan Health Service	Chief Executive	Dr Shane Kelly	Term contract
Nursing Services	Executive Director	Anthony Dolan	Term contract
PathWest Laboratory Medicine WA	Executive Director	Silvano Palladino	Term contract
PathWest Laboratory Medicine WA	Chief Pathologist	Dr Dominic Mallon	Term contract
Public Health and Ambulatory Care (including Dental Services)	Executive Director	Ros Elmes	Substantive
Safety, Quality and Performance	Executive Director	Sandra Miller	Term contract
Sir Charles Gairdner Osborne Park Health Care Group	Executive Director	Dr Robyn Lawrence	Term contract
Swan Kalamunda Health Service	Executive Director	Dr Peter Wynn Owen	Term contract
Women and Newborn Health Service	Executive Director	Dr Amanda Frazer	Substantive
Workforce	Executive Director	Cynthia Seenikatty	Term contract

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

Area of responsibility	Title	Name	Basis of appointment
Armadale Health Service	Executive Director	Chris Bone	Term contract
Clinical Services	Area Director	Vacant	Term contract
Corporate Operations	Group General Manager	Shaun Strachan	Term contract
Finance and Performance	Group General Manager	Ian Male	Term contract
Fremantle Hospital and Health Service (including Fremantle Hospital, Kaleeya Hospital and Rottnest Island Nursing Post)	Executive Director	Dr David Blythe	Term contract
Mental Health Strategy and Leadership Unit	Executive Director	Dr Elizabeth Moore	Term contract
Nursing and Midwifery Services	Area Director	Michelle Dillon	Acting
Organisational Development and Human Resources	Group General Manager	Marshall Warner	Acting
Public Health, Ambulatory Care and Strategic Allied Health	Executive Director	Kate Gatti	Term contract
Rockingham Peel Group (including Rockingham General Hospital, Murray Districts Hospital and Peel Community Health)	Executive Director	Geraldine Carlton	Term contract
Royal Perth Group (including Royal Perth Hospital, Bentley Hospital and Shenton Park Campus)	Executive Director	Prof. Frank Daly	Term contract
Safety, Quality and Risk	Group General Manager	Carol Saunders	Term contract
South Metropolitan Health Service	Chief Executive	Ian Smith	Term contract
Strategy and Development	Group General Manager	Jodie South	Term contract

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

Area of responsibility	Title	Name	Basis of appointment
Aboriginal Services	Executive Director	Leah Bonson	Substantive
Child and Adolescent Health Service	Chief Executive	Philip Aylward	Term contract
Child and Adolescent Community Health	Executive Director	Mark Morrissey	Substantive
Child and Adolescent Mental Health Service	Executive Director	Mark Morrissey	Acting
Child and Adolescent Mental Health Service	Clinical Director	Dr Caroline Goossens	Term contract
Clinical Planning and Reform	Executive Director	Lisa Brennan	Substantive
Finance and Business	Executive Director	Gordon Haywood	Substantive
Governance and Performance	Executive Director	Debbie Bryan	Substantive
Medical Services	Executive Director	Dr Mark Salmon	Substantive
Nursing and Patient Support Services	Executive Director	Anne Bourke	Substantive
Paediatric Medicine Clinical Care Unit	Chairperson	Dr Geoff Knight	Term contract
Paediatric Medicine Clinical Care Unit	Nursing Director	Anne Stynes	Substantive
Perth Children's Hospital	Executive Director	Greg Italiano	Term contract
Surgical Services Clinical Care Unit	Chairperson	Dr Tanya Farrell	Term contract
Surgical Services Clinical Care Unit	Nursing Director	Carrie Dunbar	Substantive
Workforce	Executive Director	Graham Coleman	Substantive

Metropolitan Health Service 2013–14

North Metropolitan Health Service

The North Metropolitan Health Service provides public hospital, community, and mental health services to 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
- Graylands Hospital Campus
- Osborne Park Hospital.

It also oversees the provision of contracted public health care from the privately operated Joondalup Health Campus, and the construction of the new public hospital at Midland Health Campus.

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

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

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 WA, 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
- Fremantle Hospital and Health Service (including Kaleeya Hospital and Rottnest Island Nursing Post)
- 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 Districts Hospital)
- Royal Perth Group (including Bentley Hospital, the Shenton Park Campus, and the Wellington Street Campus).

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

The South Metropolitan Health Service is undergoing significant reconfiguration of its services to prepare for the opening of Fiona Stanley Hospital, and meet the hospital and health needs of the south metropolitan area and the broader WA community. As part of this reconfiguration, the focus, roles and functions of our hospitals will change to improve access to healthcare services and enable patients to receive more complex care closer to home, often in new or refurbished facilities.

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.

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

The $1.2 billion Perth Children's Hospital project, located at the QEII Medical Centre site in Nedlands, will replace Princess Margaret Hospital for Children. The new hospital, due for completion in late 2015, will include an integrated paediatric research and education facility, and provide inpatient, ambulatory and outpatient services. It will also house WA's only paediatric trauma centre.

Child and Adolescent Community Health Service provides a comprehensive range of health promotion, early identification and intervention community-based services to children and families in metropolitan Perth. It provides 10 community clinics across the metropolitan area, and a number of statewide specialist intervention programs. These services focus on growth and development in the early years, and promoting wellbeing during childhood and adolescence. Service delivery is both universal and targeted. Groups at risk of poorer health outcomes, such as Aboriginal people and newly arrived refugees, are of particular focus.

The Child and Adolescent Mental Health Service also provides mental health services to infants, children, young people and their families across the metropolitan area. Services include inpatient care at Princess Margaret Hospital and the Bentley Adolescent Unit, which is WA's only authorised inpatient facility for young people under the age of 18 years.

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 2013–14 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 2013–14 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.

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 by:
   - 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**

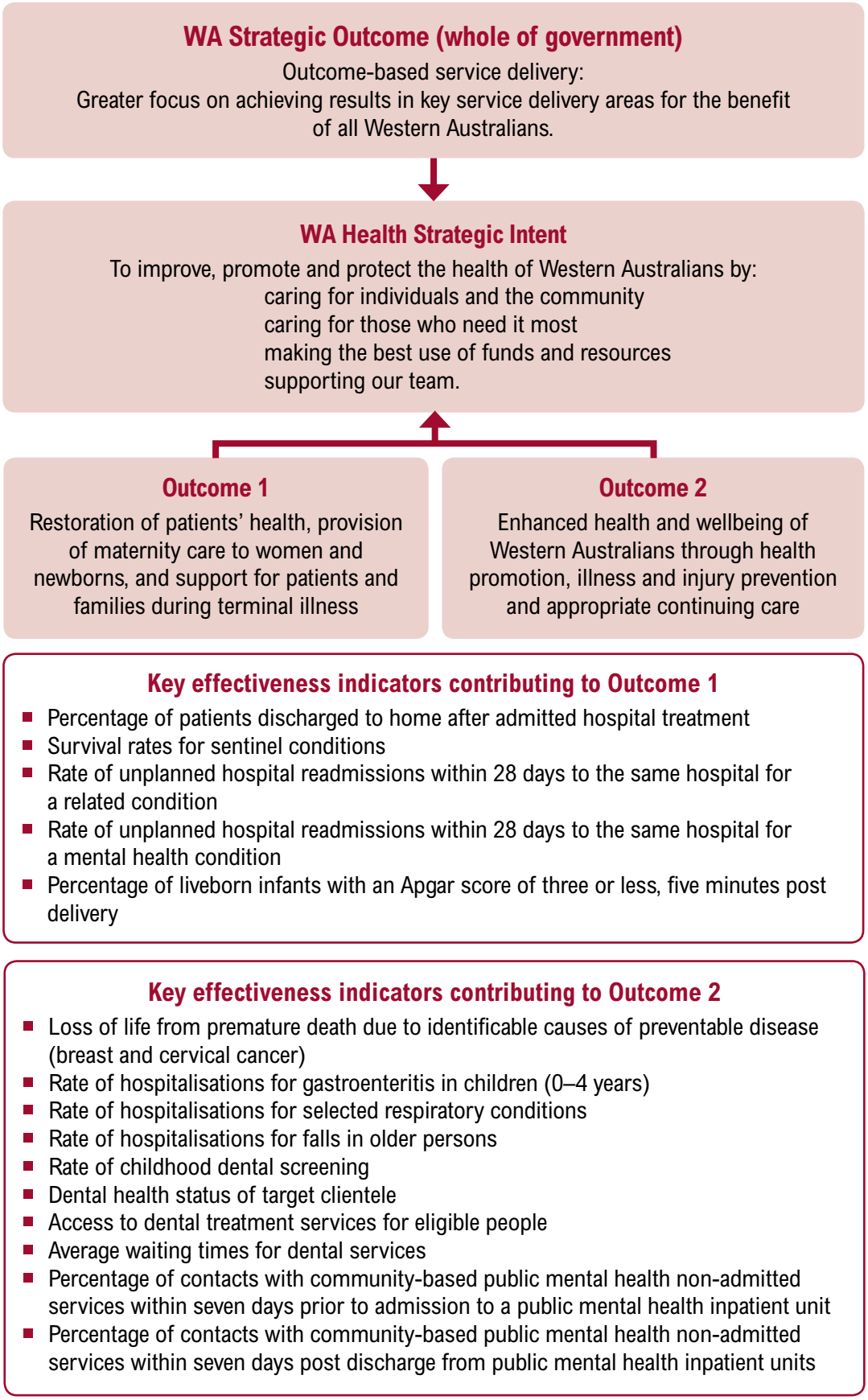


Figure 6: **Services delivered to achieve WA Health outcomes and key efficiency indicators for the Metropolitan Health Service**

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 well-being 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 doctor attended episode in an outpatient clinic for Metropolitan Health Service hospitals
- Average cost per non-admitted hospital based occasion of service for rural hospitals
- 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

Agency Performance

Financial

The total cost of providing health services to WA in 2013–14 was $7.4 billion. Results for 2013–14 against agreed financial targets (based on Budget statements) are presented in Table 4.

Full details of the Metropolitan Health Service's financial performance during 2013–14 are provided in the Financial statements.

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

Financial	2013–14 Target $'000	2013–14 Actual $'000	Variation $ +/–
Total cost of service	7,562,797	7,424,416	-138,381
Net cost of service	4,531,942	4,373,407	-158,535
Total equity	8,423,348	8,766,188	342,840
Net increase/decrease in cash held	(16,474)	110,780	127,254
Approved full time equivalent staff level	4,191,586	4,243,667	52,081

Note: 2013–14 targets are specified in the 2013–14 Budget Statements.
Data source/s: 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 2013–14 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	2013–14 Target	2013–14 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%	98.0%	0.1
Survival rates for sentinel conditions: Stroke, by age group:			
0–49 years	≥95.3%	93.3%	2.0
50–59 years	≥94.1%	91.2%	2.9
60–69 years	≥92.5%	91.6%	0.9
70–79 years	≥89.0%	90.8%	1.8
80+ years	≥81.5%	81.7%	0.2
Acute Myocardial Infarction (AMI), by age group:			
0–49 years	≥99.5%	99.0%	0.5
50–59 years	≥99.2%	98.9%	0.3
60–69 years	≥98.4%	96.8%	1.6
70–79 years	≥96.0%	96.0%	0.0
80+ years	≥91.1%	92.7%	1.6
Fractured neck or femur (FNOF), by age group:			
70–79 years	≥98.3%	98.8%	0.5
80+ years	≥96.2%	96.0%	0.2
Rate of unplanned hospital readmissions within 28 days to the same hospital for a related condition	≤2.0%	3.5%	1.5
Rate of unplanned hospital readmissions within 28 days to the same hospital for a mental health condition	≤4.9%	6.6%	1.7
Percentage of live births with an Apgar score of three or less five minutes post-delivery, by birth weight:			
0–1499 grams	3.7%	4.9%	1.2
1500–1999 grams	0.3%	0.8%	0.5
2000–2499 grams	0.2%	0.5%	0.3
2500+ grams	0.1%	0.1%	0.0
Key efficiency indicators:			
Average cost per casemix adjusted separation for tertiary hospitals	$6,284	$6,769	$485
Average cost per casemix adjusted separation for non-tertiary hospitals	$4,778	$5,551	$773
Average cost of public admitted patient treatment episodes in private hospitals	N/A	$4,707	N/A
Average cost per bed-day for admitted patients (small hospitals)	$1,811	$1,553	$258
Average cost per home based hospital patient day	$211	$289	$78

Key performance indicators	2013–14 Target	2013–14 Actual	Variation
Average cost per client receiving contracted palliative care services	N/A	$1,359	N/A
Average cost per emergency department attendance	$628	$614	$14
Average cost per doctor attended episode in an outpatient clinic for Metropolitan Health Service hospitals	$618	$591	$27
Average cost per non-admitted occasion of service for Metropolitan Health Service hospitals	$141	$325	$184
Average cost per non-admitted hospital based occasion of service for rural hospitals	$162	$558	$396
Average cost per trip of Patient Assisted Travel Scheme	$57	$23	$34
Outcome 2: Enhanced health and wellbeing of Western Australians through 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			
Breast cancer	2.4	2.1	0.3
Cervical cancer	0.3	0.6	0.3
Rate of hospitalisations for gastroenteritis in children (0-4 years)	≤3.8	3.8	0.0
Rate of hospitalisation for selected respiratory conditions			
Asthma, by age group:			
0–4 years	≤3.1	3.6	0.5
5–12 years	≤1.8	2.7	0.9
13–18 years	≤0.2	0.7	0.5
19–34 years	≤0.4	0.5	0.1
35+ years	≤0.6	0.7	0.1
Acute Bronchitis (0-4 years of age)	≤0.1	0.1	0.0
Bronchiolitis (0-4 years of age)	≤7.0	9.3	2.3
Croup (0-4 years of age)	≤1.6	2.2	0.6
Rate of hospitalisation for falls in older persons	0.5% reduction per annum	30.2	-0.4
Rate of childhood dental screening			
(a) Percentage of eligible school children who are enrolled in the School Dental Service program			
• Pre-primary program	≥72%	84.6%	12.6
• Primary program	≥79%	73.0%	6.0
• Secondary program	≥72%	87.5%	15.5
(b) Percentage of school children who are free of dental caries	≥65%	66.3%	1.3

Key performance indicators	2013–14 Target	2013–14 Actual	Variation
Dental health status of target clientele (a) Average number of DMFT for school children (age 12 years) (b) Average number of DMFT for adults	 0.90–1.5 N/A	 0.65 10.3	 N/A N/A
Access to dental treatment services for eligible people (a) People who accessed Dental Health Services (b) People who completed dental treatment • Emergency • Non-Emergency	 >17% 50% 50%	 16% 39% 61%	 1.0 11 11
Average waiting times for dental services	<14 months	13 months	1 month
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	70%	51.5%	18.5
Percentage of contacts with community-based public mental health non-admitted services within seven days post discharge from public mental health inpatient units	75%	56.1%	18.9
Key efficiency indicators:			
Average cost per capita of Population Health Units	$77	$94	$17
Average cost per breast screening	$145	$158	$13
Average cost of service for school dental service	$134	$135	$1
Average cost of completed courses of adult dental care	$376	$341	$35
Average cost per bed-day in specialised mental health inpatient units	$1,051	$1,575	$524
Average cost per three month period of care for community mental health	$2,413	$2,083	$330

Note: Actual results to target for the following key performance indicators are reported as per total population in the summary table above. Aboriginal and non-Aboriginal population results are provided in the Disclosure and Compliance section of this report.

1. Rate of hospitalisations for gastroenteritis in children (0–4 years)
2. Rate of hospitalisation for selected respiratory conditions
3. Rate of hospitalisation for falls in older persons.

Performance towards the National Health Partnership Agreement targets

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

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 focuses on two areas. Under NEST Part 1 of the national agreement, WA has a target to increase the percentage of elective surgery admissions for all urgency categories. Under NEST Part 2 of the national agreement, WA has 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 are:

- 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 is required to progressively increase the number of elective surgeries performed within the clinically recommended time by 2016.

From 2010 to 2013, for categories 1, 2 and 3, the number of patients treated within clinically recommended times has gradually increased by approximately 9.7 per cent, 12.9 per cent and 0.5 per cent respectively (see Table 6).

From 1 January to 31 December 2013, 95.9 per cent of urgency category 1 patients were admitted within 30 days, just below the set target of 100 per cent, and 97.7 per cent of urgency category 3 patients were admitted within the recommended 365 days, also just below the set target of 98.0 per cent. For urgency category 2 patients, 89.4 per cent were admitted within the recommended 90 days, which is above the set target of 88.0 percent (see Table 6).

WA Health is performing above baseline for all urgency categories and above the 2013 target for urgency category 2.

Table 6: **Percentage of WA patients admitted within the clinically recommended time, by category, 2010–2013**

		2010 Baseline (%)	2011 (%)	2012 (%)	2013 (%)
Category 1	Performance	87.4	86.6	86.3	**95.9**
	Target	–	87.4	94.0	**100.0**
Category 2	Performance	79.2	83.5	82.0	**89.4**
	Target	–	79.2	84.0	**88.0**
Category 3	Performance	97.2	96.3	96.4	**97.7**
	Target	–	97.2	98.0	**98.0**

Note: Data extraction occurred on the 3 June 2014.
Data source/s: 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 2013 shows that WA's overall performance did not meet the 2013 targets for each urgency category. However, WA's performance has exceeded the baseline for all categories (see Table 7).

Table 7: **Average overdue wait time (in days) for WA patients who have waited beyond clinically recommend times, by category, 2010–2013**

		31 Dec 2010 (baseline)	31 Dec 2011	31 Dec 2012	31 Dec 2013
Category 1	Performance	27	27.3	12.1	**12.9**
	Target	–	27	0	**0**
Category 2	Performance	90	77.4	54.2	**55.0**
	Target	–	90	68	**45**
Category 3	Performance	87	69.3	66.9	**75.8**
	Target	–	87	65	**44**

Notes:
1. Data extraction occurred on the 3 June 2014.
2. As part of the National agreement, this measure is assessed at the 31 December as a point in time measure.

Data source/s: Wait List Data Collection, Inpatient Data Collections.

WA Health aims to ensure that patients who had waited beyond the clinically recommended time (long waits) will have received surgery, or have appropriate alternative treatment options identified. As at June 2013 for all categories, long wait overdue patients were found to have either had surgery or received appropriate alternative treatment within the first quarter of 2013 (see Table 8).

Table 8: **The number of overdue long wait patients as at 31 December 2012 remaining on elective surgery wait lists at 31 December 2013**

Period	Category 1	Category 2	Category 3
31 Dec 12	7	49	27
31 Mar 13	0	6	9
30 Jun 13	0	0	0
30 Sep 13	0	0	0
31 Dec 13	**0**	**0**	**0**

Data source/s: Wait List Data Collection, Inpatient Data Collections.

National Emergency Access Target (NEAT)

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

Between 2012 and 2015 all States and Territories are striving to meet progressive annual interim targets with the aim to ensure that patients presenting to a public hospital emergency department will be admitted, transferred or discharged within four hours. By 2015, WA Health aims to ensure that 90 per cent of patients presenting to a public hospital emergency department will be admitted, transferred or discharged within four hours.

NEAT performance is calculated as an average of all participating hospitals over the calendar year. In the Metropolitan Health Service, the participating hospitals include all tertiary hospitals (Fremantle Hospital, King Edward Memorial Hospital, Princess Margaret Hospital, Royal Perth Hospital and Sir Charles Gairdner Hospital) as well as general hospitals (Armadale-Kelmscott Memorial Hospital, Rockingham General Hospital, Swan District Hospital, Joondalup Health Campus and Peel Health Campus).

Results for Metropolitan Health Service compared to the State result and National targets are presented in Table 9. In 2013, 75.1 per cent of patients presenting to a Metropolitan Health Service emergency department were admitted, transferred or discharged within four hours. This is slightly below the 2013 State average and National target of 77.6 per cent and 81.0 per cent respectively, but above the baseline.

Table 9: **Percentage of emergency department presentations at Metropolitan Health Service hospitals with a length of stay of 4 hours or less, 2010–2013**

Year	MHS (%)	State (%)	Target (%)
2010	70.0	74.0	n/a
2011	76.9	79.3	71.3 (baseline)
2012	75.7	78.3	76.0
2013	**75.1**	**77.6**	**81.0**

Data source/s: 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 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.

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 recommended for prioritising those who present to an emergency department. A patient is allocated a triage code between 1 (most severe) and 5 (least severe) that indicates their treatment acuity. Treatment should commence within the recommended time of the triage category allocated (see Table 10).

Table 10: **Triage category, treatment acuity and WA performance targets**

Triage Category	Description	Treatment Acuity	Performance Indicator Threshold
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 2013–14, 93.0 per cent of all patients attending a metropolitan emergency department who were assigned as triage 5, were seen within the clinically recommended times. Triage category 2 patients were also seen within recommended times at 85.0 per cent; above the target of 80 per cent (see Table 11).

In 2013–14 the Australasian College for Emergency Medicine targets for patients categorised as triage 1, 3 and 4 were not met (see Table 11). While consistent with previous years' performance, significant increases have been made since 2012–13 in patients being seen within recommended times for category 3 and 4.

While it is indicated that Australasian College for Emergency Medicine targets are not being achieved for triage categories 1, 3 and 4, it is important to note that the targets are based on commencement of care by a nurse, mental health practitioner or other health professional. In WA, performance is calculated based on being seen by a doctor only, and as such does not align with the Australasian College for Emergency Medicine target definition.

It is also common practice in WA to see patients in triage categories 3, 4, and 5 according to time of arrival rather than triage category. This practice developed during implementation of the Four Hour Rule program so that lower triage category patients did not keep moving down the priority list, and therefore not get seen for long periods of time. As a consequence it is more difficult to be compliant with patients triaged as category 3, 4 or 5.

Table 11: **Percentage of emergency department patients seen within recommended times, by triage category, 2009–10 to 2013–14**

Triage Category	2009–10 (%)	2010–11 (%)	2011–12 (%)	2012–13 (%)	2013–14 (%)	Performance Indicator Threshold
1	98.8	98.8	97.3	99.5	**99.6**	**100%**
2	68.6	69.9	73.6	78.1	**85.0**	**≥80%**
3	48.4	43.2	44.1	42.4	**52.4**	**≥75%**
4	58.4	57.5	61.5	58.8	**66.9**	**≥70%**
5	88.8	85.6	92.1	89.7	**93.0**	**≥70%**

Data source/s: 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 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 from the initial 65 per cent to the current 85 per cent.

Between 2009–10 and 2013–14 there has been steady improvement in the percentage of patients transferred to an inpatient ward within 8 hours of arrival to an emergency department (see Table 12).

Table 12: **Percentage of admitted patients transferred to an inpatient ward within 8 hours of emergency department arrival, 2009–10 to 2013–14**

	2009–10 (%)	2010–11 (%)	2011–12 (%)	2012–13 (%)	2013–14 (%)
Percentage of patients transferred within 8 hours	71.1	81.9	86.9	84.5	**86.4**
Target	65	65	75	80	**85.0**

Data source/s: 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 for the Older Person in Western Australia[2], 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. 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 2013, the rate of persons aged 80 years and older who attended a metropolitan emergency department was 92.4 per 1,000 persons (see Table 13). The rate of emergency department attendances for falls for persons aged 55 to 79 was consistent with prior years.

Table 13: **Rate of emergency attendances for falls per 1,000 by age group, 2009–2013**

Age Group (Years)	2009	2010	2011	2012	2013
55–64	13.0	14.1	14.3	13.8	**14.0**
65–79	25.6	26.5	26.7	26.1	**26.0**
80+	97.1	99.7	99.3	96.5	**92.4**

Notes:
1. While the results for this KPI are based on patient's residential code, it does not equate that the patient will have been admitted to an emergency department in which they reside.
2. Refer to the Key Performance Indicator section of this report for information on the 'Rate of hospitalisations for falls per 1,000 by age group, 2009 to 2012'.

Data source/s: Emergency Department Data Collection.

[2] http://www.healthnetworks.health.wa.gov.au/modelsofcare/docs/Falls_Model_of_Care.pdf

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Significant Issues

WA Health continually strives to improve its performance and align its efforts to the four key pillars of the *WA Health Strategic Intent 2010–15*:

- caring for individuals and the community
- caring for those who need it most
- making the best use of funds and resources
- supporting our team.

In alliance with these key pillars, WA Health has continued to deliver health system reform through a broad range of mechanisms in a rapidly changing environment. This has occurred while managing the challenges of current and emerging issues affecting WA Health's operations. The population growth and its geographical dispersion across WA presents a challenge in ensuring the health needs and expectations of the public are met. With the changing demography and disease patterns, a diverse range of programs and initiatives are required. In turn, this impacts upon health service planning decisions for the future while managing reform and costs efficiently.

North Metropolitan Health Service

Demand and activity

The population of the North Metropolitan Health Service is growing and becoming more culturally diverse. There has also been an increased need for maternity care at some sites, as well as cancer services.

With the population growth and proportionate demand for hospital and community care, this has had implications for the delivery of services, and the need to plan accordingly for future complex medical, pathology and health service needs.

Maternity and obstetric care services remain a priority for the North Metropolitan Health Service. King Edward Memorial Hospital, the State's only dedicated public maternity hospital, continues to focus on meeting the needs of women with complex cases and medical risk factors requiring specialist care.

Maternity care services at Swan Districts Hospital have experienced an increase in women seeking locally accessible services. To support demand for services closer to home, the construction of new birthing suites at Osborne Park Hospital is under way.

Demand for treatment at emergency departments across the north-eastern suburbs of the metropolitan area continues to increase. Most notably there has been a rise in the throughput of patients at Swan Districts Hospital and Joondalup Health Campus Emergency Departments.

Progress has been made in the implementation of clinical reform processes at Swan District Hospital to meet the growing volume of patients through the Emergency Department and Obstetric Care Services. This has resulted in improved performance in meeting patient needs.

In order to meet the multifaceted medical and surgical needs of patients, updated and enhanced pathology services were identified by the North Metropolitan Health Service as essential. Consequently, the opening of new pathology laboratories at Queen Elizabeth II Medical Centre, and approval of funding for replacement of the Laboratory Information System was welcomed.

The needs of mental health patients, for both inpatients and also for those in the community, continue to be priority, with a focus on addressing the needs of vulnerable populations. In response, youth mental health programs and the Metropolitan Specialist Aboriginal Mental Health Service have been implemented.

Following the successful implementation of the mental health Hospital in the Home program at Sir Charles Gairdner Hospital, the Graylands Hospital in the Home service for eligible mental health patients has commenced at Graylands Campus. General practitioner care services have also been implemented at Graylands Campus for inpatients.

An increase in patients with cancer presenting to the North Metropolitan Health Service has increased demand for treatment. There is also a requirement for the delivery of care to be provided in more appropriate clinical settings. For example, to support young people with cancer the You Can Centre was opened at Sir Charles Gairdner Hospital to provide treatment and support in a non-clinical environment. The Cyberknife, a specialised cancer treatment that is not available elsewhere in Australia, has also recently opened to meet WA and interstate patient demand.

Workforce challenges

There are significant workforce issues and challenges facing the North Metropolitan Health Service with the reconfiguration of services associated with the soon to be opened Fiona Stanley Hospital, the Perth Children's Hospital, and the Midland Public Hospital. Workforce issues associated with the transition, recruitment and retention of staff are being carefully managed to continue to provide safe, accessible and timely health care for patients.

With the imminent closure of the Swan District Hospital and the opening of the new Midland Public Hospital to be operated by St John of God Health Care, the North Metropolitan Health Service has implemented strategies to address the issues associated with the decommissioning and transition process. A key challenge for existing employees at Swan District Hospital has been maintaining clinical service continuity due to the inability of staff to be offered permanent or long term fixed contracts. To manage and support staff, the Swan-Kalamunda Health Service Transition and Decommissioning Project has been implemented to identify staff intentions post closure, assist with informed employment choices and offer assistance with placement, and up skilling, if required.

Managing funding reform and cost efficiencies

The North Metropolitan Health Service continues to implement the National Activity Based Funding/Activity Based Management (ABF/M) reforms and cost efficiencies across all service streams to deliver safe, high quality care at an affordable level.

All North Metropolitan Health Service sites are reconfiguring their workforce and resources to address clinical areas of demand, and model evidence-based clinical services under the funding reforms.

In 2013–14, the ABF/M program commenced at Sir Charles Gairdner Hospital and Osborne Park Hospital, focusing on five work streams:

- allied health
- length of stay
- nursing
- administration and clerical
- coding.

Health inequalities

The North Metropolitan Health Service seeks to support the most vulnerable and at risk groups of the population. These include:

- service provision for rural and remote and Aboriginal people
- effective prevention and management of chronic health conditions
- ease of access to clinically integrated health care across government and non-government services for consumers, particularly Aboriginal people
- attracting and retaining suitable pathology staff in remote and rural locations
- caring for adolescents and young adults with cancer in age appropriate treatment areas
- providing integrated health care services for inpatient and community mental health consumers.

North Metropolitan Health Statewide services, including BreastScreen WA and PathWest, have increased access to their services by:

- expanding mobile breast screening services for women in remote and disadvantaged communities
- increasing pathology hours of service at Rockingham and Geraldton laboratories.

Managing chronic health conditions is being addressed through a partnership arrangement with Medicare Local services, specifically targeting Aboriginal people and people with mental health issues. Also, through a partnership association, a general practice at Graylands Hospital has been developed to support the general health care needs of mental health inpatients.

The North Metropolitan Health Service has recently opened the You Can Centre, the first of its kind in Australia for young people aged 15–25 years receiving treatment for cancer. The unique space has been designed to reflect young people's preferences and attitudes, allowing the social aspect of life to be maintained while undergoing treatment.

South Metropolitan Health Service

Demand and activity

Similar to North Metropolitan Health Service, the population of the South Metropolitan Health Service is culturally diverse and growing. Some health districts are growing more rapidly than others and tend to have a higher prevalence of people of lower socio-economic status. Other more established areas have a high proportion of residents aged 65 years and over. With an increasing and ageing population, people suffering from chronic health conditions and lifestyle-related health issues are also becoming more prevalent.

There has also been a proportionate demand for emergency, elective surgery, and outpatient services in the south metropolitan area. Mental health activity has also increased with a rise in emergency attendances, and accordingly the need to provide inpatient and community services.

In the context of managing budget reform, service planning needs to reflect these demographic changes with a focus on patient health outcomes. This requires appropriate population-based prevention services, a strong primary health care system that includes community and ambulatory care, and a streamlined hospital system. A range of strategies and initiatives are underway.

An unprecedented level of clinical service reforms and infrastructure development is in progress. Preparations for the opening of Fiona Stanley Hospital are now well advanced and a staged opening will commence from October 2014. The provision of care closer to home will be possible through the expansion of Rockingham General Hospital and Armadale Kelmscott Memorial Hospital through to 2020. Following the successful implementation of the community rehabilitation services based at Armadale Health Service, this service is being rolled out across the south metropolitan health area. This service works closely with other programs supporting people in the community, including Rehabilitation in the Home, Aged Care Assessment Teams, and Complex Needs Coordination Teams.

Through the South Metropolitan Health Service Public Health Unit, a range of communicable disease control services, health promotion, and Aboriginal health programs have been delivered in 2013–14. Success of such programs is highlighted in the increase in number of Aboriginal clients attending diabetes and podiatry services and Aboriginal women enrolled in the Maternity Group Practice program.

Despite necessary changes, the focus remains on the provision of a patient focused, accessible and safe service. Safety and quality are key tenets of health service delivery, and this includes ensuring input from consumers to provide advice and feedback on health services. This has included regular meetings with the Aboriginal community to support the implementation of local programs, including diabetes and maternity care.

The South Metropolitan Health Service continues to undertake research with the view to improve policies, practices and health outcomes. This has included the identification of Aboriginal health priorities and service gaps, and the implementation of culturally secure, accessible and relevant health services. Similar planning is also occurring with respect to the development of a coordinated mental health plan to address service needs and gaps.

Workforce challenges

There are significant issues and challenges associated with the necessary reconfiguration of the workforce and services across the South Metropolitan Health Service to commission Fiona Stanley Hospital. Crucial to this process is ensuring that the South Metropolitan Health Service workforce profile post reconfiguration is sustainable within the new ABF/M model.

Workforce issues associated with transitioning, recruiting and retaining staff have been carefully managed to ensure continued access to quality and timely health services for consumers. Key to this has been achieving:

- medical accreditation for Fiona Stanley Hospital and maintaining accreditation status at other south metropolitan health services
- targeted recruitment to address workforce gaps
- maintaining a strong focus on supporting staff through the change process.

There are a number of challenges associated with aligning the South Metropolitan Health Service workforce to a reconfigured service footprint. During 2013–14, the South Metropolitan Health Service implemented a comprehensive range of strategies to address the issues associated with the transition, recruitment of staff and accreditation process for medical staff.

In addition to the considerable volume of work associated with transition and recruitment, specialist information technology systems have been required to support the process. Careful planning has been required to ensure effective communication and engagement.

Preparedness for the transition of staff has been assisted by targeted engagement with employees affected by the South Metropolitan Health Service reconfiguration. Employees were notified in writing, invited to attend engagement forums and to complete a Preference Registration Form indicating their preferred work location. This process has been supported by a comprehensive Staff Communication Plan aimed at providing effective and timely communications to staff about workforce matters, including regular newsletters, bulletins and commissioning updates.

A total of 45 area-wide recruitment pools targeted high priority nursing, medical, allied health, and health science roles. An additional 10 recruitment pools were used to backfill non-clinical positions. In collaboration with Central TAFE, the Assistant-in-Nursing education program was implemented as a targeted retention strategy to up-skill existing patient support staff for future nursing assistant opportunities, particularly at Fiona Stanley Hospital.

Workforce profiles have been developed in line with ABF/M constraints, however, specific transition and recruitment workforce profiles have been difficult to define. It has also been difficult to predict the number of displaced non-clinical staff who will move to Fiona Stanley Hospital under contract with Serco.

To determine future workforce requirements for the South Metropolitan Health Service, the Affordable Workforce Costing Program is being undertaken. This includes development of a specialised workforce provisioning tool, guidelines, checklists and training, to support workforce provisioning for the Royal Perth Hospital Group and Fremantle Hospital and Health Service.

There has been significant engagement with the Postgraduate Medical Council of WA and the Learned Medical Colleges to facilitate pre-vocational and vocational accreditation processes. A provisional accreditation process has been implemented at Fiona Stanley Hospital, and reconfigured South Metropolitan Health Service sites will undertake postgraduate medical re-accreditation processes in the near future.

Managing funding reform and cost efficiencies

A number of funding reform issues are affecting service delivery within the South Metropolitan Health Service. Of significance are the challenges posed by the reconfiguration and transitioning of services across the south metropolitan area coinciding with the phased opening of Fiona Stanley Hospital, and planning for the full rollout of ABF/M across WA Health.

On an area wide-basis, the South Metropolitan Health Service Fiscal Action Plan has guided funding reform activities and initiatives with a strong focus on integrating service planning, workforce and funding models. This includes consideration of bed numbers, purchased activity, outpatient activity and a costed workforce across the existing and the reconfigured footprint.

In the context of this significant funding reform and reconfiguration of services, the provision of timely, safe and high quality services to consumers continues to underpin all South Metropolitan Health Service activity. This includes a focus on providing care closer to home and improving patient access to timely emergency services and elective surgery under the National Partnership Agreement on Improving Public Health Services. This involves improving performance against the National Elective Surgery Targets and National Emergency Assessment Targets. In 2013–14 patient flow and timely access to emergency services and elective surgery has improved. Specific strategies associated with these improvements included:

- improved planning of theatre schedules
- a focus on clinical service redesign to improve patient flow.

In an ABF/M environment, there is a need for greater ground level, devolved accountability for managing demand, funding reform and costs efficiently across all service streams. The South Metropolitan Health Service has a strong focus on clinical practice improvement and on implementing standardised evidence-based clinical practice standards. This includes implementation of initiatives to reduce adverse events, average length of stay and associated health care costs.

To further improve efficiencies, real time access to budget and activity information has assisted decision-making and managing activity within an efficient cost. To support this process a range of initiatives were implemented in 2013–14 including education of key leadership teams, and the reporting of activity against performance targets.

Health inequalities

The South Metropolitan Health Service has a strong focus on improving health outcomes for the most vulnerable and at risk groups of the population, including Aboriginal people and people with mental health issues.

A number of programs have been developed for Aboriginal people living in the south metropolitan area, targeting antenatal care, childhood immunisation, chronic disease, and improved access to mainstream services. Program achievements in 2013–14 included:

- increased numbers of enrolments of Aboriginal women in the Aboriginal Maternity Group Practice antenatal program
- liaison with Child and Adolescent Community Health and Medicare Locals to develop strategies to improve Aboriginal childhood immunisation
- effective delivery of mobile community outreach chronic disease assessment, diabetes education and podiatry service.

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

- ongoing work in implementing the recommendations from the *Stokes Review (2012)*[2]
- partnering with Medicare Locals in the planning and delivery of the Partners in Recovery program that supports people with severe, persistent mental illness with unmet needs
- greater involvement of consumers and carers in service planning, delivery and care, teaching and training, and in the recruitment of staff.

Child and Adolescent Health Service

Demand and activity

The Child and Adolescent Health Service experienced an increase in the assessment and treatment needs of children with social and developmental issues, particularly due to the growth and cultural diversity of the population. This has implications for the delivery of services, and the need to plan accordingly for the future treatment needs of children and adolescents in WA.

Consistent with the growth in population, Princess Margaret Hospital has experienced a proportionate demand for emergency, inpatient, and outpatient services. Over the next six years admissions are projected to increase annually by approximately 5 per cent. Referrals to child and adolescent community health services have also increased.

[2] Stokes B. (2012). Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia.

Princess Margaret Hospital experiences challenges in meeting emergency care needs and for patients requiring elective surgery. Outpatient room facilities at Princess Margaret Hospital are at capacity, limiting the ability to meet increasing demand for outpatient services resulting in increased wait times for patients.

The Perth Children's Hospital, being built on the QEII Medical Centre site in Nedlands, will replace Princess Margaret Hospital as the State's dedicated children's hospital. The new hospital is expected to partly address increasing patient demand due to an increase in inpatient bed availability, and a greater capacity to enable throughput of presentations to the emergency department. A new short-stay surgical unit will increase bed numbers and will support the process of addressing elective surgery wait times.

Strategies to address the current patient demand for services at Princess Margaret Hospital include:

- expanding emergency surgery services to improve patient throughput after-hours
- fortnightly review of elective surgery waitlist numbers
- collaboration with community organisations to establish several outreach outpatient clinics to deliver care to patients closer to home
- development of a paediatric implementation plan to reduce the demand for secondary services by redirecting activity to general hospital paediatric units.

The Child and Adolescent Health Service is experiencing extended wait times for patients requiring community-based care. This situation is challenged by insufficient funding and staffing resources. To address this situation, a financial analysis has been conducted to determine the impact of the lack of growth in funding on Child and Adolescent Community Health Service base activities.

Further initiatives in 2013–14 have been achieved including:

- recruitment of an estimated 46 new child health nurses
- three contracts being awarded to non–government organisations to deliver child health services in key locations in metropolitan Perth
- budget allocation of 20 school health nurses for 2013–14 allocated to primary schools to assist with school health entry assessments
- ongoing recruitment of 110 school health nurses to be achieved by 2016–17.

Limited additional funding to support the Child Adolescent Mental Health Service has required innovative steps to ensure client needs are met. These include the implementation of the Choice and Partnership Approach that uses a pioneering referral intake process aimed at empowering children and their families to make decisions about their therapeutic journey. A Child and Adolescent Network has also been established. This virtual network allows children and young people to give views, feedback and advice to the Child Adolescent Mental Health Service.

The Child Development Service provides a range of services for children with, or at risk of, developmental difficulties. Referrals for this service are up by 18 per cent since 2010.
In 2013–14 the Child Development Service implemented service reform projects to support the sustainability of the service in the face of increasing patient need. One key reform is the introduction of clinical information workshops that are available to parents shortly after referral to a centre. Also, the introduction of an electronic child health record has enabled streamlined referral pathways and information sharing between child and school health nurses and the Child Development Service.

Workforce challenges

Significant challenges have occurred with delivery of the Perth Children's Hospital transition program due to delays with the release of project funding. This created challenges in the recruitment to key positions required to achieve business case deliverables. It has also delayed implementation of the Children's Hospital Organisational Change and Readiness Program initiated to support the transition process from Princess Margaret Hospital to the Perth Children's Hospital.

Despite the anticipated staff shortages at Perth Children's Hospital, including experienced managers with project expertise, a substantial number of national and international staff with significant project experience have been recruited.

To address demand at Princess Margaret Hospital for emergency and surgical treatment and the need for community care services, the Child and Adolescent Health Service has undertaken a review of its recruitment, selection and appointment practices. Implementation of an Aboriginal Workforce Plan has also commenced. Budget was also allocated for additional school health nurses, which has resulted in better support for some primary schools.

Managing funding reform and cost efficiencies

The Child and Adolescent Health Service is undergoing the transition toward ABF/M arrangements to be completed by 2017–18. The need to address funding for services not recognised at the national level, while addressing wage escalations and leave liability growth, is currently under consideration as part of funding reforms.

Maintaining safe and high quality services for patients is paramount, and strategies to improve service delivery are continuously being implemented. Benchmarking the average length of stay of patients with peer paediatric hospitals throughout Australia is an example of monitoring timely service provision.

Health inequalities

The Child and Adolescent Health Service is focusing on the service needs of disadvantaged and underserviced populations that include Aboriginal people, remote and regional families, and recent refugees to WA.

Current initiatives have included:

- commencement of the implementation of a Child and Adolescent Health Service Aboriginal Workforce Plan
- appointment of a Director of Aboriginal Health to lead improvements in health services for Aboriginal children
- implementation of the Aboriginal Ambulatory Care Coordination Program to improve care coordination for Aboriginal children
- provision of a comprehensive health care service to refugee children
- provision of Telehealth services to improve access for remote and regional families.

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Disclosure and Compliance

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 2014, the Statement of Comprehensive Income, Statement of Changes in Equity and Statement of Cash Flows for the year then ended, and Notes comprising a summary of significant accounting policies and other explanatory information.

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

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

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the 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.

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 2014 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.

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 2014.

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.

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

Auditor's Responsibility
As required by the Auditor General Act 2006, my responsibility is to express an opinion on the controls exercised by The 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 qualified audit opinion.

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 2014.

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 2014.

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

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

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

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

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

Opinion
In my opinion, 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 2014.

Matters of Significance
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 time indicators has not been finalised for the year ended 30 June 2014. Consequently, the "Elective Surgery Waiting Times" KPI has not been included in the audited KPIs for the year ended 30 June 2014.

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 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 for falls per 1,000 by age group

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 2014. Consequently, the three KPIs have not been included in the audited KPIs for the year ended 30 June 2014. My opinion is not modified in respect of these matters.

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

Matters Relating to the Electronic Publication of the Audited Financial Statements and Key Performance Indicators
This auditor's report relates to the financial statements and key performance indicators of The Minister for Health in his Capacity as the Deemed Board of the Metropolitan Public Hospitals for the year ended 30 June 2014 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
22 September 2014

Certification Statement

METROPOLITAN HEALTH SERVICE

CERTIFICATION OF FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2014

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 2014 and financial position as at 30 June 2014.

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.

Graeme Jones
CHIEF FINANCE OFFICER
DEPARTMENT OF HEALTH

Date: 16 September 2014

Professor Bryant Stokes
ACTING DIRECTOR GENERAL
DEPARTMENT OF HEALTH
ACCOUNTABLE AUTHORITY

Date: 16 September 2014

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 2014

	Note	2014 $000	2013 $000	
COST OF SERVICES				
Expenses				
Employee benefits expense	8	3,275,697	3,084,340	
Fees for visiting medical practitioners		61,255	55,779	
Patient support costs	9	936,844	679,463	(a)
Finance costs	10	11,703	4,507	
Depreciation and amortisation expense	11	159,394	154,314	
Loss on disposal of non-current assets	12	344	1,525	
Repairs, maintenance and consumable equipment	13	104,789	112,091	(a)
Fiona Stanley Hospital set-up costs	14	74,088	46,367	
Other supplies and services	15	28,719	31,303	(a)
Other expenses	16	320,533	317,121	(a)
Total cost of services		**4,973,366**	**4,486,810**	
INCOME				
Revenue				
Patient charges	17	220,417	202,189	
Other fees for services	18	212,843	181,905	(a)
Commonwealth grants and contributions	19(i)	1,239,646	1,088,595	
Other grants and contributions	19(ii)	345,906	270,684	(a)
Donation revenue	20	4,667	5,897	
Interest revenue		397	530	
Commercial activities	21	5,243	5,396	
Other revenue	22	42,245	45,589	(a)
Total revenue		2,071,364	1,800,785	
Total income other than income from State Government		**2,071,364**	**1,800,785**	
NET COST OF SERVICES		**2,902,002**	**2,686,025**	
INCOME FROM STATE GOVERNMENT				
Service appropriations	23	2,805,851	2,406,851	
Assets transferred	24	(1,644)	13,624	
Services received free of charge	25	4,647	4,852	
Royalties for Regions Fund	26	1,276	754	
Total income from State Government		**2,810,130**	**2,426,081**	
DEFICIT FOR THE PERIOD		**(91,872)**	**(259,944)**	
OTHER COMPREHENSIVE LOSS				
Items not reclassified subsequently to profit or loss				
Changes in asset revaluation reserve	42	55,710	(21,783)	
TOTAL COMPREHENSIVE LOSS FOR THE PERIOD		**(36,162)**	**(281,727)**	

Refer also to note 59 'Schedule of Income and Expenses by Service'.
The Statement of Comprehensive Income should be read in conjunction with the accompanying notes.

(a) Restated amounts for 2013 (see note 6 'Prior year restatement').

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

Statement of Financial Position

As at 30 June 2014

	Note	2014 $000	2013 $000	
ASSETS				
Current Assets				
Cash and cash equivalents	27	82,173	75,972	
Restricted cash and cash equivalents	28	68,679	86,548	
Receivables	29	133,964	106,192	(a)
Amounts receivable for services	30	-	27,432	
Inventories	31	20,295	24,036	
Other current assets	32	33,805	35,485	
Total Current Assets		338,916	355,665	(a)
Non-Current Assets				
Amounts receivable for services	30	1,104,489	961,750	
Property, plant and equipment	33	5,643,305	4,482,092	
Intangible assets	35	265,144	217,091	
Total Non-Current Assets		7,012,938	5,660,933	
Total Assets		**7,351,854**	**6,016,598**	(a)
LIABILITIES				
Current Liabilities				
Payables	37	394,061	312,078	(a)
Borrowings	38	43,146	8,851	
Provisions	39	620,255	594,096	
Other current liabilities	40	1,538	1,326	
Total Current Liabilities		1,059,000	916,351	(a)
Non-Current Liabilities				
Borrowings	38	219,959	146,425	
Provisions	39	149,263	140,719	
Other non-current liabilities	40	340	326	
Total Non-Current Liabilities		369,562	287,470	
Total Liabilities		**1,428,562**	**1,203,821**	(a)
NET ASSETS		**5,923,292**	**4,812,777**	
EQUITY				
Contributed equity	41	5,329,077	4,182,400	
Reserves	42	1,018,269	962,559	
Accumulated deficit	43	(424,054)	(332,182)	
TOTAL EQUITY		**5,923,292**	**4,812,777**	

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

(a) Restated amounts for 2013 (see note 6 'Prior year restatement').

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 2014

	Note	2014 $000	2013 $000
CONTRIBUTED EQUITY	41		
Balance at start of period		4,182,400	3,451,973
Transactions with owners in their capacity as owners:			
Capital appropriations		662,341	734,427
Other contributions by owners		508,358	-
Distributions to owners		(24,022)	(4,000)
Balance at end of period		5,329,077	4,182,400
RESERVES	42		
Asset Revaluation Reserve			
Balance at start of period		962,559	984,342
Other Comprehensive loss for the period		55,710	(21,783)
Balance at end of period		1,018,269	962,559
ACCUMULATED DEFICIT	43		
Balance at start of period		(332,182)	(72,238)
Deficit for the period		(91,872)	(259,944)
Balance at end of period		(424,054)	(332,182)
TOTAL EQUITY			
Balance at start of period		4,812,777	4,364,077
Total comprehensive loss for the period		(36,162)	(281,727)
Transactions with owners in their capacity as owners		1,146,677	730,427
Balance at end of period		**5,923,292**	**4,812,777**

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 2014

	Note	2014 $000 Inflows (Outflows)	2013 $000 Inflows (Outflows)
CASH FLOWS FROM STATE GOVERNMENT			
Service appropriations		2,665,892	2,271,077
Capital appropriations		658,289	730,559
Holding account drawdown		23,358	-
Royalties for Regions Fund		1,276	754
Net cash provided by State Government	44	**3,348,815**	**3,002,390**
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Employee benefits		(3,225,353)	(2,975,236)
Supplies and services		(1,468,241)	(1,230,000)
Finance costs		(3,527)	-
Receipts			
Receipts from customers		215,992	199,931
Commonwealth grants and contributions		1,239,646	1,088,595
Other grants and contributions		345,906	269,648
Donations received		2,389	4,751
Interest received		397	530
GST refunds from taxation authority	2(q)	-	30,261
Other receipts		242,382	224,918
Net cash used in operating activities	44	**(2,650,410)**	**(2,386,602)**
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments			
Payment for purchase of non-current physical and intangible assets		(734,674)	(710,607)
Receipts			
Proceeds from sale of non-current physical assets	12	62	192
Net cash used in investing activities		**(734,612)**	**(710,415)**
CASH FLOWS FROM FINANCING ACTIVITIES			
Payments			
Repayment of finance lease liabilities		(8,830)	-
Net cash provided by / (used in) financing activities		**(8,830)**	**-**
Net increase / (decrease) in cash and cash equivalents		(45,037)	(94,627)
Cash and cash equivalents at the beginning of the period		162,520	257,147
Cash and cash equivalents transferred from Department of Health	41	40,867	-
Cash and cash equivalents transferred to Main Roads	41	(7,499)	-
CASH AND CASH EQUIVALENTS AT THE END OF PERIOD	44	**150,852**	**162,520**

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

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 2014

Note 1 Australian Accounting Standards

General

The Health Service's financial statements for the year ended 30 June 2014 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*'. There has been no early adoption of Australian Accounting Standards that have been issued or amended (but not operative) by the Health Service for the annual reporting period ended 30 June 2014.

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 and buildings which have been measured at fair value.

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

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

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

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

(c) Consolidation of the Annual Reports of the Metropolitan Health Services, Peel Health Service and Fiona Stanley Hospital

The Minister has approved the consolidation of the Annual Reports of the Fiona Stanley Hospital, Peel Health Service and the Metropolitan Health Services under section 24 (3) of the Hospitals and Health Service Act 1927. For several years the Peel Health Service has been operating as a business unit of the South Metropolitan Health Service, with operational reporting and accountability through the Metropolitan Health Services to the Minister.

Fiona Stanley Hospital was constituted as a separate statutory authority on 11 April 2014 under the Hospitals and Health Services (Fiona Stanley Hospital Board) Instrument 2014.

(d) 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 41 '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 2014

Note 2 Summary of significant accounting policies (continued)

(e) Income

Revenue recognition

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

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.

(f) Borrowing costs

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

(g) Property, plant and equipment

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

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

For items of property, plant and equipment acquired at no cost or for nominal cost, the cost is 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 and buildings and historical cost for all other property, plant and equipment. Land and buildings are carried at fair value less accumulated depreciation (buildings) and accumulated impairment losses. All other items of property, plant and equipment are stated at historical cost less accumulated depreciation and accumulated impairment losses.

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

In the absence of market-based evidence, fair value of land and buildings (clinical sites) is determined on the basis of existing use. This normally applies where buildings are specialised or where land use is restricted. Fair value for existing use buildings 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).

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

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

The 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 2014

Note 2 Summary of significant accounting policies (continued)

(g) Property, plant and equipment (continued)

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 33 'Property, plant and equipment' for further information on rev aluation.

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 as described in note 33 'Property, plant and equipment'.

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

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

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

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

Buildings	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, which 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.

(h) Intangible assets

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

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 treated as an intangible asset. Software costing less than $5,000 is expensed in the year of acquisition.

(i) 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 profit or loss. 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 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 2014

Note 2 Summary of significant accounting policies (continued)

(i) Impairment of assets (continued)

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

(j) 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.

(k) 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 and computer equipment and 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.

(l) Financial instruments

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

Financial instruments have been disaggregated into the following classes:

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

Financial liabilities:
* Payables
* Borrowings
* 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.

(m) Cash and cash equivalents

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

(n) Accrued salaries

Accrued salaries (see note 37 '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.

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 2014

Note 2 Summary of significant accounting policies (continued)

(o) Amounts receivable for services (holding account)

The Health Service receives income from the State Government partly in cash and partly as an asset (holding account receivable). The holding account receivable balance, resulting from service appropriation funding, 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'.

(p) 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').

(q) 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(l) '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, Peel Health Service, WA Country Health Service, WA Alcohol and Drug Authority, 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.

(r) 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(l) 'Financial instruments' and note 37 'Payables'.

(s) 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(l) 'Financial instruments' and note 38 'Borrowings'.

(t) 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 39 'Provisions'.

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 that 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.

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 2014

Note 2 Summary of significant accounting policies (continued)

(t) Provisions (continued)

Long service leave

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

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

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

Sick Leave

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

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

Deferred Salary Scheme

The provision for the deferred salary scheme relates to Health Service 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.

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(u) '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 39 'Provisions'.

(u) Superannuation expense

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

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 2014

Note 2 Summary of significant accounting policies (continued)

(v) 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.

(w) 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.

(x) Comparative figures

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

(y) 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 56).

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

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

Buildings

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

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 7.2%. 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.

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 2014

Note 4 Key sources of estimation uncertainty (continued)

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.

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 2013 that impacted on the Health Service.

Title	
AASB 13	*Fair Value Measurement* This Standard defines fair value, sets out a framework for measuring fair value and requires additional disclosures for assets and liabilities measured at fair value. There is no financial Impact.
AASB 119	*Employee Benefits* This Standard supersedes AASB 119 (October 2010), making changes to the recognition, presentation and disclosure requirements. The Health Service assessed employee leave patterns to determine whether annual leave is a short-term or other long-term employee benefit. The resultant discounting of annual leave liabilities that were previously measured at the undiscounted amounts is not material.
AASB 1048	*Interpretation of Standards* This Standard supersedes AASB 1048 (June 2012), enabling references to the Interpretations in all other Standards to be updated by reissuing the service Standard. There is no financial impact.
AASB 2011-8	*Amendments to Australian Accounting Standards* arising from AASB 13 [AASB 1, 2, 3, 4, 5, 7, 9, 2009-11, 2010-7, 101, 102, 108, 110, 116, 117, 118, 119, 120, 121, 128, 131, 132, 133, 134, 136, 138, 139, 140, 141, 1004, 1023 & 1038 and Int 2, 4, 12, 13, 14, 17, 19, 131 & 132] This Standard replaces the existing definition and fair value guidance in other Australian Accounting Standards and Interpretations as the result of issuing AASB 13 in September 2011. There is no financial impact.
AASB 2011-10	*Amendments to Australian Accounting Standards arising from AASB 119 (September 2011) [AASB 1, 8, 101, 124, 134, 1049 & 2011-8 and Int 14]* This Standard makes amendments to other Australian Accounting Standards and Interpretations as a result of issuing AASB 119 in September 2011. The resultant discounting of annual leave liabilities that were previously measured at the undiscounted amounts is not material.
AASB 2012-5	*Amendments to Australian Accounting Standards arising from Annual Improvements 2009-11 Cycle [AASB 1, 101, 116, 132 & 134 and Int 2]* This Standard makes amendments to the Australian Accounting Standards and Interpretations as a consequence of the annual improvements process. There is no financial impact.
AASB 2012-6	*Amendments to Australian Accounting Standards - Mandatory Effective Date of AASB 9 and Transition Disclosures [AASB 9, 2009-11, 2010-7, 2011-7 & 2011-8]* This Standard amends the mandatory effective date of AASB 9 Financial Instruments to 1 January 2015 (instead of 1 January 2013). Further amendments are also made to numerous consequential amendments arising from AASB 9 that will now apply from 1 January 2015. There is no financial impact.
AASB 2012-10	*Amendments to Australian Accounting Standards - Transition Guidance and Other Amendments [AASB 1, 5, 7, 8, 10, 11, 12, 13, 101, 102, 108, 112, 118, 119, 127, 128, 132, 133, 134, 137, 1023, 1038, 1039, 1049 & 2011-7 and Int 12]* This Standard introduces a number of editorial alterations and amends the mandatory application date of Standards for not-for-profit entities accounting for interests in other entities. There is no financial impact.
AASB 2013-9	*Amendments to Australian Accounting Standards - Conceptual Framework, Materiality and Financial Instruments.* Part A of this omnibus Standard, makes amendments to other Standards arising from revisions to the Australian Accounting Conceptual Framework for periods ending on or after 20 December 2013. Other Parts of this Standard become operative in later periods. There is no financial impact for Part A of the Standard.

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 2014

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

Future impact of Australian Accounting Standards not yet operative

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

Title		Operative for reporting periods beginning on/after
AASB 9	*Financial Instruments* This Standard supersedes AASB 139 Financial Instruments: Recognition and Measurement, introducing a number of changes to accounting treatments. The mandatory application date of this Standard was amended to 1 January 2017. The Health Service has not yet determined the application or the potential impact of the Standard. This Standard supersedes AASB 1031 (February 2010), removing Australian guidance on materiality that is not available in IFRSs and refers to other Australian pronouncements that contain guidance on materiality. There is no financial impact.	1 Jan 2017
AASB 1055	*Budgetary Reporting* This Standard requires specific budgetary disclosures in the financial statements of not-for-profit entities within the General Government Sector. The Health Service will be required to disclose additional budgetary information and explanations of major variances between actual and budgeted amounts, though there is no financial impact.	1 Jul 2014
AASB 2010-7	*Amendments to Australian Accounting Standards arising from AASB 9 (December 2010) [AASB 1, 3, 4, 5, 7, 101, 102, 108, 112, 118, 120, 121, 127, 128, 131, 132, 136, 137, 139, 1023 & 1038 and Int 2, 5, 10, 12, 19 & 127]* This Standard makes consequential amendments to other Australian Accounting Standards and Interpretations as a result of issuing AASB 9 in December 2010. The Health Service has not yet determined the application or the potential impact of the Standard.	1 Jan 2015
AASB 2013-3	*Amendments to AASB 136 - Recoverable Amount Disclosures for Non-Financial Assets.* This Standard introduces editorial and disclosure changes. There is no financial impact.	1 Jan 2014
AASB 2013-9	*Amendments to Australian Accounting Standards - Conceptual Framework, Materiality and Financial Instruments.* The omnibus Standard makes amendments to other Standards arising from the deletion of references to AASB 1031 in other Standards for periods beginning on or after 1 January 2014 (Part B), and, defers the application of AASB 9 to 1 January 2017 (Part C). The Health Service has not yet determined the application or the potential impact of AASB 9, otherwise there is no financial impact for Part B.	1 Jan 2014 1 Jan 2017

Note 6 Prior year restatements

(a) GST on unpaid purchases invoices

The prior year's amount for Receivables and Payables have been adjusted to include the GST amounting to $7.01 m on accrued expenses.

Information on the accounting procedure for Goods and Services Tax is provided at note 2(q).

Statement of Financial Position (Extract)	Note	2013 (Previously stated) $000	Increase / (Decrease) $000	2013 (Restated) $000
Current Assets				
Receivables				
GST receivables	29	-	7,010	7,010
Total receivables		99,182	7,010	106,192
Current Liabilities				
Payables				
Accrued expenses	37	96,273	7,010	103,283
Total payables		305,069	7,010	312,078

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 2014

Note 6 Prior year restatements (continued)

(b) Reclassification of other supplies and services

In 2014, a process was implemented to more accurately classify the purchase of outsourced service expenditure into the relevant expenditure categories for financial reporting purposes. For comparative purposes, this methodology has now been applied to the prior year balances resulting in a reclassification of expenditure categories.

		2013 (Previously stated) $000	Increase / (Decrease) $000	2013 (Restated) $000
Statement of Comprehensive Income (Extract)	**Note**			
Expenses				
Patient support costs				
Medical supplies and services	9	534,711	20,079	554,790
Total patient support costs		659,384	20,079	679,463
Repairs, maintenance and consumable equipment				
Consumable equipment	13	45,816	1,278	47,094
Total repairs, maintenance and consumable equipment		110,813	1,278	112,091
Other supplies and services				
Administration and management services	15	9,150	1,785	10,935
Other	15	37,791	(28,312)	9,479
Total other supplies and services		57,830	(26,527)	31,303
Other expenses				
Computer services	16	51,452	2,907	54,359
Other	16	22,214	2,263	24,477
Total other expenses		311,951	5,170	317,121

(c) Reclassification of other revenue

In 2014, a process was implemented to more accurately classify other revenue into the relevant revenue categories for financial reporting purposes. For comparative purposes, this methodology has now been applied to the prior year balances resulting in a reclassification of revenue categories.

Revenue				
Other fee for services	18			
Non clinical services to other health organisations		-	15,043	15,043
Pathology services to other organisations		16,123	2,505	18,628
Other		36,562	(14,083)	22,479
Total other fee for services		178,440	3,465	181,905
Other grants and contributions	19 ii)			
Other		7,192	1,036	8,228
Total other grants and contributions		269,648	1,036	270,684
Other revenue	22			
Parking		-	3,690	3,690
Research and clinical trial revenue		-	4,375	4,375
Sale of radiopharmacies		-	591	591
Revenue from training		-	539	539
Other		25,831	(13,696)	12,135
Total other revenue		50,090	(4,501)	45,589

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 2014

Note 7 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 59. 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), Rehabilitation in the Home (RITH) 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 'Friend-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. These services are provided by WA Area Health Services and contracted not-for-profit service providers.

Emergency Department
Emergency department services describe the treatment provided in metropolitan hospitals 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
Mental health services describe inpatient care in an authorised ward and community mental health services provided by Health Services under agreement with the Mental Health Commission for specialised admitted and community mental health.

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 2014

Note 8 Employee benefits expense

	2014 $000	2013 $000
Salaries and wages (a)	3,010,650	2,843,632
Superannuation - defined contribution plans (b)	265,047	240,708
	3,275,697	3,084,340

(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 payments of $4.619m ($0.202m for 2013).

(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'.

Note 9 Patient support costs

Medical supplies and services	791,693	554,790 (a)
Domestic charges	50,573	47,710
Fuel, light and power	51,220	45,079
Food supplies	26,177	23,926
Patient transport costs	8,548	6,818
Research, development and other grants	8,633	1,140
	936,844	679,463

(a) See note 6 'Prior year restatements' with respect to reclassification of 2013 expenses into more appropriate expenditure categories.

Note 10 Finance costs

Finance lease charges	10,420	2,891
Interest expense	1,283	1,616
	11,703	4,507

Note 11 Depreciation and amortisation

Depreciation		
Buildings	98,483	94,750
Leasehold improvements	1,020	996
Computer equipment	7,174	6,568
Furniture and fittings	1,686	1,255
Motor vehicles	744	1,035
Medical equipment	32,028	31,102
Other plant and equipment	7,732	4,649
	148,867	140,355
Amortisation		
Computer software	10,527	13,959
	159,394	154,314

Note 12 Loss on disposal of non-current assets

Cost of disposal of non-current assets		
Property, plant and equipment	406	1,717
Proceeds from disposal of non-current assets:		
Property, plant and equipment	(62)	(192)
Net loss	344	1,525

See note 33 'Property, plant and equipment'.

Note 13 Repairs, maintenance and consumable equipment

Repairs and maintenance	66,548	64,997
Consumable equipment	38,241	47,094 (a)
	104,789	112,091

(a) See note 6 'Prior year restatements' with respect to reclassification of 2013 expenses into more appropriate expenditure categories.

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 2014

Note 14 Fiona Stanley Hospital set-up costs

	2014 $000	2013 $000
Pre-operational costs (a)	26,133	46,367
Transitional costs (b)	47,955	-
	74,088	46,367

(a) Pre-operational activities commenced in the 2011-12 financial year to prepare for the opening of the Fiona Stanley Hospital in 2014-15. These include the development of asset procurement plans, supervision and management of asset installations, development of operational services and recruitment and training of human resources.

(b) During the 2013-14 financial year, the Hospital advanced from the pre-operational to the transitional phase which involves 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.

Note 15 Other supplies and services

Sanitisation and waste removal services	6,082	5,471
Administration and management services	12,620	10,935 (a)
Interpreter services	4,358	3,852
Security services	2,007	1,566
Other	3,652	9,479 (a)
	28,719	31,303

(a) See note 6 'Prior year restatements' with respect to reclassification of 2013 expenses into more appropriate expenditure categories.

Note 16 Other expenses

Capital grants to the Western Australian Institute of Medical Research	-	43,420
Donation of building to Telethon Diabetes Juvenile Family Centre	-	413
Communications	20,154	17,685
Computer services	86,173	54,359 (b)
Workers compensation insurance (a)	52,497	62,912
Other insurances	28,712	19,911
Other employee related expenses	14,104	15,052
Legal expenses	1,152	358
Motor vehicle expenses	4,197	4,489
Operating lease expenses	36,220	35,977
Printing and stationery	14,418	14,423
Doubtful debts expense	10,640	12,125
Write-down of assets	14,132	87
Consultancy fees	14,038	11,433
Other	24,096	24,477 (b)
	320,533	317,121

(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 39 '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 6 'Prior year restatements' with respect to reclassification of 2013 expenses into more appropriate expenditure categories.

Note 17 Patient charges

Inpatient bed charges	132,586	117,853
Inpatient other charges	16,796	15,543
Outpatient charges	26,295	23,955
Pathology services to patients	44,740	44,838
	220,417	202,189

Note 18 Other fees for services

Recoveries from the Pharmaceutical Benefits Scheme (PBS)	104,882	89,010
Clinical services to other health organisations	42,588	36,745
Non clinical services to other health organisations	17,893	15,043 (a)
Pathology services to other organisations	18,412	18,628 (a)
Other	29,068	22,479 (a)
	212,843	181,905 (a)

(a) See note 6 'Prior year restatements' with respect to reclassification of 2013 revenue amounts into more appropriate revenue categories.

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 2014

	2014 $000	2013 $000	
Note 19 Grants and contributions			
i) Commonwealth grants and contributions			
Capital Grants:			
Midland Health Campus	28,000	-	
State Rehabilitation Unit	5,700	-	
Project funded under the National Partnership Agreement (b)	15,671	(9,452)	
Project funded under the Four Hour Rule Initiative	130	1,785	
Digital mammography technology	2,164	7,536	
Clinical training equipment	2,349	4,619	
Other	1,047	-	
Recurrent Grants:			
National e-Health program	388	155	
National Health Reform Agreement (c)	1,183,775	1,082,746	
Other	422	1,206	
	1,239,646	1,088,595	
ii) Other grants and contributions			
Mental Health Commission – service delivery agreement (c)	317,615	247,039	
Mental Health Commission – other	12,385	11,066	
Disability Services Commission - community aids & equipment program	4,406	4,316	
Lotteries Commission	52	35	
Princess Margaret Hospital Foundation	2,350	-	
Other	9,098	8,228	(a)
	345,906	270,684	(a)

(a) See note 6 'Prior year restatements' with respect to reclassification of 2013 revenue amounts into more appropriate revenue categories.

(b) A net refund of $9.452 million was made in the 2012-13 financial year, as the funds received in 2011-12 were in excess of the requirements of the NPA project.

(c) 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			
General public contributions	4,667	5,897	
Note 21 Commercial activities			
Sales:			
Coffee shop sales revenue	7,009	7,105	
Car parking fees revenue	2,560	2,501	
	9,569	9,606	
Cost of sales (a)	(4,326)	(4,210)	
Gross profit	5,243	5,396	

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

Note 22 Other revenues			
Use of hospital facilities	14,798	16,151	
Rent from commercial properties	1,910	1,801	
Rent from residential properties	919	1,074	
Boarders' accommodation	1,606	1,872	
RiskCover insurance premium rebate	5,245	3,361	
Parking	3,892	3,690	(a)
Research and clinical trial revenue	3,388	4,375	(a)
Sale of radiopharmacies	815	591	(a)
Revenue from training	484	539	(a)
Other	9,188	12,135	(a)
	42,245	45,589	(a)

(a) See note 6 'Prior year restatements' with respect to reclassification of 2013 revenue amounts into more appropriate revenue categories.

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 2014

		2014 $000	2013 $000
Note 23	**Service appropriations**		
	Appropriation revenue received during the period:		
	Service appropriations (funding via the Department of Health)	2,805,851	2,406,851

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

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

- Transfer of building external services from the Queen Elizabeth II Medical Centre Trust		-	17,376
- Transfer of siteworks to the Queen Elizabeth II Medical Centre Trust		-	(2,297)
- Transfer of computer equipment to the WA Country Health Service		-	(1,028)
- Transfer of land and buildings to WA Country Health Service		(182)	(471)
- Transfer of medical equipment to the WA Country Health Service		-	(26)
- Transfer of land and buildings to the Department of Health		(1,471)	-
- Transfer of medical equipment from/(to) the Department of Health		9	65
- Transfer of office equipment from the Department of Health		-	5
		(1,644)	13,624

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 - procurement, information and communication technology, government accommodation and project management services	4,647	4,852

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	1,276	754

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.

Note 27 Cash and cash equivalents

Current	82,173	75,972

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)	12,266	29,412
Other capital grants from the Commonwealth Government	698	-
Restricted cash assets held for other specific purposes (b)	55,715	57,136
	68,679	86,548

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 2014

Note 28 Restricted cash and cash equivalents (continued)

Current (continued)

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 Service.

(b) These include medical research grants, donations for the benefits of patients, medical education and scholarships.

Note 29 Receivables

	2014 $000	2013 $000
Current		
Patient fee debtors	91,088	79,647
Other receivables	25,236	28,682
Less: Allowance for impairment of receivables	(43,842)	(36,826)
Accrued revenue	49,171	27,679
GST Receivables	12,311	7,010 (a)
	133,964	106,192
Reconciliation of changes in the allowance for impairment of receivables:		
Balance at start of period	36,826	27,426
Doubtful debts expense	10,640	12,125
Amounts written off during the period	(3,624)	(2,725)
Balance at end of period	43,842	36,826

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

See also note 2(q) 'Receivables' and note 58 'Financial instruments'.

(a) See note 6 'Prior year restatements'.

Note 30 Amounts receivable for services (Holding Account)

Current	-	27,432
Non-current	1,104,489	961,750
	1,104,489	989,182

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(o) 'Amounts receivable for services'.

Note 31 Inventories

Current		
Supply stores - at cost (a)	388	4,051
Pharmaceutical stores - at cost	18,027	18,045
Engineering stores - at cost	1,880	1,940
	20,295	24,036

(a) The financial responsibility for the supply inventory stores has been transferred from the Health Service to the Department of Health since the opening of the State Distribution Centre at Jandakot in the 2013-14 financial year.

See also note 2(p) 'Inventories'.

Note 32 Other current assets

Prepayments	31,811	35,485
Other	1,994	-
	33,805	35,485

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 2014

Note 33 Property, plant and equipment	2014 $000	2013 $000
Land		
At fair value (a)	589,109	522,146
Buildings		
At fair value (a)	1,979,649	1,581,394
Accumulated depreciation	-	-
	1,979,649	1,581,394
Total land and buildings	2,568,758	2,103,540
Leasehold improvements		
At cost	7,919	7,919
Accumulated depreciation	(6,193)	(5,173)
	1,726	2,746
Computer equipment		
At cost	31,062	45,198
Accumulated depreciation	(21,823)	(29,751)
	9,239	15,447
Furniture and fittings		
At cost	24,445	18,886
Accumulated depreciation	(11,281)	(9,356)
	13,164	9,530
Motor vehicles		
At cost	4,117	4,075
Accumulated depreciation	(2,960)	(2,216)
	1,157	1,859
Medical equipment		
At cost	392,094	357,580
Accumulated depreciation	(228,200)	(201,080)
	163,894	156,500
Other plant and equipment		
At cost	124,976	96,987
Accumulated depreciation	(25,693)	(18,832)
	99,283	78,155
Works in progress		
Buildings under construction (at cost)	2,633,798	2,035,248
Other works in progress (at cost)	150,988	77,799
	2,784,786	2,113,047
Artworks		
At cost	1,298	1,268
Total property, plant and equipment	5,643,305	4,482,092

(a) Land and buildings were revalued as at 1 July 2013 by the Western Australian Land Information Authority (Valuation Services). The valuations were performed during the year ended 30 June 2014 and recognised at 30 June 2014. In undertaking the revaluation, fair value was determined by reference to the market value for land: $92.415 million and buildings: $13.505 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(g) 'Property, plant and equipment'.

Information on fair value measurements is provided in Note 34.

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	522,146	522,305
Additions	1,001	-
Transfer from Department of Health (a)	46,900	-
Transfer to other reporting entities	(6,623)	(340)
Disposals	-	(617)
Revaluation increments/(decrements)	25,685	798
Carrying amount at end of period	589,109	522,146

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 2014

Note 33 Property, plant and equipment (continued)	2014 $000	2013 $000
Buildings		
Carrying amount at start of period	1,581,394	1,437,380
Additions	4,088	69,478
Transfers from works in progress	210,042	177,696
Transfer from Department of Health (a)	263,737	-
Transfers from/(to) other reporting entities	(11,093)	14,948
Disposals	(61)	(364)
Donation to non-government organisation	-	(413)
Revaluation increments/(decrements)	30,025	(22,581)
Depreciation	(98,483)	(94,750)
Carrying amount at end of period	1,979,649	1,581,394
Leasehold improvements		
Carrying amount at start of period	2,746	3,671
Additions	-	71
Depreciation	(1,020)	(996)
Carrying amount at end of period	1,726	2,746
Computer equipment		
Carrying amount at start of period	15,447	11,784
Additions	528	4,925
Transfers from works in progress	355	5,305
Disposals	(2)	-
Depreciation	(7,174)	(6,568)
Transfers between asset classes	85	1
Carrying amount at end of period	9,239	15,447
Furniture and fittings		
Carrying amount at start of period	9,530	9,201
Additions	4,546	1,645
Transfer from Department of Health (a)	342	-
Transfer from other reporting entities	-	5
Disposals	(22)	(17)
Depreciation	(1,686)	(1,255)
Transfers between asset classes	454	(49)
Carrying amount at end of period	13,164	9,530
Motor vehicles		
Carrying amount at start of period	1,859	816
Additions	42	199
Transfers from works in progress	-	1,879
Depreciation	(744)	(1,035)
Carrying amount at end of period	1,157	1,859
Medical equipment		
Carrying amount at start of period	156,500	159,666
Additions	31,674	28,061
Transfers from works in progress	167	848
Transfer from Department of Health (a)	8,342	-
Transfers from/(to) other reporting entities	9	39
Disposals	(270)	(686)
Depreciation	(32,028)	(31,102)
Transfers between asset classes	(500)	(276)
Write-down of assets (b)	-	(50)
Carrying amount at end of period	163,894	156,500

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 2014

Note 33 Property, plant and equipment (continued)	2014 $000	2013 $000
Other plant and equipment		
Carrying amount at start of period	78,155	10,077
Additions	5,271	7,794
Transfers from works in progress	23,641	64,807
Disposals	(52)	(33)
Depreciation	(7,732)	(4,649)
Transfers between asset classes	-	159
Carrying amount at end of period	99,283	78,155
Works in progress		
Carrying amount at start of period	2,113,047	1,759,090
Additions	702,204	609,557
Transfer from Department of Health (a)	204,443	-
Capitalised to asset classes	(234,205)	(250,535)
Transfers to other reporting entities	-	(5,028)
Write-down of assets (b)	(703)	(37)
Carrying amount at end of period (c)	2,784,786	2,113,047
Artworks		
Carrying amount at start of period	1,268	1,268
Additions	30	-
Carrying amount at end of period	1,298	1,268
Total property, plant and equipment		
Carrying amount at start of period	4,482,092	3,915,258
Additions	749,384	721,730
Disposals	(407)	(1,717)
Donation to non-government organisation	-	(413)
Transfer from Department of Health (a)	523,764	-
Transfers from/(to) other reporting entities	(17,707)	9,624
Revaluation increments/(decrements)	55,710	(21,783)
Depreciation	(148,867)	(140,355)
Reclassification of intangible assets	39	(165)
Write-down of assets (b)	(703)	(87)
Carrying amount at end of period (c)	5,643,305	4,482,092

(a) Property, plant and equipment relating to Joondalup Health Campus, Peel Health Campus and Midland Health Campus were transferred from the Department of Health on 1 January 2014. Refer to note 41 'Contributed equity' for further information.

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

(c) At 30 June 2014, the net carrying amount includes leased medical, computer and other plant and equipment $130.709 million (2013: $60.042 million). Refer details at note 38 '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 2014

Note 34 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 2014.

	Level 1 $000	Level 2 $000	Level 3 $000	Total $000
Land				
Vacant land	-	40,560	-	40,560
Residential	-	295	-	295
Specialised	-	51,560	496,694	548,254
Buildings				
Residential and commercial car park	-	3,715	-	3,715
Specialised	-	9,790	1,966,144	1,975,934
	-	105,920	2,462,838	2,568,758

(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. 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.

As at 30 June 2014, the Landgate Valuation Services provided market valuation for a hospital that will be available for sale in the next financial year and a site on which the construction for a new hospital is being underway.

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 valued under the cost approach. The staff accomodation and car parks on hospital grounds are also considered as specialised land and buildings for valuation purpose. This approach uses the depreciated replacement cost method which estimates the current cost of reproduction or replacement of the buildings, 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 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 2014

Note 34 Fair value measurements (continued)

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

Cost Approach (continued)

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
   • Tertiary 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 is 50 years. The effective age of a building is initially calculated from the commissioning date, and is reviewed after the building has 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 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 income statement as depreciation expenses over their remaining useful life.

(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 2014:

2014	**Land $000**	**Buildings $000**
Fair value at start of period	458,001	1,575,530
Additions	32,000	477,761
Revaluation increments/(decrements)	19,843	37,701
Transfers from/(to) Level 2 (a)	(6,250)	(15,972)
Disposals	(6,900)	(11,048)
Depreciation	-	(97,828)
Fair value at end of period	496,694	1,966,144

(a) Land and buildings that are to be sold to private enterprise or transferred to other government agencies have been provided with market values in 2013-14 and have therefore moved from level 3 to 2.

(d) Information about significant unobservable inputs (Level 3) in fair value measurements

Description	Fair value at 30 June 2014 $000	Unobservable inputs	Range of inputs (probability - weighted average	Relationship of unobservable inputs to fair value
Specialised land	$496,694	Difference between hypothetical alternate land use value and current use land value	0% - 95.2% (13.9%) of hypothetical alternate land use value	The higher the difference, the lower the fair value
Specialised buildings	$1,966,144	Residual value of 25% of current replacement cost	$179,000 - $102,690,000 per facility	A change of residual value percentage by +/- 5% (i.e. 20% or 30%) results in a change in fair value of $78,616,000

Residual values used in the calculation of depreciated replacement costs is an unobservable input for specialised buildings, as the valuation processes do not involve physical inspection on site to determine the actual conditions of the assets.

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 2014

Note 34 Fair value measurements (continued)

(e) Valuation processes

The Financial Services Branch at the Health Corporate Network (HCN) 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. Discussions of valuation processes and results are held between the HCN and the chief finance officer at least once every year.

Landgate Valuation Service determines the fair values of the Health Service's land and buildings annually. A quantity surveyor is engaged by the Department of Health to provide an annual update of the current replacement costs for specialised buildings. The Landgate Valuation Services endorses the current replacement costs calculated by the quantity surveyor and calculates the depreciated replacement costs.

Note 35 Intangible assets

	2014 $000	2013 $000
Computer software		
At cost	144,146	136,980
Accumulated amortisation	(35,186)	(24,682)
	108,960	112,298
Works in progress		
Computer software under development (at cost)	156,184	104,793
Total intangible assets	265,144	217,091

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	112,298	10,405
Additions	3,086	76
Transfers from works in progress	8,381	115,611
Write-down of assets	(4,239)	-
Amortisation expense	(10,527)	(13,959)
Transfers between asset classes	(39)	165
Carrying amount at end of period	108,960	112,298
Works in progress		
Carrying amount at start of period	104,793	127,012
Additions	68,962	93,392
Capitalised to computer software	(8,381)	(115,611)
Write-down of assets (b)	(9,190)	-
Carrying amount at end of period (a)	156,184	104,793
Total intangible assets		
Carrying amount at start of period	217,091	137,417
Additions	72,048	93,468
Write-down of assets (b)	(13,429)	-
Amortisation expense	(10,527)	(13,959)
Reclassification from property, plant and equipment	(39)	165
Carrying amount at end of period (a)	265,144	217,091

(a) At 30 June 2014, the net carrying amount of leased computer software was $70.959 million (2013: $51.621 million). Also refer to note 38 'Borrowings'."

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

Note 36 Impairment of assets

There were no indications of impairment to property, plant and equipment and intangible assets at 30 June 2014.

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

All surplus assets at 30 June 2014 have either been classified as assets held for sale or written off.

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 2014

Note 37 Payables	2014 $000	2013 $000
Current		
Trade creditors	97,534	101,660
Other creditors	306	442
Accrued expenses	173,902	103,283 (a)
Accrued salaries	122,205	106,567
Accrued interest	114	126
	394,061	312,078

See also note 2(r) 'Payables' and note 58 'Financial instruments'.

(a) See note 6 'Prior year restatements'.

Note 38 Borrowings		
Current		
Department of Treasury loans (a)	3,814	4,204
Finance lease liabilities - Fiona Stanley Hospital (b)	35,513	4,647
Finance lease liabilities - Joondalup Health Campus (c)	3,819	-
	43,146	8,851
Non-current		
Department of Treasury loans (a)	24,974	28,636
Finance lease liabilities - Fiona Stanley Hospital (b)	183,748	117,789
Finance lease liabilities - Joondalup Health Campus (c)	11,237	-
	219,959	146,425
Total borrowings	263,105	155,276

(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 $90.005 million was acquired and $1.981 million of procurement fees were expensed to the Statement of Comprehensive Income.

The carrying amounts of non-current assets pledged as security are:

Leased computer software	70,959	51,621
Leased computer equipment	59,094	53,980
Leased medical equipment	56,703	3,313
Leased other plant and equipment	14,912	2,749
	201,668	111,663

(c) The finance lease relating to Joondalup Health Campus was transferred from the Department of Health to the Health Service on 1 January 2014. Refer to note 41 Contributed equity for further information.

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:	102,615	-

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 2014

Note 39 Provisions	2014 $000	2013 $000
Current		
Employee benefits provision		
Annual leave (a)	295,747	284,075
Time off in lieu leave (a)	91,364	87,233
Long service leave (b)	229,034	219,124
Deferred salary scheme (c)	4,110	3,664
	620,255	594,096
Non-current		
Employee benefits provision		
Long service leave (b)	149,263	140,719
Total provisions	769,518	734,815

(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	279,089	274,190
More than 12 months after the end of the reporting period	108,022	97,118
	387,111	371,308

(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	45,275	41,837
More than 12 months after the end of the reporting period	333,022	318,006
	378,297	359,843

(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	874	1,868
More than 12 months after the end of the reporting period	3,236	1,796
	4,110	3,664

Note 40 Other liabilities		
Current		
Income received in advance	247	60
Refundable deposits	839	746
Lease discount received in advance	-	183
Other	452	337
	1,538	1,326
Non-Current		
Lease discount received in advance	340	326

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 2014

Note 41 Contributed equity

	2014 $000	2013 $000
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 42).		
Balance at start of period	4,182,400	3,451,973
Contributions by owners		
Capital appropriation (a)	662,341	734,427
Transfer of net assets (other than cash) from other agencies (b) (c)	460	-
Transfer of cash from Department of Health (d)	40,867	-
Transfer of assets and liabilities (other than cash) from Department of Health (d)	467,031	-
	1,170,699	734,427
Distributions to owners		
Transfer of cash to Main Roads	(7,499)	-
Transfer of net assets (other than cash) to other agencies (b) (c)	(16,523)	(4,000)
Balance at end of period	5,329,077	4,182,400

(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) In accordance with the Minister's direction, the assets and liabilities relating to Joondalup Health Campus, Peel Health Campus and Midland Health Campus were transferred from the Department of Health to the Health Service on 1 January 2014. This transfer of assets and liabilities has been formally designated as contribution by owner under AASB Interpretation 1038 and forms part of the contribution equity of the Health Service.

	$000
Assets	
Cash	40,867
Land	46,900
Buildings	263,737
Medical equipments	8,342
Furniture and fittings	342
Works in progress	204,443
Prepayments	1,775
Total Assets	566,406
Liabilities	
Accrued expenses	(41,660)
Finance lease liability	(16,848)
Total Liabilities	(58,508)
Net assets transferred from Department of Health	507,898

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 2014

	2014 $000	2013 $000
Note 42 Reserves		
Asset revaluation reserve (a)		
Balance at start of period	962,559	984,342
Net revaluation increments/(decrements) (b):		
Land	25,685	798
Buildings	30,025	(22,581)
Balance at end of period	1,018,269	962,559

(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 43 Accumulated deficit		
Balance at start of period	(332,182)	(72,238)
Result for the period	(91,872)	(259,944)
Balance at end of period	(424,054)	(332,182)

Note 44 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	82,173	75,972
Restricted cash and cash equivalents	68,679	86,548
	150,852	162,520

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

Net cash used in operating activities (Statement of Cash Flows)	(2,650,410)	(2,386,602)
Increase/(decrease) in assets:		
GST receivable	5,301	(30,261)
Other current receivables	29,487	20,884
Inventories	(3,742)	373
Prepayments and other current assets	13,713	18,558
Decrease/(increase) in liabilities:		
Payables	(110,531)	(41,078)
Current provisions	(26,160)	(62,212)
Non-current provisions	(8,544)	(31,993)
Finance lease liabilities - capitalised interest	3,527	-
Other current liabilities	(212)	(301)
Other non-current liabilities	(15)	183
Transfer of cash from other agencies for payments relating to operating activities	40,552	-
Non-cash items:		
Doubtful debts expense (note 16)	(10,640)	(12,125)
Write off of receivables (note 29)	3,624	2,725
Depreciation and amortisation expense (note 11)	(159,394)	(154,314)
Net loss from disposal of non-current assets (note 12)	(344)	(1,525)
Interest paid by Department of Health	(1,294)	(1,653)
Capitalisation of finance lease charges (note 10)	(10,420)	(2,891)
Net donation of non-current assets	2,279	1,146
Services received free of charge (note 25)	(4,647)	(4,852)
Write down of intangible assets (note 35)	(13,429)	-
Write down of property, plant and equipment (note 33)	(703)	(87)
Net cost of services (Statement of Comprehensive Income)	(2,902,002)	(2,686,025)

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 2014

	2014 $000	2013 $000
Note 44 Notes to the Statement of Cash Flows (continued)		
Notional cash flows		
Service appropriations as per Statement of Comprehensive Income	2,805,851	2,406,851
Capital contributions credited directly to Contributed equity (Refer note 41)	662,341	734,427
Royalties for Regions Fund as per Statement of Comprehensive Income	1,276	754
Holding account drawdowns credited to Amounts receivable for services	23,358	-
	3,492,826	3,142,032
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	(1,294)	(1,653)
Repayment of interest-bearing liabilities to Department of Treasury	(4,052)	(3,868)
Accrual appropriations	(138,665)	(134,121)
	(144,011)	(139,642)
Cash Flows from State Government as per Statement of Cash Flows	3,348,815	3,002,390

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 45 Revenue, public and other property written off

a) Revenue and debts written off under the authority of the Accountable Authority	3,763	-
b) Public and other property written off under the authority of the Accountable Authority	209	62
c) Revenue and debts written off under the authority of the Minister	1,661	2,725
	5,633	2,787

Note 46 Losses of public moneys and other property

Losses of public moneys and public or other property through theft or default	7	-
Less amount recovered	-	-
Net losses	7	-

(a) Items pending settlement of claims through insurance.

Note 47 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 Corrective Services - dental treatment	1,454	1,242
Disability Services Commission - dental treatment	683	605
Department of Corrective Services - radiology services	40	36
Aboriginal Community Controlled Health Services (ACCHS) - dental treatment	286	-
Mental Health Commission - contracted mental health services	-	30,489
	2,463	32,372

Note 48 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.

The number of members of the Accountable Authority, whose total of fees, salaries, superannuation, non-monetary benefits and other benefits for the financial year fall within the following bands are:

$110,001 - $120,000	-	1
$400,001 - $410,000	-	1
$650,001 - $660,000	1	-
Total:	1	2
	$000	**$000**
Base remuneration and superannuation	593	627
Annual leave and long service leave accruals	67	(100)
Other benefits	-	-
The total remuneration of members of the Accountable Authority is:	660	527

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 2014

Note 48 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:

	2014	2013
$90,001 - $100,000	1	-
$180,001 - $190,000	-	1
$200,001 - $210,000	1	-
$210,001 - $220,000	1	2
$220,001 - $230,000	1	2
$230,001 - $240,000	1	-
$240,001 - $250,000	-	1
$340,001 - $350,000	1	1
$420,001 - $430,000	1	-
$480,001 - $490,000	-	1
$520,001 - $530,000	-	1
$540,001 - $550,000	1	-
$550,001 - $560,000	1	-
Total:	9	9

	$000	$000
Base remuneration and superannuation	2,736	2,557
Annual leave and long service leave accruals	45	50
Other benefits	74	66
Total remuneration of senior officers	2,855	2,673

The total remuneration includes the superannuation expense incurred by the Health Service in respect of senior officers other than senior officers reported as memebers of the Accountable Authority.

Note 49 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	686	700

Note 50 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	476,775	675,507
Later than 1 year, and not later than 5 years	13,198	237,479
	489,973	912,986

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	29,912	29,098
Later than 1 year, and not later than 5 years	46,705	49,624
Later than 5 years	2,066	2,684
	78,683	81,406

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 2014

	2014 $000	2013 $000
Note 50 Commitments (continued)		
Finance lease commitments:		
Minimum lease payment commitments in relation to finance leases are payable as follows:		
Within 1 year	51,879	5,680
Later than 1 year, and not later than 5 years	167,917	105,072
Later than 5 years	63,281	37,606
Minimum finance lease payments	283,077	148,358
Less future finance charges	(48,760)	(25,922)
Present value of finance lease liabilities (Refer note 38)	234,317	122,436
The present value of finance leases payable is as follows:		
Within 1 year	39,332	4,647
Later than 1 year, and not later than 5 years	139,392	83,382
Later than 5 years	55,593	34,407
Present value of finance lease liabilities	234,317	122,436
Included in the financial statements as:		
Current (note 38)	39,332	4,647
Non-current (note 38)	194,985	117,789
	234,317	122,436
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	486,592	-
Later than 1 year and not later than 5 yea	1,884,915	-
Later than 5 years and not later than 10 y	2,414,584	-
Later than 10 years	1,970,480	-
	6,756,571	-
Other expenditure commitments:		
Other expenditure commitments contracted for at the reporting period but not recognised as liabilities are payable as follows:		
Within 1 year	326,582	226,917
Later than 1 year, and not later than 5 years	865,183	787,018
Later than 5 years	1,135,726	1,178,614
	2,327,491	2,192,549

Note 51 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.	7,542	7,194
Number of claims	41	45

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 and Conservation (DEC). In accordance with the Act, DEC classifies these sites on the basis of the risk to human health, the environment and environmental values. Where sites are classified as *contaminated – remediation required* or *possibly contaminated – investigation required*, the Health Service may have a liability in respect of investigation or remediation expenses.

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.

Note 52 Events occurring after the end of the reporting period

The Fiona Stanley Hospital (FSH) was temporarily constituted as a separate statutory authority on 11 April 2014, while legal processes were being completed to include FSH as part of the Metropolitan Health Service statutory authority. See also note 2(c) 'Consolidation of the Annual Reports of the Metropolitan Health Services, Peel Health Service and Fiona Stanley Hospital'. FSH has been formally amalgamated into the Metropolitan Health Service on 1 July 2014.

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 2014

		2014 $000	2013 $000
Note 53	**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 54	**Affiliated bodies**		
	An affiliated body is a body which receives more than half its funding and resources from the Health Service but is not subject to operational control by the Health Service.		
	The 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	6,109	5,855
	Community Health Services	843	-
	Australian Red Cross Practical Support Programme	168	173
		7,120	6,028
Note 55	**Other statement of receipts and payments**		
	Commonwealth Grant - Christmas and Cocos Island		
	Balance at the start of period	-	-
	Receipts		
	Commonwealth grant	91	77
	Payments		
	Purchase of WA Health Services	91	77
	Balance at the end of period	-	-
Note 56	**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	149	154
	Add Receipts	1,148	1,210
		1,297	1,364
	Less Payments	(1,152)	(1,215)
	Balance at the end of period	145	149
	b) The Health Service administers a trust account for salaried medical practitioners under the Rights to Private Practice Scheme.		
	A summary of the transactions for this trust account is as follows:		
	Balance at the start of period	790	550
	Add Receipts	12,464	11,718
		13,254	12,268
	Less Payments	(12,105)	(11,478)
	Balance at the end of period	1,149	790
	c) Other trust accounts not controlled by the Health Service.		
	RF Shaw Foundation	1,333	1,289
	RPH Private Trust Account	316	334
	King Edward Memorial Clinical Staff Association	39	32
		1,688	1,655
	Balance at the start of period	1,655	2,021
	Add Receipts	77	215
		1,732	2,236
	Less Payments	(44)	(581)
	Balance at the end of period	1,688	1,655

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 2014

Note 57 Explanatory statement

Significant variances between actual results for 2013 and 2014

Significant variations between actual results with the corresponding items of the preceding reporting period are detailed below. Significant variations are those greater than 10% or that are 4% or more of the current year's Total Cost of Services.

	Note	2014 Actual $000	2013 Actual $000	Variance $000
Expenses				
Employee benefits expense		3,275,697	3,084,340	191,357
Fees for visiting medical practitioners		61,255	55,779	5,476
Patient support costs	(a)	936,844	679,463	257,381
Finance costs	(b)	11,703	4,507	7,196
Depreciation and amortisation expense		159,394	154,314	5,080
Loss on disposal of non-current assets	(c)	344	1,525	(1,181)
Repairs, maintenance and consumable equipment		104,789	112,091	(7,302)
Fiona Stanley Hospital set-up costs	(d)	74,088	46,367	27,721
Other supplies and services		28,719	31,303	(2,584)
Other expenses		320,533	317,121	3,412
Income				
Patient charges		220,417	202,189	18,228
Other fees for services	(e)	212,843	181,905	30,938
Commonwealth grants and contributions	(f)	1,239,646	1,088,595	151,051
Other grants and contributions	(g)	345,906	270,684	75,222
Donation revenue	(h)	4,667	5,897	(1,230)
Interest revenue		397	530	(133)
Commercial activities		5,243	5,396	(153)
Other revenue		42,245	45,589	(3,344)
Service appropriations	(i)	2,805,851	2,406,851	399,000
Assets transferred	(j)	(1,644)	13,624	(15,268)
Services received free of charge		4,647	4,852	(205)
Royalties for Regions Fund	(k)	1,276	754	522

(a) Patient support costs
Expenditure relating to the service delivery of public patients at Joondalup and Peel Health Campuses, mental health services, drug supplies and outsourced child and adolescent community services had a large impact for the Health Service. The Joondalup and Peel Health Campuses were transferred from the Department of Health to the Health Service on 1 January 2014.

(b) Finance costs
While there was a reduction in interest expense on the Department of Treasury loans, the Health Service incurred additional finance lease charges relating to the finance lease facility for the Fiona Stanley Hospital and the finance lease liability transferred from the Department of Health for the Joondalup Health Campus.

(c) Loss on disposal of non-current assets
Fewer assets were disposed of in 2013-14.

(d) Fiona Stanley Hospital set-up costs
During the 2013-14 financial year, the Fiona Stanley Hospital advanced from the pre-operational to the transitional phase resulting in additional costs [see note 14].

(e) Other fees for services
Systems and business process improvements have enabled more timely recoveries from the Commonwealth for eligible pharmacy products under the Pharmaceutical Benefits Scheme ($15.9 million). There was a general increase in other recoveries.

(f) Commonwealth grants and contributions
The Health Service received capital grants for the State Rehabilitation Unit at Fiona Stanley Hospital ($28.0 million), the new Midland Health Campus ($5.7 million) and a project funded under the National Partnership Agreement ($15.7 million) and a significant increase ($101.0 million) in Commonwealth contributions under the National Health Reform Agreement [see note 19 (i)].

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 2014

Note 57 Explanatory statement (continued)

(g) Other grants and contributions
There was an increase in funding from the Mental Health Commission to address the demands for mental health services [see note 19 (ii)].

(h) Donation revenue
Donations come from a number of sources and can vary from year to year. Receipts from cash and asset donations declined further in 2013-14.

(i) Service appropriations
Service Appropriations increased in 2013-14 to meet general escalation of costs of providing health services and growth in hospital activity.

(j) Assets transferred
Department of Health's building on the Queen Elizabeth II Medical Centre site was demolished to make way for new construction. A new building to replace the demolished building was constructed at another venue and transferred to the Department ($1.47 million). Vacant land in Kalgoorlie was transferred to the WA Country Health Service ($0.18 million). Changes in Assets Transferred are detailed in note 24.

(k) Royalties for Regions Fund
Royalties for Regions funding varies from year to year according to the cashflow requirements of the projects.

Significant variances between estimated and actual results for 2014

Significant variations between the estimates and actual results for 2014 are detailed below. Significant variations are considered to be those greater than 10% of the budget estimates.

	2014 Actual $000	2014 Estimates $000	Variance $000
Operating expenses			
Employee benefits expense	3,275,697	3,245,461	30,236
Other goods and services	1,697,669	1,819,455	(121,786)
Total expenses	4,973,366	5,064,916	(91,550)
Less: Revenues	(2,071,364)	(2,151,246)	79,882
Net cost of services	2,902,002	2,913,670	(11,668)

There were no significant variances between estimated and actual results for 2013-14.

Notes to the Financial Statements

For the year ended 30 June 2014

Note 58 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 58(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 58 (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:

	2014 $000	2013 $000
Financial Assets		
Cash and cash equivalents	82,173	75,972
Restricted cash and cash equivalents	68,679	86,548
Loans and receivables (a)	1,226,142	1,088,364
Financial Liabilities		
Financial liabilities measured at amortised cost	657,166	467,354

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

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 2014

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

			Past due but not impaired				
	Carrying amount	Not past due and not impaired	1 - 3 months	3 - 12 months	1-5 years	More than 5 years	Impaired Financial assets
	$000	$000	$000	$000	$000	$000	$000
2014							
Cash and cash equivalents	82,173	82,173	-	-	-	-	-
Restricted cash and cash equivalents	68,679	68,679	-	-	-	-	-
Receivables (a)	121,653	87,876	13,449	12,415	5,767	2,146	-
Amounts receivable for services	1,104,489	1,104,489	-	-	-	-	-
	1,376,994	1,343,217	13,449	12,415	5,767	2,146	-
2013							
Cash and cash equivalents	75,972	75,972	-	-	-	-	-
Restricted cash and cash equivalents	86,548	86,548	-	-	-	-	-
Receivables (a)	99,182	55,510	14,405	9,386	15,369	4,512	-
Amounts receivable for services	989,182	989,182	-	-	-	-	-
	1,250,884	1,207,212	14,405	9,386	15,369	4,512	-

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

Notes to the Financial Statements

For the year ended 30 June 2014

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
2014										
Financial Assets										
Cash and cash equivalents	-	82,173	-	-	82,173	82,173	82,173	-	-	-
Restricted cash and cash equivalents	-	68,679	-	-	68,679	68,679	68,679	-	-	-
Receivables (a)	-	121,653	-	-	121,653	121,653	121,653	-	-	-
Amounts receivable for services	-	1,104,489	-	-	1,104,489	1,104,489	-	-	-	1,104,489
		1,376,994	-	-	1,376,994	1,376,994	272,505	-	-	1,104,489
Financial Liabilities										
Payables	-	394,061	-	-	394,061	394,061	394,061	-	-	-
Department of Treasury Loans	4.10%	28,788	-	28,788	-	32,530	1,207	3,621	19,308	8,394
Finance lease liabilities - Joondalup Health campus	9.46%	15,056	15,056	-	-	17,763	1,256	3,768	12,739	-
Finance lease liabilities - Fiona Stanley Hospital	5.51%	219,261	219,261	-	-	265,315	11,714	35,142	155,179	63,280
		657,166	234,317	28,788	394,061	709,669	408,238	42,531	187,226	71,674

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

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 2014

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
2013										
Financial Assets										
Cash and cash equivalents	-	75,972	-	-	75,972	75,972	75,972	-	-	-
Restricted cash and cash equivalents	-	86,548	-	-	86,548	86,548	86,548	-	-	-
Receivables (a)	-	99,182	-	-	99,182	99,182	99,182	-	-	-
Amounts receivable for services	-	989,182	-	-	989,182	989,182	-	27,432	-	961,750
		1,250,884	-	-	1,250,884	1,250,884	261,702	27,432	-	961,750
Financial Liabilities										
Payables	-	312,078	-	-	312,078	312,078	312,078	-	-	-
Department of Treasury Loans	4.65%	32,840	-	32,840	-	39,340	1,407	4,324	22,900	10,709
Finance lease liabilities - Fiona Stanley Hospital	5.38%	122,436	122,436	-	-	148,359	-	5,680	105,072	37,607
		467,354	122,436	32,840	312,078	499,777	313,485	10,004	127,972	48,316

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

Notes to the Financial Statements

For the year ended 30 June 2014

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 Surplus $000	-100 basis points Equity $000	+100 basis points Surplus $000	+100 basis points Equity $000
2014					
Financial Liabilities					
Department of Treasury Loans	28,788	288	288	(288)	(288)
Total Increase/(Decrease)		288	288	(288)	(288)
2013					
Financial Liabilities					
Department of Treasury Loans	32,840	328	328	(328)	(328)
Total Increase/(Decrease)		328	328	(328)	(328)

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.

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 2014

Note 59 Schedule of income and expenses by service

	Public Hospital Admitted Patient		Home-Based Hospital Programs		Emergency Department		Public Hospital Non-Admitted Patients		Prevention, Promotion & Protection	
	2014 $000	2013 $000	2014 $000	2013 $000	2014 $000	2013 $000	2014 $000	2013 $000	2014 $000	2013 $000
COST OF SERVICES										
Expenses										
Employee benefits expense	1,972,387	1,899,953	10,616	20,974	288,250	218,063	460,041	454,632	132,222	118,439
Fees for visiting medical practitioners	37,555	34,359	202	379	5,488	3,944	8,759	8,222	2,518	2,142
Patient support costs	567,847	418,549	3,056	4,620	82,986	48,038	132,445	100,153	38,066	26,091
Finance costs	7,175	2,776	39	31	1,049	319	1,673	664	481	173
Depreciation and amortisation expense	96,978	95,057	522	1,049	14,172	10,910	22,619	22,746	6,501	5,926
Loss on disposal of non-current assets	199	939	1	10	29	108	46	225	13	59
Repairs, maintenance and consumable equipment	62,580	69,048	337	762	9,146	7,925	14,597	16,522	4,195	4,304
Fiona Stanley Hospital set-up costs	56,855	36,254	-	-	6,638	3,278	10,595	6,835	-	-
Other supplies and services	17,528	19,283	94	213	2,561	2,213	4,088	4,614	1,175	1,202
Other expenses	191,625	195,348	1,031	2,156	28,004	22,420	44,695	46,744	12,846	12,177
Total cost of services	3,010,729	2,771,566	15,898	30,194	438,323	317,218	699,558	661,357	198,017	170,513
Income										
Patient charges	160,463	142,755	-	-	1,102	1,011	53,028	52,748	-	-
Other fees for services	130,404	115,223	702	1,237	19,057	12,861	30,415	26,813	8,742	6,985
Commonwealth grants and contributions	759,922	681,602	4,090	7,402	111,057	76,964	177,244	160,459	50,942	41,802
Other grants and contributions	10,671	9,267	57	86	1,559	889	2,490	1,854	716	483
Donation revenue	2,638	3,737	14	40	386	417	616	869	177	226
Interest revenue	243	336	1	4	36	37	57	78	16	20
Commercial activities	4,195	4,317	-	-	262	270	786	809	-	-
Other revenue	24,959	27,241	134	310	3,647	3,223	5,821	6,720	1,673	1,751
Total income other than income from State Government	1,093,495	984,478	4,998	9,079	137,106	95,672	270,457	250,350	62,266	51,267
NET COST OF SERVICES	**1,917,234**	**1,787,088**	**10,900**	**21,115**	**301,217**	**221,546**	**429,101**	**411,007**	**135,751**	**119,246**
INCOME FROM STATE GOVERNMENT										
Service appropriations	1,853,296	1,603,641	10,537	18,920	291,171	198,519	414,791	368,289	131,224	106,852
Assets transferred	9	8,459	-	-	-	1,268	-	1,973	(1,471)	564
Services received free of charge	2,881	2,904	-	-	418	382	651	595	186	170
Royalties for Regions Fund	1,273	416	-	-	-	-	-	-	-	-
Total income from State Government	1,857,459	1,615,420	10,537	18,920	291,589	200,169	415,442	370,857	129,939	107,586
DEFICIT FOR THE PERIOD	**(59,775)**	**(171,668)**	**(363)**	**(2,195)**	**(9,628)**	**(21,377)**	**(13,659)**	**(40,150)**	**(5,812)**	**(11,660)**

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.

Notes to the Financial Statements

For the year ended 30 June 2014

Note 59 Schedule of income and expenses by service (continued)

	Dental Health		Mental Health (a)		Total		
	2014 $000	2013 $000	2014 $000	2013 $000	2014 $000	2013 $000	
COST OF SERVICES							
Expenses							
Employee benefits expense	58,625	54,284	353,556	317,995	3,275,697	3,084,340	
Fees for visiting medical practitioners	-	982	6,733	5,751	61,255	55,779	
Patient support costs	10,656	11,959	101,788	70,053	936,844	679,463	(b)
Finance costs	-	79	1,286	465	11,703	4,507	
Depreciation and amortisation expense	1,219	2,716	17,383	15,910	159,394	154,314	
Loss on disposal of non-current assets	20	27	36	157	344	1,525	
Repairs, maintenance and consumable equipment	2,716	1,973	11,218	11,557	104,789	112,091	(b)
Fiona Stanley Hospital set-up costs	-	-	-	-	74,088	46,367	
Other supplies and services	131	551	3,142	3,227	28,719	31,303	(b)
Other expenses	7,983	5,581	34,349	32,695	320,533	317,121	(b)
Total cost of services	81,350	78,152	529,491	457,810	4,973,366	4,486,810	
Income							
Patient charges	5,824	5,675	-	-	220,417	202,189	
Other fees for services	148	32	23,375	18,754	212,843	181,905	(b)
Commonwealth grants and contributions	-	-	136,391	120,366	1,239,646	1,088,595	
Other grants and contributions	413	-	330,000	258,105	345,906	270,684	(b)
Donation revenue	363	-	473	608	4,667	5,897	
Interest revenue	-	-	44	55	397	530	
Commercial activities	-	-	-	-	5,243	5,396	
Other revenue	1,537	1,644	4,474	4,700	42,245	45,589	(b)
Total income other than income from State Government	8,285	7,351	494,757	402,588	2,071,364	1,800,785	
NET COST OF SERVICES	**73,065**	**70,801**	**34,734**	**55,222**	**2,902,002**	**2,686,025**	
INCOME FROM STATE GOVERNMENT							
Service appropriations	71,257	61,148	33,575	49,482	2,805,851	2,406,851	
Assets transferred	(182)	(190)	-	1,550	(1,644)	13,624	
Services received free of charge	-	85	511	716	4,647	4,852	
Royalties for Regions Fund	3	338	-	-	1,276	754	
Total income from State Government	71,078	61,381	34,086	51,748	2,810,130	2,426,081	
DEFICIT FOR THE PERIOD	**(1,987)**	**(9,420)**	**(648)**	**(3,474)**	**(91,872)**	**(259,944)**	

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.
(b) Restated amounts for 2013 (see note 6 'Prior year restatement').

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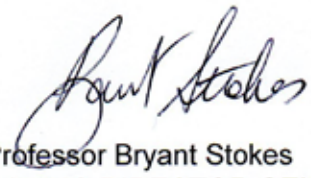
Certification Statement

METROPOLITAN HEALTH SERVICE

CERTIFICATION OF PERFORMANCE INDICATORS
FOR THE YEAR ENDED 30 JUNE 2014

I hereby certify that the performance indicators are based on proper records, are relevant and appropriate for assisting users to assess the performance of the Metropolitan Health Service and fairly represent the performance of the Health Service for the financial year ended 30 June 2014.



Professor Bryant Stokes
ACTING DIRECTOR GENERAL
DEPARTMENT OF HEALTH
ACCOUNTABLE AUTHORITY

16 September 2014

Key performance indicators index

Outcome 1

Outcome 2

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

Rate of hospitalisations for gastroenteritis in children (0–4 years)

Rate of hospitalisation for selected respiratory conditions

Rate of hospitalisation for falls in older persons

Rate of childhood dental screening

Dental health status of target clientele

Access to dental treatment services for eligible people

Average waiting times for dental 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

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

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 health

Percentage of patients discharged to home after admitted hospital treatment

Outcome 1
Effectiveness KPI

Rationale

The main goals of health care provision are to ensure that people receive appropriate evidenced-based health care without experiencing preventable harm and that effective partnerships are forged between consumers, health care 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 assist in ensuring the WA health system is effective and efficient, and yet delivers safe high-quality care and the best outcomes for patients.

Target

The 2013 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 2013, a total of 98.0 per cent of Metropolitan Health Service public patients, across all ages, were discharged home after receiving admitted hospital treatment (see Table 14). This result is consistent with prior years.

Table 14: **Percentage of public patients discharged to home after admitted hospital treatment in Metropolitan Health Service public hospitals, by age group, 2009–2013**

Age group (years)	Calendar years				
	2009 (%)	2010 (%)	2011 (%)	2012 (%)	2013 (%)
0–39	98.7	98.7	98.5	98.4	**98.5**
40–49	98.0	98.0	97.5	97.7	**97.5**
50–59	98.2	98.3	98.2	98.3	**98.1**
60–69	98.5	98.5	98.4	98.3	**98.3**
70–79	98.0	97.8	97.9	98.0	**98.1**
80+	95.4	95.2	95.7	95.8	**96.0**
All ages	98.1	98.0	98.0	98.0	**98.0**
Target (≥)	98.0	98.1	98.1	98.1	**98.1**

Data source/s: 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 health care of the community and are leading causes of death and hospitalisation in Australia.

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

Target

The 2013 target for each condition by age group:

Age group (years)	Sentinel condition		
	Stroke (%)	AMI (%)	FNOF (%)
0–49	≥93.6	≥99.5	
50–59	≥94.1	≥99.2	
60–69	≥92.5	≥98.4	
70–79	≥89.0	≥96.0	≥98.3
80+	≥81.5	≥91.1	≥96.2

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 (see Table 15). In 2013, the survival rate for stroke was slightly above the target for patients aged 70–79 years (90.8 per cent compared to 89.0 per cent) and aged 80 years and over (81.7 per cent compared to 81.5 per cent). For patients aged 69 years and under performance was below target.

Table 15: **Survival rate for stroke, by age group, 2009–2013**

Age group (years)	Calendar years					
	2009 (%)	2010 (%)	2011 (%)	2012 (%)	2013 (%)	Target (%)
0–49	91.4	93.6	91.8	95.3	**93.3**	**≥95.3**
50–59	88.8	94.1	89.8	92.3	**91.2**	**≥94.1**
60–69	92.5	89.7	91.4	91.4	**91.6**	**≥92.5**
70–79	86.6	88.9	89.0	87.2	**90.8**	**≥89.0**
80+	78.6	80.4	81.5	81.2	**81.7**	**≥81.5**

Data source/s: Hospital Morbidity Data System.

Similar results were found for patients with an acute myocardial infarction, with survival rates below the target for all age groups with the exception of patients aged 70 years and over (see Table 16).

Table 16: **Survival rate for acute myocardial infarction, by age group, 2009–2013**

Age group (years)	Calendar years					
	2009 (%)	2010 (%)	2011 (%)	2012 (%)	2013 (%)	Target (%)
0–49	97.8	99.5	99.1	99.5	**99.0**	**≥99.5**
50–59	98.3	98.6	98.5	99.2	**98.9**	**≥99.2**
60–69	98.0	98.4	98.4	97.4	**96.8**	**≥98.4**
70–79	96.0	93.1	94.5	95.8	**96.0**	**≥96.0**
80+	89.4	89.8	90.1	91.1	**92.7**	**≥91.1**

Data source/s: Hospital Morbidity Data System.

The survival rate for patients aged 70–79 years with a fractured neck of femur (98.8 per cent), was above the target of 98.3 per cent in 2013 (see Table 17).

Table 17: **Survival rate for fractured neck of femur, by age group, 2009–2013**

Age group (years)	Calendar years					
	2009 (%)	2010 (%)	2011 (%)	2012 (%)	2013 (%)	Target (%)
70–79	96.8	97.7	98.3	97.7	**98.8**	**≥98.3**
80+	95.6	94.1	96.2	95.5	**96.0**	**≥96.2**

Data source/s: Hospital Morbidity Data System.

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

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 health care 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.

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 2013 target is ≤2.0 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 2013 the percentage of unplanned readmissions within 28 days to a public hospital in metropolitan WA was 3.5 per cent; above the target of 2.0 per cent (see Table 18).

Table 18: **Percentage of unplanned readmissions within 28 days to the same hospital for which they were treated, 2009–2013**

	2009 (%)	2010 (%)	2011 (%)	2012 (%)	2013 (%)
Unplanned readmissions	2.0	2.1	2.3	2.3	**3.5**
Target	≤2.3	≤2.0	≤2.0	≤2.0	**≤2.0**

Note: This indicator is based on a 3 month period each year. For 2013, data is reported from 1 September – 30 November.
Data source/s: 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 health care 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 can 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 2013 target is ≤4.9 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 2013 the percentage of unplanned readmissions within 28 days to a public hospital by patients with a mental health condition was 6.6 per cent (see Table 19). This was above the target of 4.9 per cent and consistent with prior year results.

Table 19: **Percentage of unplanned readmissions within 28 days to the same hospital relating to the previous mental health condition for which they were treated, 2009–2013**

	2009 (%)	2010 (%)	2011 (%)	2012 (%)	2013 (%)
Unplanned readmissions	4.9	5.6	6.8	7.8	**6.6**
Target	≤5.4	≤4.9	≤4.9	≤4.9	**≤4.9**

Note: This indicator is based on a 3 month period each year. For 2013, data is reported from 1 September – 30 November.
Data source/s: 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 Western Australian infants.

Target

The 2013 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 2013, the percentage of liveborn infants with a birth weight between 0–2499 grams and an Apgar score of 3 or less were above set targets (see Table 20).

Table 20: **Percentage of liveborn infants with an Apgar score of three or less, five minutes post-delivery, by birth weight, 2009–2013**

Birth Weight (grams)	Calendar years					
	2009 (%)	2010 (%)	2011 (%)	2012 (%)	2013 (%)	Target (%)
0–1499	7.6	6.7	7.2	3.7	**4.9**	**3.7**
1500–1999	1.7	1.1	0.3	1.0	**0.8**	**0.3**
2000–2499	0.5	0.3	0.4	0.2	**0.5**	**0.2**
2500+	0.1	0.1	0.2	0.1	**0.1**	**0.1**

Note: Caution should be taken in the interpretation of results as:
- public births at contracted private provided 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/s: 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 health care to ensure healthier, longer, and better quality lives for all Western Australians.

Tertiary hospitals provide critical health care 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 health care services such as acute medical care, emergency and intensive care services, complex speciality procedures, clinical research and training.

Target

The target for 2013–14 is $6,284 per casemix weighted separation from a tertiary hospital.

A result below the target is desirable.

Results

For 2013–14, the average cost per casemix adjusted separation for metropolitan tertiary hospitals was $6,769, and above the target (see Figure 7).

Figure 7: **Average cost per casemix weighted separation from a tertiary hospital, 2009–10 to 2013–14**

	2009–10	2010–11	2011–12	2012–13	2013–14
Ave cost	$5,874	$5,686	$6,184	$6,245	$6,769
Target	$5,847	$6,300	$6,562	$6,252	$6,284

Note: Changes in the counting, classification and costing of public hospital admitted patients, is occurring as part of the implementation of the national Activity Based Funding framework.
Data source/s: Hospital Morbidity Data System, health service financial systems.

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 health care 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 crucial health care 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 health care 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

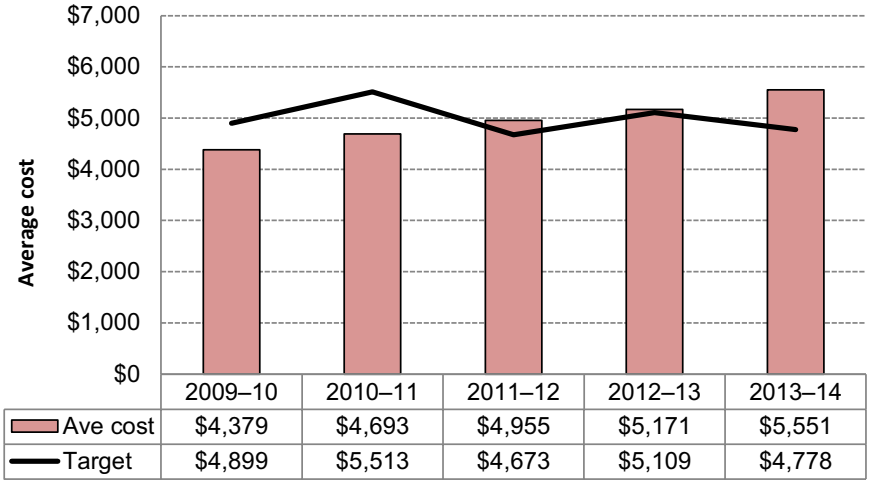
The target for 2013–14 is $4,778 per casemix weighted separation from a non–tertiary hospital.

A result below the target is desirable.

Results

The average cost per casemix weighted separation from a metropolitan non–tertiary hospital in 2013–14 was $5,551, and above the target (see Figure 8). The higher expenditure is attributable to a decrease in activity as a result of re-classification of non-admitted activity and the transition toward improved costing systems associated with a nationally agreed costing allocation methodology.

Figure 8: **Average cost per casemix weighted separation from a non–tertiary hospital, 2009–10 to 2013–14**



	2009–10	2010–11	2011–12	2012–13	2013–14
Ave cost	$4,379	$4,693	$4,955	$5,171	$5,551
Target	$4,899	$5,513	$4,673	$5,109	$4,778

Note: Changes in the counting, classification and costing of public hospital admitted patients, is occurring as part of the implementation of the national Activity Based Funding framework.
Data source/s: Hospital Morbidity Data System, health service financial systems.

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 health care 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 health care, the State Government has entered into collaborative agreement with private sector health providers in the State to deliver hospital services to the community.

Target

A target unit cost is not applicable for the 2013–14 financial year as no prior year baseline expenditure data is available.

Results

The average cost per public admitted patient treatment episodes at contracted health services for July to December 2013 and January to June 2014 was $4,242 and $4,707 respectively (see Table 21).

Table 21: **Average cost of public admitted patient treatment episodes in private hospitals, 2013– 2014**

	July to December 2013 ($)	January to June 2014 ($)
Average cost	4,242	4,707

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. The average cost of providing this service in 2013–14 is presented at 6 month intervals to account for changes to contract arrangements previously managed and reported in the Department of Health annual report until 31 December 2013.

Data source/s: 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 health care to ensure healthier, longer, and better quality lives for all Western Australians.

Small hospitals provide essential health care and treatment within the metropolitan area in WA.

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

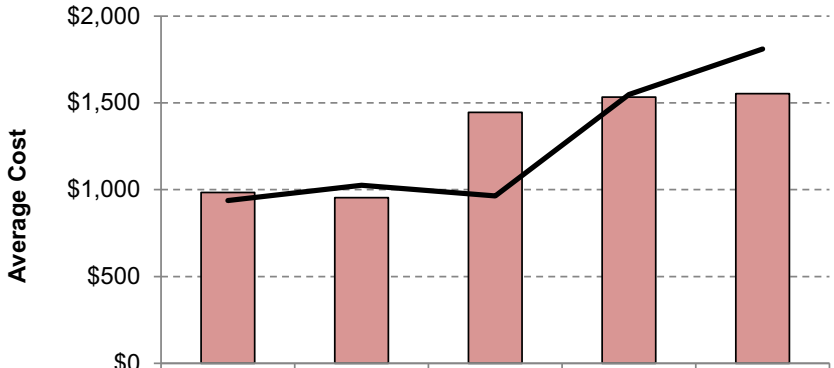
The target for 2013–14 is $1,811 per bed-day for admitted patients (small hospitals).

A result below the target is desirable.

Results

In 2013–14 the average cost per bed-day for admitted patients for small metropolitan public hospitals was $1,553 (see Figure 9). The variance to target is attributable to lower expenditure and higher than predicted activity, comparable to 2012–13 results.

Figure 9: **Average cost per bed-day for admitted patients (small hospitals), 2009–10 to 2013–14**



	2009–10	2010–11	2011–12	2012–13	2013–14
Ave cost	$984	$954	$1,445	$1,534	$1,553
Target	$938	$1,025	$965	$1,549	$1,811

Note: This key performance indicator measures the cost per bed-day for admitted patients at the Murray District Hospital.
Data source/s: 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 health care 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 health care. 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

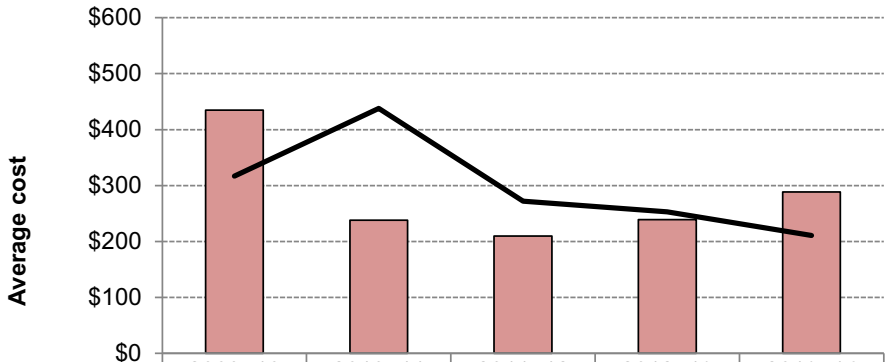
The target for 2013–14 is $211 per home based hospital patient day.

A result below the target is desirable.

Results

The average cost per home based hospital patient day in 2013–14 was $289, and above target (see Figure 10). The higher expenditure is a result of a decrease in activity attributable to the Rehabilitation in the Home program no longer being considered continuous hospital based care, but rather non-admitted patient care.

Figure 10: **Average cost per home based hospital patient day, 2009–10 to 2013–14**



	2009–10	2010–11	2011–12	2012–13	2013–14
Ave cost	$435	$238	$210	$239	$289
Target	$317	$438	$272	$253	$211

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 source/s: 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 health care 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

A target unit cost is not applicable for the 2013–14 financial year as no prior year baseline expenditure data is available.

Results

The average cost per client receiving contracted palliative care services for July to December 2013 was $1,087. For January to June 2014 the average cost was $1,359 (see Table 22).

Table 22: **Average cost per client receiving contracted palliative care services, 2013–2014**

	July to December 2013 ($)	January to June 2014 ($)
Average cost	1,087	1,359

Notes:
1. This KPI measures the average cost per client receiving contracted palliative care services that operate on behalf of the State Government.
2. The average cost of providing this service in 2013–14 is presented at 6 month intervals to account for changes to contract arrangements previously managed and reported in the Department of Health annual report until 31 December 2013.

Data source/s: 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 health care 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

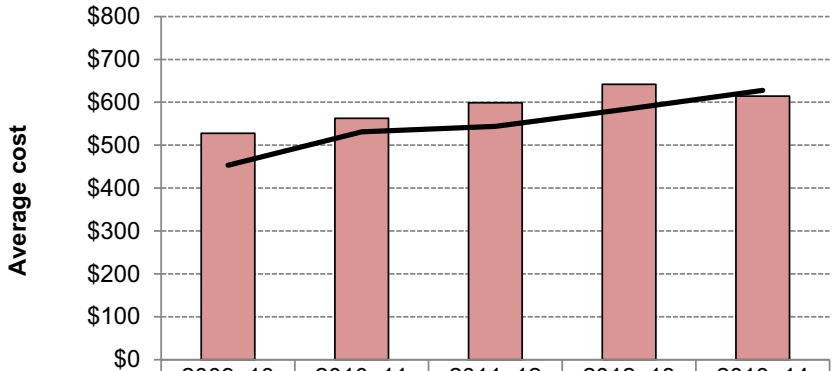
The target for 2013–14 is $628 per emergency department attendance.

A result below the target is desirable.

Results

For 2013–14, the average cost per emergency department attendance for Metropolitan Health Service hospitals was $614 (see Figure 11).

Figure 11: **Average cost per emergency department attendance for Metropolitan Health Service hospitals including Department of Health private/public contracts, 2009–10 to 2013–14**



	2009–10	2010–11	2011–12	2012–13	2013–14
Ave cost	$528	$563	$599	$642	$614
Target	$453	$531	$544	$585	$628

Note: Department of Health contracted metropolitan hospitals contributing to this key performance indicator include Peel Health Campus, Joondalup Health Campus and St John of God Murdoch.
Data source/s: Emergency Department Data Collection, health service financial systems.

Average cost per doctor attended episode in an outpatient clinic for Metropolitan Health Service hospitals

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

Rationale

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

Outpatient clinics offer an extensive range of medical and surgical services that do not require a hospital admission. These clinics also provide consultations with specialists to determine the most appropriate treatment of a patient's condition. Outpatient services aim to ensure patients have access to the care they need in the most appropriate setting to address the patient's clinical needs.

Target

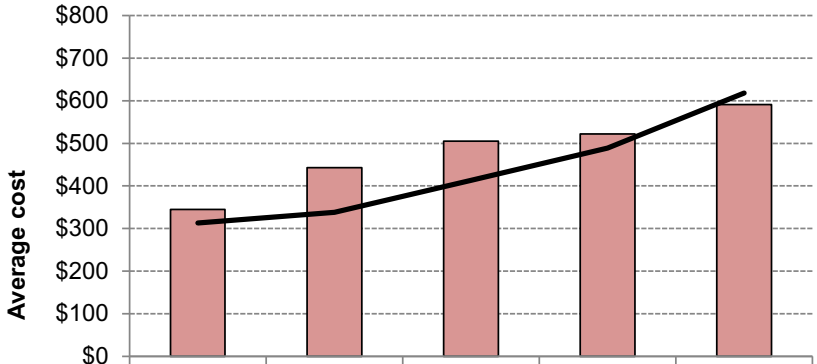
The target for 2013–14 is $618 per doctor attended outpatient episode.

A result below the target is desirable.

Results

For 2013–14, the average cost of a doctor attended outpatient episode in a Metropolitan Health Service hospital was $591; below the target (see Figure 12).

Figure 12: **Average cost of an occasion of service provided by a doctor to a patient that is not admitted into hospital (Metropolitan Health Service), 2009–10 to 2013–14**



	2009–10	2010–11	2011–12	2012–13	2013–14
Ave cost	$345	$443	$505	$522	$591
Target	$313	$338	$413	$489	$618

Data source/s: Health service financial systems.

Average cost per non-admitted occasion of service for Metropolitan Health Service hospitals

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

Rationale

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

A non-admitted occasion of service 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 health care 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

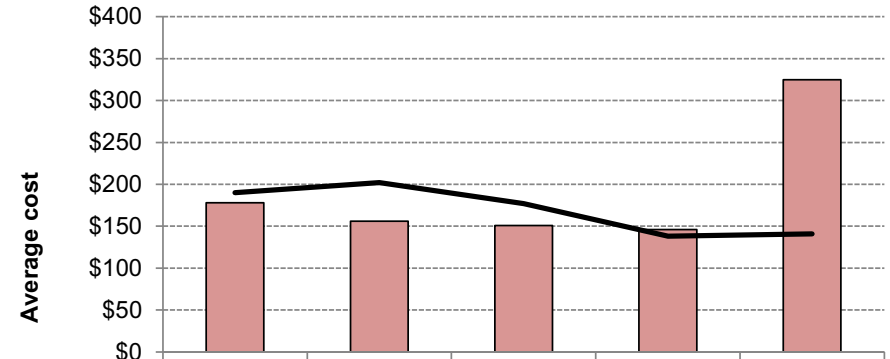
The target for 2013–14 is $141 per non–admitted occasion of service in a Metropolitan Health Service hospital.

A result below the target is desirable.

Results

The average cost per non-admitted occasion of service for Metropolitan Health Service hospitals in 2013–14 was $325 and above the target (see Figure 13). The higher expenditure is attributable to a decrease in activity as a result of re-classification of non-admitted activity associated with a nationally agreed costing allocation methodology.

Figure 13: **Average cost per non–admitted occasion of service for Metropolitan Health Service hospitals, 2009–10 to 2013–14**



	2009–10	2010–11	2011–12	2012–13	2013–14
Ave Cost	$178	$156	$151	$146	$325
Target	$190	$202	$177	$138	$141

Note: The average cost of providing this service in 2013–14 takes into account changes to contract arrangements as at 31 December 2013.
Data source/s: Non Admitted Patient Activity and Wait List Data Collection, HA215B forms, health service financial systems.

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

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

Rationale

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

A non-admitted occasion of service is essentially the provision of medical or surgical services that does not require a hospital admission, and is typically provided in an outpatient setting. The provision of non-admitted health care services aims to ensure patients have access to the care they need in the most appropriate setting to address the patient's clinical needs.

Target

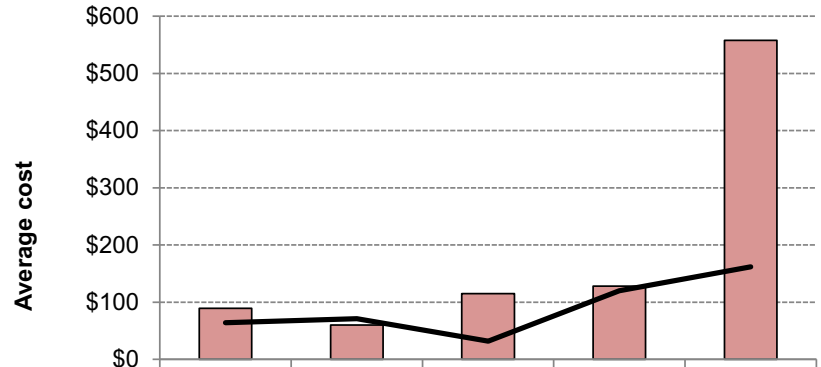
The target for 2013–14 is $162 per non–admitted occasion of service (rural hospitals).

A result below the target is desirable.

Results

For 2013–14, the average cost per non-admitted hospital-based occasion of service for rural hospitals was $558; above target (see Figure 14). This increase in expenditure is attributable to a decrease in activity as a result of re-classification of non-admitted activity, and the transition toward improved costing systems associated with a nationally agreed costing allocation methodology.

Figure 14: **Average cost per non–admitted hospital-based occasion of service for rural hospitals, 2009–10 to 2013–14**



	2009–10	2010–11	2011–12	2012–13	2013–14
Ave cost	$89.53	$60.22	$115	$128	$558
Target	$64	$71	$32	$120	$162

Note: The key performance indicator measures the cost of an occasion of service for non–admitted patients at the Murray District Hospital.
Data source/s: HA215B forms, 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 health care 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 health care when needed.

Target

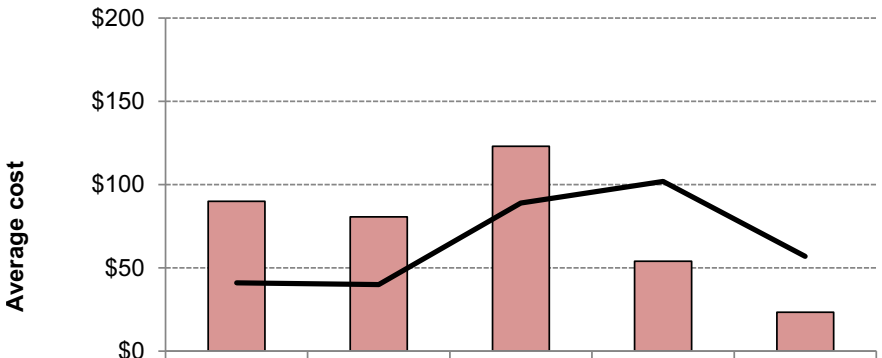
The target for 2013–14 is $57 per Patient Assisted Travel Scheme trip.

A result below the target is desirable.

Results

For 2013–14 the average cost per Patient Assisted Travel Scheme trip was $23 and below the target (see Figure 15). The lower expenditure can be attributed to ongoing efficiency measures applied in 2012–13, while maintaining access to services.

Figure 15: **Average cost per Patient Assisted Travel Scheme trip, 2009–10 to 2013–14**



	2009–10	2010–11	2011–12	2012–13	2013–14
Ave cost	$89.94	$80.60	$123	$54	$23
Target	$41	$40	$89	$102	$57

Note: This key performance indicator measures the cost per trip of patient assisted travel at the Peel Health Service.
Data source/s: 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 2012 target by preventable disease:

Preventable disease	Target (in years)
Breast cancer	2.4
Cervical cancer	0.3

The 2011 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 2012, the person years of life lost for breast and cervical cancer were 2.1 and 0.6 per 1000 population respectively. Neither target was met (see Table 23).

Table 23: **Person years of life lost due to premature death associated with breast and cervical cancer, 2003–2012**

Condition	Calendar years										
	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	Target
Breast cancer	2.8	2.3	2.3	2.7	2.5	2.9	2.5	2.2	2.2	**2.1**	**2.4**
Cervical cancer	0.3	0.4	0.4	0.4	0.4	0.3	0.5	0.4	0.3	**0.6**	**0.3**

Notes:
1. Age-standardised Person Years of Life Lost per 1,000 population.
2. The 2012 deaths are preliminary.
3. The following ICD 10 codes were used:
   - Breast cancer C50 to C50.9 (females only)
   - Cervix cancer C53 to C53.9 (females only).

Data source/s: Epidemiology Branch, 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 5 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 well-being of Western Australian children and the sustainability of the public health system.

Target

The target for 2013 is ≤3.8 hospitalisations per 1,000 children less than 5 years of age.

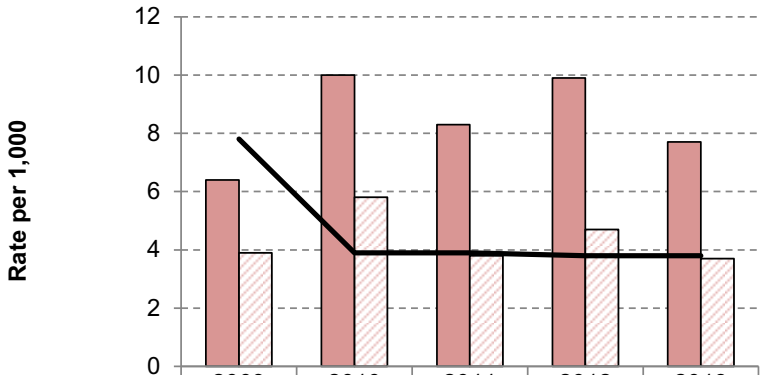
The target is based on the best result achieved within the previous five years for either population group reported i.e. Aboriginal and non-Aboriginal groups.

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

Results

In 2013, the rate of non-Aboriginal children aged 0–4 years hospitalised for gastroenteritis was 3.7 per 1,000 children (see Figure 16). This rate was almost double for Aboriginal children (7.7 per 1,000 children), consistent with prior years, and well above the target of 3.8 per 1,000 children.

Figure 16: **Rate of hospitalisations for gastroenteritis per 1,000 children aged 0–4 years, 2009–2013**



	2009	2010	2011	2012	2013
Aboriginal	6.4	10	8.3	9.9	7.7
Non-Aboriginal	3.9	5.8	3.8	4.7	3.7
Target	7.8	3.9	3.9	3.8	3.8

Notes:

1. The total population used in the calculation of this KPI is based on the Australian Bureau of Statistics Estimated Resident Population for 2011 for areas defined by the Australian Standard Geographical Classification. The Australian Bureau of Statistics has changed its geographical boundaries and WA Health is currently updating their processes for estimating and projecting populations based on the reclassification of Australian Bureau of Statistics geographical boundaries.
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 source/s: 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, cigarette 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 2013 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.

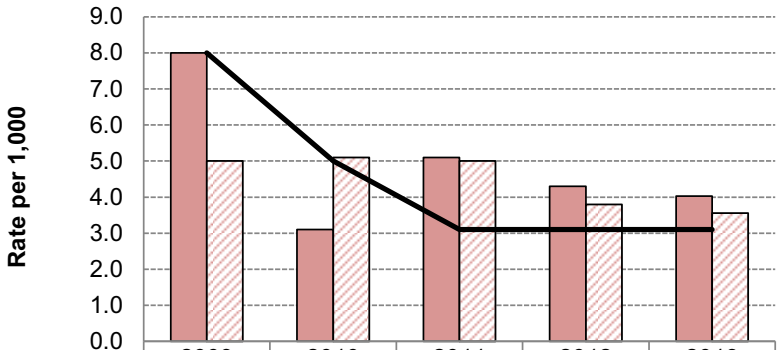
Respiratory condition	Age group (years)	Target
Asthma	0–4	≤ 3.1
	5–12	≤ 1.8
	13–18	≤ 0.2
	19–34	≤ 0.4
	35+	≤ 0.6
Acute bronchitis	0–4	≤ 0.1
Bronchiolitis	0–4	≤ 7.0
Croup	0–4	≤1.6

Results

Acute asthma

For Aboriginal and non-Aboriginal children aged 0–4 years, hospitalisation rates for asthma were above the target of 3.1 per 1,000 children (see Figure 17).

Figure 17: **Rate of hospitalisation for acute asthma per 1,000 children aged 0–4 years, 2009–2013**



	2009	2010	2011	2012	2013
Aboriginal	8.0	3.1	5.1	4.3	4.0
Non-Aboriginal	5.0	5.1	5.0	3.8	3.6
Target	8.0	5.0	3.1	3.1	3.1

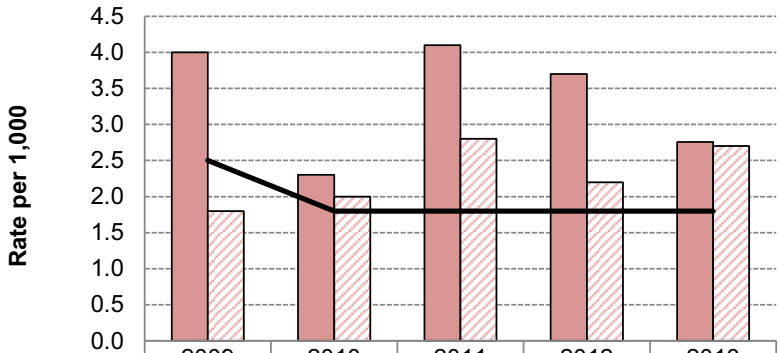
Notes:

1. The total population used in the calculation of this KPI is based on the Australian Bureau of Statistics Estimated Resident Population for 2011 for areas defined by the Australian Standard Geographical Classification. The Australian Bureau of Statistics has changed its geographical boundaries and WA Health is currently updating their processes for estimating and projecting populations based on the reclassification of Australian Bureau of Statistics geographical boundaries.
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 source/s: Hospital Morbidity Data System, Australian Bureau of Statistics.

The overall rate and of hospitalisation of children aged 5–12 years for acute asthma was 2.7 per 1,000 children and above the target (see Figure 18).

Figure 18: **Rate of hospitalisation for acute asthma per 1,000 children aged 5–12 years, 2009–2013**



	2009	2010	2011	2012	2013
Aboriginal	4.0	2.3	4.1	3.7	2.8
Non-Aboriginal	1.8	2.0	2.8	2.2	2.7
Target	2.5	1.8	1.8	1.8	1.8

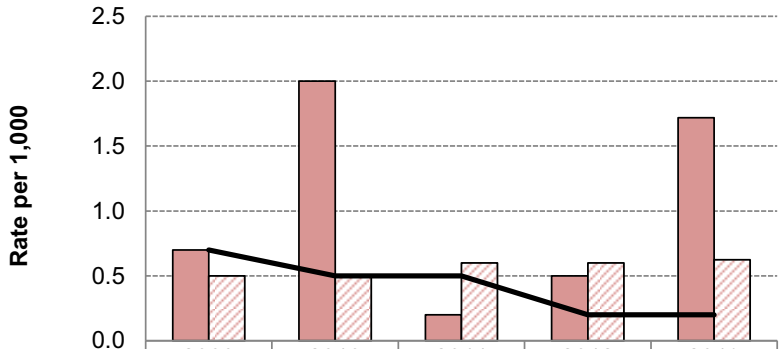
Notes:

1. The total population used in the calculation of this KPI is based on the Australian Bureau of Statistics Estimated Resident Population for 2011 for areas defined by the Australian Standard Geographical Classification. The Australian Bureau of Statistics has changed its geographical boundaries and WA Health is currently updating their processes for estimating and projecting populations based on the reclassification of Australian Bureau of Statistics geographical boundaries.
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 source/s: Hospital Morbidity Data System, Australian Bureau of Statistics.

The rate of hospitalisation of non-Aboriginals aged 13–18 years for asthma was 0.6 per 1,000 children. In contrast, Aboriginal people were more likely to be hospitalised at a rate of 1.7 per 1,000 children (see Figure 19). Hospitalisation rates for both non-Aboriginal and Aboriginal children were above the target.

Figure 19: **Rate of hospitalisation for acute asthma per 1,000 children aged 13–18 years, 2009–2013**



	2009	2010	2011	2012	2013
Aboriginal	0.7	2.0	0.2	0.5	1.7
Non-Aboriginal	0.5	0.5	0.6	0.6	0.6
Target	0.7	0.5	0.5	0.2	0.2

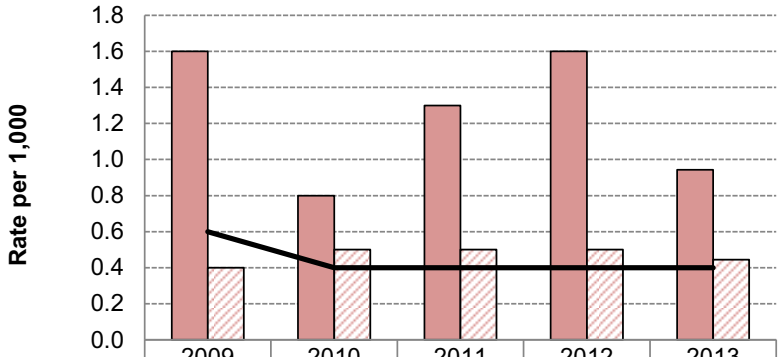
Notes:

1. The total population used in the calculation of this KPI is based on the Australian Bureau of Statistics Estimated Resident Population for 2011 for areas defined by the Australian Standard Geographical Classification. The Australian Bureau of Statistics has changed its geographical boundaries and WA Health is currently updating their processes for estimating and projecting populations based on the reclassification of Australian Bureau of Statistics geographical boundaries.
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 source/s: Hospital Morbidity Data System, Australian Bureau of Statistics.

The rate of hospitalisation of non–Aboriginal adults for asthma was equal to the target of 0.4 per 1,000 persons. In contrast Aboriginal people aged 19–34 years were hospitalised at a rate of 0.9 per 1,000 children (see Figure 20).

Figure 20: **Rate of hospitalisation for acute asthma per 1,000 persons aged 19–34 years, 2009–2013**



	2009	2010	2011	2012	2013
Aboriginal	1.6	0.8	1.3	1.6	0.9
Non-Aboriginal	0.4	0.5	0.5	0.5	0.4
Target	0.6	0.4	0.4	0.4	0.4

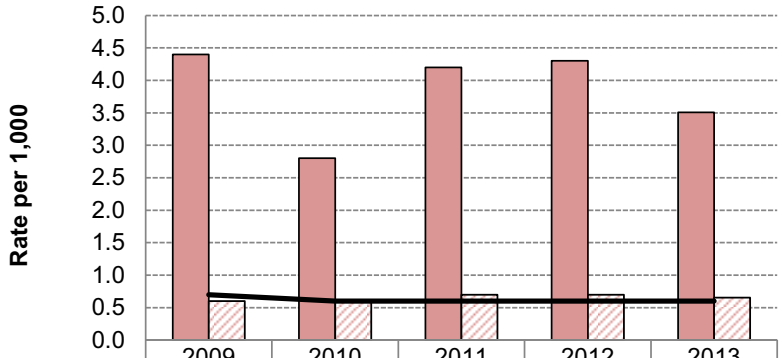
Notes:

1. The total population used in the calculation of this KPI is based on the Australian Bureau of Statistics Estimated Resident Population for 2011 for areas defined by the Australian Standard Geographical Classification. The Australian Bureau of Statistics has changed its geographical boundaries and WA Health is currently updating their processes for estimating and projecting populations based on the reclassification of Australian Bureau of Statistics geographical boundaries.
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 source/s: Hospital Morbidity Data System, Australian Bureau of Statistics.

Asthma hospitalisation rates for non-Aboriginal people aged 35 years and older are slightly above the target of 0.6 per 1,000 persons. In contrast, Aboriginal people were hospitalised at a rate of 3.5 per 1,000 persons (see Figure 21).

Figure 21: **Rate of hospitalisation for acute asthma per 1,000 persons aged 35 years and older, 2009–2013**



	2009	2010	2011	2012	2013
Aboriginal	4.4	2.8	4.2	4.3	3.5
Non-Aboriginal	0.6	0.6	0.7	0.7	0.7
Target	0.7	0.6	0.6	0.6	0.6

Notes:

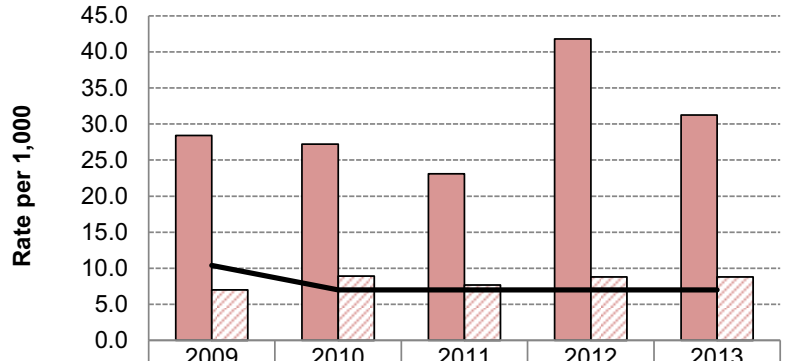
1. The total population used in the calculation of this KPI is based on the Australian Bureau of Statistics Estimated Resident Population for 2011 for areas defined by the Australian Standard Geographical Classification. The Australian Bureau of Statistics has changed its geographical boundaries and WA Health is currently updating their processes for estimating and projecting populations based on the reclassification of Australian Bureau of Statistics geographical boundaries.
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 source/s: Hospital Morbidity Data System, Australian Bureau of Statistics.

Bronchiolitis

In 2013, the rate of non-Aboriginal children aged 0–4 years hospitalised for bronchiolitis was 8.8 per 1,000 children (see Figure 22). In comparison the rate of Aboriginal children for this age admitted to hospitals was 31.3 per 1,000 children. This trend is consistent with prior years, with Aboriginal children more likely to be hospitalised for bronchiolitis. In 2013, the hospitalisation rates for both non-Aboriginal and Aboriginal children aged 0–4 were higher than the target.

Figure 22: **Rate of hospitalisation for bronchiolitis per 1,000 children aged 0–4 years, 2009–2013**



	2009	2010	2011	2012	2013
Aboriginal	28.4	27.2	23.1	41.8	31.3
Non-Aboriginal	7.0	8.9	7.7	8.8	8.8
Target	10.4	7.0	7.0	7.0	7.0

Notes:

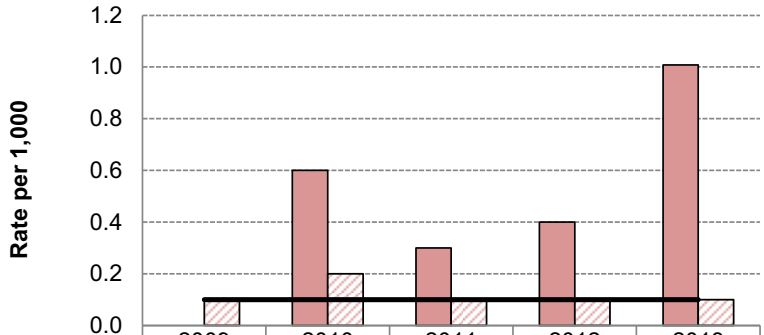
1. The total population used in the calculation of this KPI is based on the Australian Bureau of Statistics Estimated Resident Population for 2011 for areas defined by the Australian Standard Geographical Classification. The Australian Bureau of Statistics has changed its geographical boundaries and WA Health is currently updating their processes for estimating and projecting populations based on the reclassification of Australian Bureau of Statistics geographical boundaries.
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 source/s: Hospital Morbidity Data System, Australian Bureau of Statistics.

Acute bronchitis

In 2013, the rate of non-Aboriginal children aged 0–4 years who were hospitalised for acute bronchitis was 0.1 for every 1,000 children (see Figure 23). By contrast, Aboriginal children aged 0–4 years were hospitalised at a rate of 1.0 per 1,000 children; higher than prior years.

Figure 23: **Rate of hospitalisation for acute bronchitis per 1,000 children aged 0–4 years, 2009–2013**



	2009	2010	2011	2012	2013
Aboriginal	0.0	0.6	0.3	0.4	1.0
Non-Aboriginal	0.1	0.2	0.1	0.1	0.1
Target	0.1	0.1	0.1	0.1	0.1

Notes:

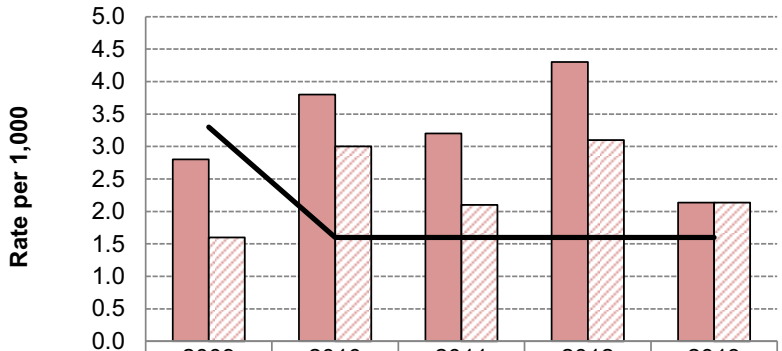
1. The total population used in the calculation of this KPI is based on the Australian Bureau of Statistics Estimated Resident Population for 2011 for areas defined by the Australian Standard Geographical Classification. The Australian Bureau of Statistics has changed its geographical boundaries and WA Health is currently updating their processes for estimating and projecting populations based on the reclassification of Australian Bureau of Statistics geographical boundaries.
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 source/s: Hospital Morbidity Data System, Australian Bureau of Statistics.

Croup

In 2013, and the rate of hospitalisation for croup was 2.1 per 1,000 for both non–Aboriginal and Aboriginal children (see Figure 24).

Figure 24: **Rate of hospitalisations for croup per 1,000 children aged 0–4 years, 2009–2013**



	2009	2010	2011	2012	2013
Aboriginal	2.8	3.8	3.2	4.3	2.1
Non-Aboriginal	1.6	3.0	2.1	3.1	2.1
Target	3.3	1.6	1.6	1.6	1.6

Notes:

1. The total population used in the calculation of this KPI is based on the Australian Bureau of Statistics Estimated Resident Population for 2011 for areas defined by the Australian Standard Geographical Classification. The Australian Bureau of Statistics has changed its geographical boundaries and WA Health is currently updating their processes for estimating and projecting populations based on the reclassification of Australian Bureau of Statistics geographical boundaries.
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 source/s: 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 WA, 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 a sustained period for both Aboriginal and non-Aboriginal populations, by 2020.

Results

Hospitalisation rates for falls for both non-Aboriginal and Aboriginal population groups increase with age (see Table 24). In 2013 the rate of falls per 1,000 non-Aboriginal people aged 55–64 years was 6.7, and at age 80 years and over the rate was 128.1 per 1,000. The rate of hospitalisation for falls of Aboriginal people was highest at age 80 years and above, at 84.1 per 1,000. Falls among Aboriginal people aged 55–64 years was 21.5 per 1,000.

Table 24: **Rate of hospitalisations for falls per 1,000 by age group, 2009–2013**

Age group (years)		Year					
		2009	2010	2011	2012	2013	Target
55–64	Aboriginal	7.0	14.6	19.6	18.3	**21.5**	**0.5 per cent per annum reduction for a sustained period for both subgroup populations by 2020**
	Non-Aboriginal	4.9	5.0	6.7	6.7	**6.7**	
65–79	Aboriginal	33.9	35.9	51.1	54.1	**33.8**	
	Non-Aboriginal	17.0	19.8	22.5	23.3	**23.4**	
80+	Aboriginal	48.2	46.5	73.7	116.5	**84.1**	
	Non-Aboriginal	98.0	114.2	124.8	130.9	**128.1**	

Notes:

1. The total population used in the calculation of this KPI is based on the Australian Bureau of Statistics Estimated Resident Population for 2011 for areas defined by the Australian Standard Geographical Classification. The Australian Bureau of Statistics has changed its geographical boundaries and WA Health is currently updating their processes for estimating and projecting populations based on the reclassification of Australian Bureau of Statistics geographical boundaries.
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 source/s: 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 2013 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	≥72%
Primary program	≥79%
Secondary program	≥72%

(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

Pre-primary and secondary school children enrolled in the school dental program in 2013 were 84.6 per cent and 87.5 per cent respectively, and above the set targets (see Table 25). However, the percentage of primary school children enrolled has decreased and is below target.
The number of eligible school children continues to increase, and with a growth in demand, delays in enrolment among primary school children has occurred.

Table 25: **Percentage of pre-primary, primary and secondary school children who are enrolled in the school dental program, 2009–2013**

		Year					
		2009 (%)	2010 (%)	2011 (%)	2012 (%)	2013 (%)	Target (%)
Pre-primary school children	Enrolled in program	76.8	78.4	72.7	54.9	**84.6**	**≥72**
Primary school children	Enrolled in program	80.0	78.2	78.0	80.0	**73.0**	**≥79**
Secondary school children	Enrolled in program	79.4	80.6	77.3	83.3	**87.5**	**≥72**

Data source/s: School dental health clinics – Dental Health Services.

The 'Free of Active Caries on Recall' rate has remained constant over the past five years, and with the excellent dental health status of children, gains are difficult to achieve. The caries free rate in 2013 of 66.3 per cent exceeds the target (see Table 26).

Table 26: **Percentage of children free of dental caries when initially examined and/or recalled for examination, 2009–2013**

	Year					
	2009 (%)	2010 (%)	2011 (%)	2012 (%)	2013 (%)	Target (%)
Children free of dental caries	65.4	67.1	67.1	66.9	**66.3**	**>65.0**

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.
2. Results are indicative of all dental health care 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/s: School dental health clinics – Dental Health Services.

Dental health status of target clientele

Outcome 2
Effectiveness KPI

Rationale

Oral health care 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 2013–14 target is applicable to children aged 12 years.

The International Benchmark is 0.90–1.5 decayed, missing or filled teeth (DMFT).

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 (2008)	0.7
Finland (2009)	0.7
Germany (2009)	0.7
Italy (2004)	1.1
Norway (2004)	1.7

Results

The average number of decayed, missing or filled teeth in children has remained consistent over the past five years. In 2013, the WA result for 12 year olds improved to 0.65 and compared favourably with international benchmarks (see Table 27).

Table 27: **Average number of decayed, missing or filled teeth for school children, 2009–2013**

Average number of DMFT for children by age	Year				
	2009	2010	2011	2012	2013
5 years	1.26	1.21	1.19	**1.09**	**1.33**
8 years	0.27	0.24	0.27	**0.18**	**0.18**
12 years	0.77	0.79	0.79	**0.69**	**0.65**
15 years	1.59	1.55	1.37	**1.38**	**1.48**

Data source/s: Dental Health Services.

The average number of decayed, missing or filled teeth for adults for 2013–14 is consistent with prior year results (see Table 28).

Table 28: **Average number of decayed, missing or filled teeth for adults, 2009–10 to 2013–14**

Average number of DMFT for adults	Year				
	2009–10	2010–11	2011–12	2012–13	2013–14
35–44 years	10.5	9.0	9.8	12.8	**10.3**

Notes:
1. The results are indicative of all dental health care activity and expenditure across WA.
2. The average number of DMFT is based on a sub–sample of the total number of randomly selected 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 [8.99 ,11.60].

Data source/s: 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 health care 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 these subsidised 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 2013–14 targets are outlined below.

(a) Eligible people who accessed Dental Health Services: greater than 17 per cent

(b) Eligible people who have completed emergency or non-emergency dental treatment:

i. Emergency 50%

ii. Non-Emergency 50%

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

Results

In 2013–14, the percentage of eligible adults that accessed dental treatment services was 16 per cent (see Table 29).

Table 29: **Percentage of eligible people that accessed dental treatment services, 2009–10 to 2013–14**

	Year					
	2009–10 (%)	2010–11 (%)	2011–12 (%)	2012–13 (%)	2013–14 (%)	Target (%)
Eligible persons who accessed dental health services (adult)	17	18	17	18	**16**	**>17**

Data source/s: School dental health – Dental Health Services.

In 2013–14, 39 per cent of eligible people received emergency dental care; below the target of 50 per cent. Since 2010–11 the proportion of eligible people receiving emergency dental treatment has decreased slightly (see Table 30).

Table 30: **Percentage of complete dental care, 2009–10 to 2013–14**

	Year					
	2009–10 (%)	2010–11 (%)	2011–12 (%)	2012–13 (%)	2013–14 (%)	Target (%)
Emergency completed dental treatments	50	48	47	43	**39**	**50**
Non-emergency completed dental treatments	50	52	53	57	**61**	**50**

Notes:
1. The results are indicative of all dental health care activity and expenditure across WA.
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 error has been amended accordingly as at 2012–13.

Data source/s: School dental health – 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 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 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 2013–14 was less than 14 months.

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

Results

In 2013–14, the average waiting time for dental services was 13 months, a marked improvement from 2011–12 to 2012–13 (see Table 31).

Table 31: **Average waiting times, in months, per patient removed from the waiting list, 2009–10 to 2013–14**

	Year					
	2009–10	2010–11	2011–12	2012–13	2013–14	Target
Waiting times for non–urgent dental care (months)	13	15	21	24	**13**	**<14**

Note: The results are indicative of all dental health care activity and expenditure across WA.
Data source/s: School dental health – 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. It is therefore 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 health care, 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 2013 was 70 per cent.

This target was endorsed by the Australian Health Ministers' Advisory Council Mental Health Standing Committee in May 2011.

Results

In 2013, 51.5 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 (see Table 32). The result is consistent with prior years.

The target of 70 per cent is based on a national definition, with the majority of jurisdictions, including WA, not being able to achieve this aspirational target from 2007–08.

Table 32: **Percentage of contacts with a community-based mental health non-admitted service seven days prior to admission, 2009–2013**

	Year					
	2009 (%)	2010 (%)	2011 (%)	2012 (%)	2013 (%)	Target (%)
Pre-admission community based contact	50.3	50.3	53.0	51.6	**51.5**	**70.0**

Notes:

1. This target is considered to be aspirational based on a national definition. Jurisdictional results can be sourced at National mental Health Key Performance Indicator performance results.
2. In 2013, to improve data quality and to align with state and national reporting requirements the denominator data source and reporting period for this KPI was modified. Data for all previously published years (2009 to 2012) has been restated for comparability purposes. Previously reported results, no longer considered appropriate, are as follows:

	2009–10	2010–11	2011–12	2012–13
Results (%)	60.8	63.2	69.1	62.7
Target (%)	65.0	70.0	70.0	70.0

Data source/s: 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 2013 the target was 75 per cent.

This target was endorsed by the Australian Health Ministers' Advisory Council Mental Health Standing Committee in May 2011.

Results

In 2013, 56.1 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 higher than the 2012 figure and trending in the right direction. The target is considered aspirational, as the measure includes follow-up by public community mental health services only.

Table 33. **Percentage of contacts with a community-based mental health non-admitted service seven days post discharge, 2009–2013**

	Year					
	2009 (%)	2010 (%)	2011 (%)	2012 (%)	2013 (%)	Target (%)
Post-admission community based contact	48.0	48.0	49.6	52.3	**56.1**	**75.0**

Notes:

1. The target is considered to be aspirational based on the national definition.
2. In 2013, to improve data quality and to align with state and national reporting requirements the denominator data source and reporting period for this KPI was modified. Data for all previously published years (2009 to 2012) has been restated for comparability purposes. Previously reported results, no longer considered appropriate, are as follows:

	2008	2009	2010	2011	2012
Results (%)	59.0	63.0	67.2	70.2	72.5
Target (%)	60.0	60.0	70.0	70.0	75.0

Data source/s: Mental Health Information System, Hospital Morbidity Data System.

Average cost per capita of Population Health Units

Outcome 2
Efficiency KPI
Service 7: Prevention, promotion and protection

Rationale

WA Health aims to provide safe, high-quality health care 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

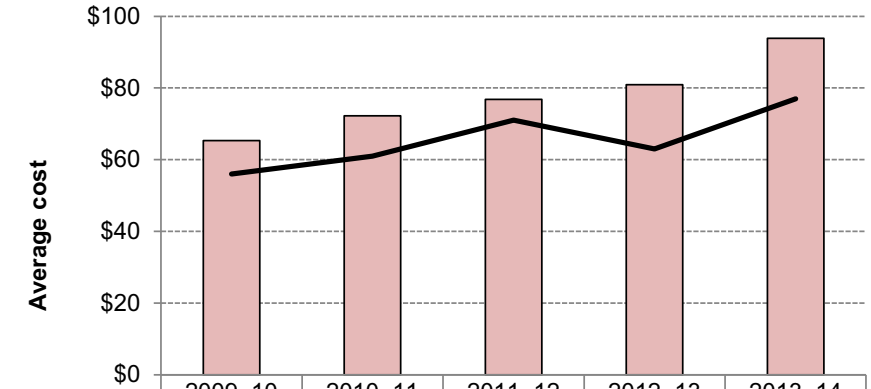
The target for 2013–14 is $77 per capita of population health units.

A result below the target is desirable.

Results

For 2013–14, the average cost per capita of Metropolitan Population Health Units was $93.87, and above the target (see Figure 25). This increase in expenditure is attributable to a revised clinical costing methodology and transition toward improved costing systems. These changes occurred in 2013–14 and have enabled more accurate alignment of revenue to service type.

Figure 25: **Average cost per capita of Metropolitan Population Health Units, 2009–10 to 2013–14**



	2009–10	2010–11	2011–12	2012–13	2013–14
Ave cost	$65.29	$72.27	$76.86	$80.90	$93.87
Target	$56	$61	$71	$63	$77

Notes:

1. The total population used in the calculation of this KPI is based on the Australian Bureau of Statistics Estimated Resident Population for 2011 for areas defined by the Australian Standard Geographical Classification. The Australian Bureau of Statistics has changed its geographical boundaries and WA Health is currently updating their processes for estimating and projecting populations based on the reclassification of Australian Bureau of Statistics geographical boundaries.
2. Population Health Units function within area boundaries defined by postcodes.

Data source/s: Australian Bureau of Statistics, health service financial systems.

Average cost per breast screening

Outcome 2
Efficiency KPI
Service 7: Prevention, promotion and protection

Rationale

WA Health aims to provide safe, high-quality health care 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

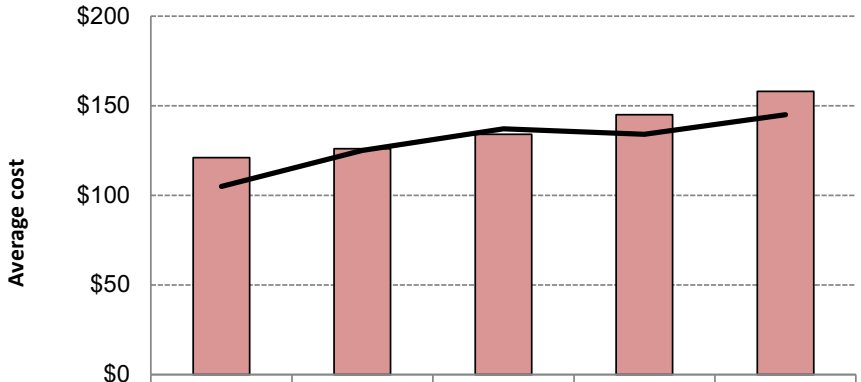
The target for 2013–14 is $145 per breast screening.

A result below the target is desirable.

Results

In 2013–14, the average cost per breast screen was $158, and above the target (see Figure 26).

Figure 26: **Average cost per breast screening, 2009–10 to 2013–14**



	2009–10	2010–11	2011–12	2012–13	2013–14
Ave cost	$121	$126	$134	$145	$158
Target	$105	$125	$137	$134	$145

Note: Breast Assessment clinic expenditure at Royal Perth Hospital and Sir Charles Gairdner Hospital are excluded in the calculation of this key performance indicator.
Data source/s: 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 health care 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

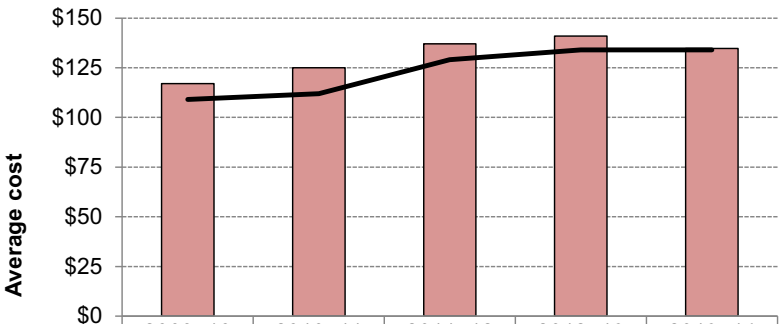
The target for 2013–14 is $134 for school dental care.

A result below the target is desirable.

Results

For 2013–14, the average cost of service for school dental care was $135 (see Figure 27).

Figure 27: **Average cost of service for school dental care, 2009–10 to 2013–14**



	2009–10	2010–11	2011–12	2012–13	2013–14
Ave cost	$117	$125	$137	$141	$135
Target	$109	$112	$129	$134	$134

Notes:
1. 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.
2. Results are indicative of all dental health care activity and expenditure across Western Australia.

Data source/s: School dental health clinics – 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 health care 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

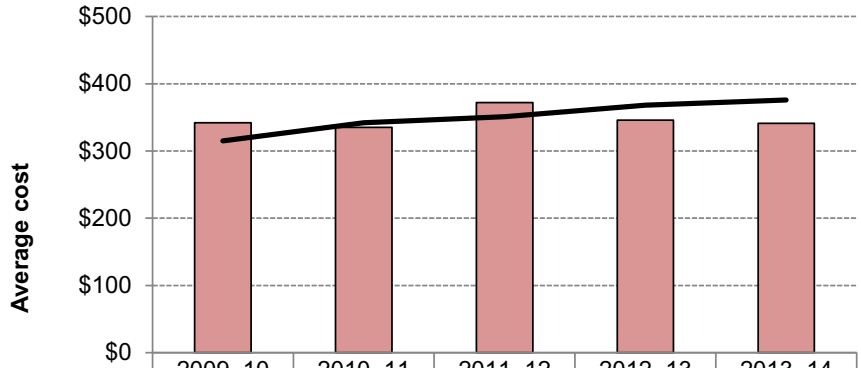
The target for 2013–14 is $376 per completed courses of adult dental care.

A result below the target is desirable.

Results

The average cost of completed courses of adult dental care in 2013–14 was $341, and below target (see Figure 28).

Figure 28: **Average cost of completed courses of adult dental care, 2009–10 to 2013–14**



	2009–10	2010–11	2011–12	2012–13	2013–14
Ave cost	$342	$335	$372	$346	$341
Target	$315	$342	$351	$368	$376

Notes:
1. Results are indicative of all dental health care 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 source/s: 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

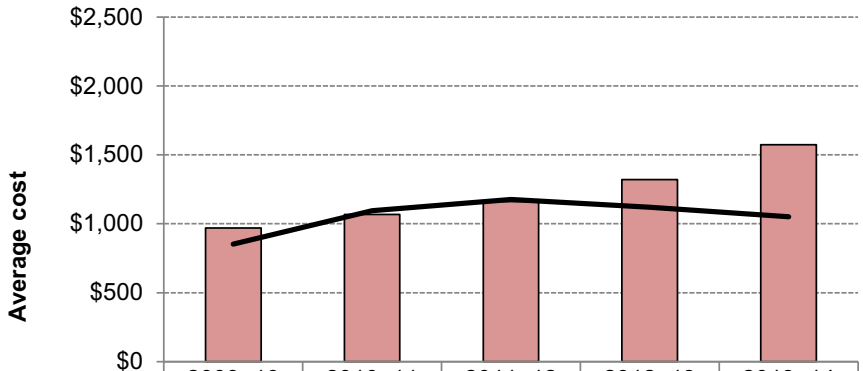
The target for 2013–14 is $1,051 per bed-day in a specialised mental health unit.

A result below the target is desirable.

Results

For 2013–14, the average cost per bed-day in specialised mental health inpatient units was $1,575 and above target (see Figure 29). The higher expenditure to target is partly attributable to additional costs borne by Metropolitan Health Services that were not included in the target methodology, or the Mental Health Commission service provision agreement.

Figure 29: **Average cost per bed-day in specialised mental health inpatient units, 2009–10 to 2013–14**



	2009–10	2010–11	2011–12	2012–13	2013–14
Ave cost	$970	$1,067	$1,162	$1,320	$1,575
Target	$853	$1,096	$1,177	$1,121	$1,051

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.
2. Changes in the counting, classification and costing of public hospital admitted patients, is occurring as part of the implementation of the national Activity Based Funding framework.

Data source/s: 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 health care.

Target

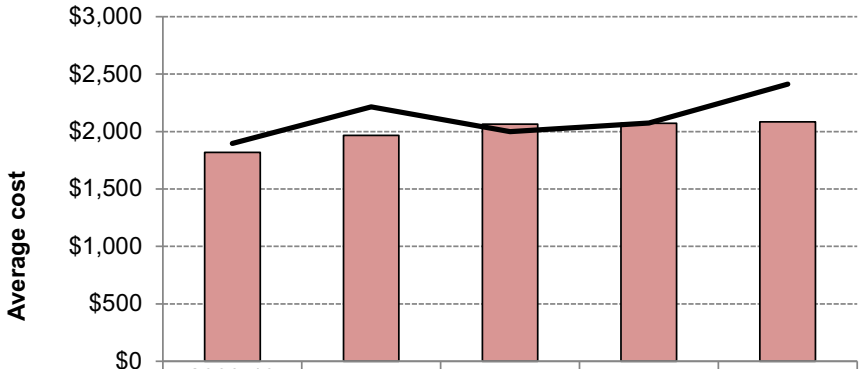
The target for 2013–14 is $2,413 per three month period of care for a person receiving public community mental health services.

A result below the target is desirable.

Results

For 2013–14, the average cost per three month period of care for a person receiving public community mental health services was $2,083 and below target (see Figure 30). The expenditure variance to target is attributable to inconsistencies in the 2013–14 budget target projection methodology.

Figure 30: **Average cost per three month period of care for a person receiving public community mental health services, 2009–10 to 2013–14**



	2009-10	2010–11	2011–12	2012–13	2013–14
Ave cost	$1,818	$1,966	$2,064	$2,072	$2,083
Target	$1,895	$2,214	$2,000	$2,075	$2,413

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 source/s: Mental Health Information System, health service financial systems.

Ministerial directives

Treasurer's Instruction 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 that are relevant to the setting of desired outcomes or operational objectives, the achievement of desired outcomes or operational objectives, investment activities, and financing activities.

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, 2013–14**

Board/Committee name	Total remuneration ($)
Armadale District Aboriginal Health Action Group	9,840
Armadale Health Service (AHS) Community Advisory Council	4,590
Bentley District Aboriginal Health Action Group	10,410
Bentley Health Service (BHS) Community Advisory Council	5,280
BreastScreen WA General Practitioner Advisory Committee	4,320
Cardiovascular Health Network Executive Advisory Group	362
Child and Adolescent Health Service Governing Council	185,068
Diabetes & Endocrine Health Network Executive Advisory Group	120
Eating Disorders Program Consumer Advisory Groups	1,320
Falls Prevention Health Network Executive Advisory Group	544
Fiona Stanley Hospital Community and Consumer Advisory Council	4,200
Fremantle District Aboriginal Health Action Group	9,030
Musculoskeletal Health Network Executive Advisory Group	240
North Metropolitan Health Service Community Advisory Council	2,040
North Metropolitan Health Service Governing Council	206,165
Osborne Park Hospital Community Advisory Council	2,490
Peel District Aboriginal Health Action Group	4,320
Renal Health Network Executive Advisory Group	816
Respiratory Health Network Executive Advisory Group	966
Rockingham General Hospital Community Advisory Council	1,860

Board/Committee name	Total remuneration ($)
Rockingham General Hospital Medical Advisory Committee	0
Rockingham Kwinana Aboriginal District Health Action Group	7,710
Royal Perth Hospital Animal Ethics Committee	28,140
Royal Perth Hospital Community Advisory Council	3,600
South Metropolitan Area Aboriginal Health Action Group	3,300
South Metropolitan Area Health Service Consumer Advisory Council	2,955
South Metropolitan Health Service Governing Council	181,398
South Metropolitan Mental Health Advisory Group (SuMMAt)	540
Western Australian Child & Youth Health Network Executive Advisory Group	60
Women's and Newborns' Health Network Executive Advisory Group	60
Women's and Newborns' Health Service Community Advisory Council (formerly King Edward Memorial Hospital)	3,960

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, if an eligible person receives public hospital services as a public patient in a public hospital or a publicly contracted bed in a private hospital, they are treated 'free of charge'.

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*. These hospital fees are reviewed annually on 1 July.

Please refer to the Department of Health's Annual Report 2013–14 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's Annual Report 2013–14 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, in comparison with the preceding financial year. Table 35 shows the year-to-date (June 2014) number of Metropolitan Health Service full time equivalent employees (FTE) for 2012–13 and 2013–14.

Table 35: **Metropolitan Health Service total full time employees by category**

Category	Definition	2012–13	2013–14
Administration & clerical	Includes all clerical-based occupations together with patient-facing (ward) clerical support staff.	4,923	5,175
Agency	Includes FTE associated with the following occupational categories: administration and clerical, medical support, hotel services, site services, medical salaried (excludes visiting medical practitioners) and medical sessional.	404	373
Agency nursing	Includes workers engaged on a 'contract for service' basis. Does not include workers employed by NurseWest.	143	128
Assistants in nursing	Support registered nurses and enrolled nurses in delivery of general patient care.	167	174
Dental nursing	Includes registered dental nurses and dental clinic assistants.	294	304
Hotel services	Includes catering, cleaning, stores/supply laundry and transport occupations.	2,640	2,646
Medical salaried	Includes all salary-based medical occupations including interns, registrars and specialist medical practitioners.	3,158	3,329
Medical sessional	Includes specialist medical practitioners that are engaged on a sessional basis.	323	329
Medical support	Includes all Allied Health and scientific/ technical related occupations.	5,121	5,167
Nursing	Includes all nursing occupations. Does not include agency nurses.	9,549	9,796
Site services	Includes engineering, garden and security-based occupations.	413	416
Other categories	Includes Aboriginal and ethnic health worker related occupations.	74	70
	Total	**27,210**	**27,906**

Notes:

1. The number of full time equivalent employees was calculated as the monthly average for full time equivalent employees and is the average hours worked during a period of time divided by the Award Full Time Hours for the same period. Hours include ordinary time, overtime, all leave categories, public holidays, time off in lieu, workers compensation.
2. Full time equivalent employee figures provided are based on Actual (Paid) month to date full time equivalent employees.
3. Data was extracted on 11 July 2014.
4. Totals may not add due to rounding.

Data source/s: Human Resource Data Warehouse.

Staff development

The Metropolitan Health Service is committed to the 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 concerning 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, either delivered internal or external to the organisation and through on-line e-learning resources.

In 2013–14 ongoing undergraduate, graduate, staff traineeship, and leadership development programs were offered to employees and included:

North Metropolitan Health Service

- Leadership Development Program including a diploma of management
- clinical placements of final year dentistry students
- site based education and training for trainee dental clinic assistants, oral health therapy students, and apprentice dental technicians
- traineeship programs for laboratory technical staff
- undergraduate Clinical Laboratory Placement training program for Bachelor of Science and Laboratory Medicine students
- Master of Laboratory Medicine scholarships for medical scientist staff
- PathWest Management Course.

South Metropolitan Health Service

- first year undergraduate medical, nursing and allied health staff training
- range of post graduate programs for all professional staff
- leading Great Care program for middle level nursing and midwifery managers.

Child and Adolescent Health Service

- Graduate nursing and postgraduate medical education programs
- Leadership program – Leading Teams

Also, new training has been implemented to support staff during the reconfiguration of the South Metropolitan Health Service. This includes:

- change management education program
- Frontline Leadership program at Royal Perth Hospital supporting the implementation and monitoring of the national safety, quality and accreditation standards
- multidisciplinary simulation program aimed at recognising and responding to rapid clinical deterioration
- Certificate III Assistant in Nursing (Acute Care) training to patient care support staff.

Industrial relations

The WA Health Industrial Relations Service provides advisory, representation and consultancy support in industrial relations and 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's Annual Report 2013–14.

Workers' compensation

The WA Workers' Compensation system is a scheme set up by the State government and exists under the statute of the *Workers' Compensation & Rehabilitation Act 1981.* The Metropolitan Health Service is committed to providing staff with a safe and healthy work environment in order to deliver effective and efficient health care services. In 2013–14 a total of 960 workers' compensation claims were made (see Table 36).

Table 36. **Number of Metropolitan Health Service workers' compensation claims in 2013–14**

Employee category	Number
Nursing Services/Dental Care Assistants	445
Administration and Clerical	93
Medical Support	115
Hotel Services	230
Maintenance	56
Medical (salaried)	21
Total	**960**

Notes:
For the purposes of the annual report Employee categories are defined as:
- Administration and clerical – includes administration staff and executives, ward clerks, receptionists and clerical staff.
- Medical support – includes physiotherapists, speech pathologists, medical imaging technologists, pharmacists, occupational therapists, dieticians and social workers.
- Hotel services – includes cleaners, caterers, and patient service assistants.

For further details on the Metropolitan Health Service's occupational injury and illness prevention and rehabilitation programs and services, please see the Occupational Safety, Health and Injury section of this report.

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 2013–14, no Metropolitan Health Service senior officer declared a pecuniary 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 $212,413 in 2013–14 (see Table 37). There was no expenditure in relation to market research, polling, or direct mail organisations.

Table 37. **Summary of Metropolitan Health Service advertising for 2013–14**

Summary of advertising	Amount ($)
Advertising agencies	49,556
Market research organisations	0
Polling organisations	0
Direct mail organisations	0
Media advertising organisations	162,857
Total advertising expenditure	**212,413**

The organisations from which advertising services were procured and the amount paid to each organisation are detailed in Table 38.

Table 38: **Metropolitan Health Service advertising, by class of expenditure, 2013–14**

Recipient/organisations	Amount ($)
Advertising agencies	
Telstra Corporation Limited	42,141
Appealing Signs & Graphics	1,463
The Poster Girls	686
Sensis PTY LTD	5,266
Total	**49,556**
Market research organisations	
Total	**0**
Polling organisations	
Total	**0**
Direct mail organisations	
Total	**0**
Media advertising organisations	
Adcorp	65,996
The Trustee for the Commerce and Trade Index	905
British Medical Journal Publishing Group Limited	1,157
ECU Student Guild	182
Media Decisions (OMD)	33,714
Curtin University Guild	182
Image Source	2,395

Recipient/organisations	Amount ($)
Medical Forum Magazine	1,275
Minnis Journals	2,684
Noongar Media Enterprises	150
Record Newspaper	71
Uniting Church	203
Anglican Church of Australia	149
Perth Diocesan Trustees	149
University of WA	943
Telstra	83
DiskBank	3,495
Impressive Promotions	5,100
Delta Print	5,300
Essential Signs	1,400
Splash Promotions	1,820
Telstra Corporation Limited	16,274
Vivid Ads Pty Ltd	1,583
Collie Mail	635
Community Newspaper	192
AMSL	666
Carat Australia Media Services PTY LTD	4,591
Corporate Communique PTY LTD	4,400
Perinatal Society Of Australia And New Zealand Limited	100
The Australasian College For Emergency Medicine	1,364
The Australian College Of Operating Room Nurses	4,800
The Royal Australasian College Of Physicians	514
The Royal Australasian College Of Surgeons	385
Total	**162,857**

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 have the opportunity to provide feedback on the quality of services received, and participate in public consultation concerning WA Health services. WA Health implemented the *Disability Access and Inclusion Plan 2010–15* which incorporates these principles. At 11 June 2014 all public authorities are now required to ensure that people with disability have equal opportunities to employment. WA Health is commencing implementation of this principle.

The following information details the current initiatives and programs being implemented by the Metropolitan Health Sevice in-line with the WA Health Disability Access and Inclusion Plan.

North Metropolitan Health Service

Access to service

The North Metropolitan Health Service has implemented and has made available a range of products and programs to support people with disability to access health services and health service information.

The Anita Clayton Centre, WA's Tuberculosis Control Program, provides information and educational material and onsite or telephone interpreters for clients who speak a language other than English. If required, Text Telephone service is available.

WoundsWest, a wound prevention and management service, also has aids available to people with disabilities to ensure they are able to access required services.

Sir Charles Gairdner Hospital has developed checklists and information for staff to ensure that printed, electronic and web based information is provided in alternative formats, and events are accessible to patients with disabilities. A revised *Disability, Access and Inclusion Plan 2012–2017* specific to Sir Charles Gairdner Hospital was implemented in May 2014.

New guidelines have been drafted by Dental Health Services to address access and inclusion issues for consumers who receive dental health care.

Access to buildings

To assist people with disability, a range of equipment and aids are provided to facilitate access to buildings and other facilities at North Metropolitan Health Service sites. Consideration is also given to ensuring access and safety of consumers when activities/events are conducted at venues within the community.

In 2013–14 a number of improvements to walkways, widening of doorways, modifications to toilets, and renovations to bathrooms were made at Queen Elizabeth II Medical Centre and Swan District Hospital to improve access to services by people with disability.

Access to information

The North Metropolitan Health Service provides information and educational material through hardcopy and the internet. The information is made available in various formats, including larger print and audio for patients with literacy or vision difficulties. Information is also available in languages other than English.

Quality of service by staff

The North Metropolitan Health Service ensures that new staff receive approved education and training on the service needs of people with disability. On-going staff training is also encouraged with intranet site resources and e-learning modules available to support this process. Recently Sir Charles Gardener Hospital frontline clerical staff received an educational update on communicating with people with disability.

Opportunity to provide feedback

North Metropolitan Health Service sites provide options for people with a disability to provide feedback including complaints. This includes the provision of posters, brochures and comments/complaints/suggestion boxes placed throughout hospital sites. Sir Charles Gairdner Hospital also has an internet complaints site available to people with disability. A Consumer Liaison Support officer is available at Swan Districts Hospital to assist with lodging complaints.

Participation in public consultation

The North Metropolitan Health Service is committed to ensuring that people with disability are given the opportunity to have input into the public consultation process.

Staff at Sir Charles Gairdner Hospital have recently taken part in the Disability Liaison Officer Project to scope the needs of people aged 18–65 years with complex disability and how hospital services can be improved and/or enhanced. Extensive consultation with people with disability, their families, carers and support workers, were included in this process.

South Metropolitan Health Service

Access to service

The South Metropolitan Health Service is committed to improving access to services for people with a disability, demonstrated by awareness raising and direct consumer input into service planning and monitoring.

During 2013–14 Armadale Health Service celebrated the International Day of People with Disability.

Bentley Health Service conducts weekly Executive Safety walk rounds including members of the Community Advisory Council. Disability Services has presented to the Bentley Health Service Mental Health Consumer Advisory Group on two occasions, generating discussions and raising awareness.

The Rockingham Peel Group Disability Access and Inclusion Plan Working Group, that includes a disabled consumer, advises on issues regarding access to services.

At Royal Perth Hospital, the Equitable Access Committee is working with the transition unit staff to ensure patients with disability are considered and included in transition and communication plans. *The Clinical Safety and Quality Strategic Plan* and the *Consumer, Carer and Community Participation Engagement Plan 2011–2015* include specific strategies and recommendations to accommodate patients and other consumers with a disability.

Access to buildings

During 2013–14, the South Metropolitan Health Service completed projects and continued delivery of initiatives that enhance access to buildings and other facilities for people with disabilities. This has included improvements to walkways, widening of doorways, modifications to toilets, and renovations to bathrooms to improve wheelchair access across health service sites. A new volunteer patient transport bus is now available at Rockingham General Hospital to assist people with mobility problems.

A review is also occurring to ensure the provision of relevant information will be available to patients with disability with the impending closure of the Shenton Park Campus.

Members of the Disability Access Committee are liaising with reconfiguration steering groups to ensure that accessible signage and pathways are considered in future capital works.

Access to information

During 2013–14, the South Metropolitan Health Service has improved access to information for people with disability by introducing a variety of formats.

At Fremantle Hospital and Health Service, work on the Disability Advisory Council intranet and internet websites is continuing, while at Royal Perth Hospital a new website for patients and visitors that will contain useful disability access information will be available by 30 June 2014.

At Rockingham General Hospital a hearing loop system has been installed at the recently completed Education Centre.

Action has also been taken to improve awareness and compliance by staff of the required publication standards for accessibility by people with disability.

Quality of service by staff

South Metropolitan Health Service sites have demonstrated a commitment to improving the quality of service provided to consumers with a disability through the provision of specialised aids and equipment, staff education and consumer input.

An Improving the Patient Journey project has commenced at Armadale Health Service, with a focus on disability. Readmission clinical documentation now allows for capture of information in regard to whether issues related to disability access and inclusion contributed to readmission.

At Fremantle Hospital and Health Service, consumer feedback is actively sought throughout the hospital by the Customer Relations Service via the display of posters and brochures. Disability awareness is included in the staff induction process and staff development courses. Where required, the Disability Advisory Committee liaises with the Consumer Advisory Committee and the Customer Relations Service to address issues concerning service provision.

Opportunity to provide feedback

The South Metropolitan Health Service ensures that people with disability have the same opportunities as other people to make complaints. At Bentley Health Service, complaints and compliments with a specific disability theme are tabled at Executive Group meetings for review or action. Complaints received from consumers with disability at Fremantle Hospital and Health Service are similarly brought to the attention of the Disability Advisory Committee for action. Consumer Liaison Officers at Rockingham Peel Group assist consumers with disability to lodge complaints and work through the complaint in a manner that suits the individual. At Royal Perth Hospital, information about how to make a complaint is available on the website and through brochures that meet Disability Access Legislation requirements.

Participation in public consultation

The participation of people with a disability is encouraged across all south metropolitan hospital sites. This includes engagement, consultation and feedback from the Consumer Advisory Council concerning events, service planning and development, with the aim to continue to improve disability services.

Child and Adolescent Health Service

Access to service

A range of equipment is provided by Child and Adolescent Health Service to assist people with disabilities to access the services. Staff awareness and application of the *Disability Access and Inclusion Plan for 2010–2015* requires that the access requirements of people with disability is considered.

The Liaising, Informing and Networking for Carers position is ongoing to support unpaid carers of children with chronic illness, disability, and/or mental illness.

Access to buildings

The Child and Adolescent Health Service continues to maintain access to facilities including Princess Margaret Hospital for Children and community health sites for children and adolescents with disability. In November 2013, access at Princess Margaret Hospital via Hay Street to the Hay Street building was upgraded with a secure pedestrian path and ramp.

The Child and Adolescent Health Service also ensures the Disability Access and Inclusion Plan is available to contracted services to encourage the provision of services in a manner consistent with the plan. The Perth Children's Hospital will comply with these requirements as per the WA Disability Services Act 1993.

Access to information

The Child and Adolescent Health Service ensures that all consumer publications are available in alternative formats and languages on request. This includes large print and audio formats for patients with literacy or vision difficulties.

The Child and Adolescent Health Service internet is currently being reviewed in accordance with the Web Content Accessibility Guidelines.

Quality of service by staff

The Child and Adolescent Health Service has available an e-learning package for staff education on Disability Access and Inclusion. Regular staff presentations are also provided in collaboration with the Disability Services Commission.

Opportunity to provide feedback

Child and Adolescent Health Service staff are available to assist people in terms of providing support and options for lodging comments and complaints via the website, or suggestion boxes. A dedicated Customer Liaison Service is also available during office hours to process and manage consumer complaints.

Complaints from people with disability are also discussed at the Consumer Advisory Council and the Disability Access and Inclusion Committee to ensure that any changes to policy or updates to services are considered.

Participation in public consultation

The Child and Adolescent Health Service ensures all venues for public consultation meet the needs of people with disability.

In July 2012 the Child and Adolescent Mental Health Service held a Youth Round Table discussion concerning the model of care for youth mental health services. In response, improvements to existing models of care are currently being implemented, and are inclusive of the needs of youth with disability.

Compliance with public sector standards

Details of the WA Health compliance with the WA 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's Annual Report 2013–14.

Recordkeeping plans

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

North Metropolitan Health Service

In 2013–14 the North Metropolitan Health Service completed a Recordkeeping plan for submission to the State Records Commission for review and endorsement.

Across the North Metropolitan Health Service, patient health records are managed with reference to relevant standards, legislation and policy, and are subject to site-based accreditation with the Australian Council on Health care Standards. All North Metropolitan Health Service hospitals maintained accreditation status in 2013–14.

Mandatory training and education concerning the governance and responsibilities relating to records management and compliance with the State Records Act is available through online learning tools available to all staff.

South Metropolitan Health Service

During 2013–14 South Metropolitan Health Service commissioned a review of corporate records management practices. The review findings guided the development of the South Metropolitan Health Service Recordkeeping Plan, which was endorsed by the Executive in March 2014. The Plan commits South Metropolitan Health Service to improving recordkeeping practices for the next 5 years and will be implemented in 2014–15.

Child and Adolescent Health Service

The Child and Adolescent Health Service is focussing on achieving document management reform at the Perth Children's Hospital as part of the development of a Recordkeeping Plan across service sites. This process has involved assistance from the State Records Office, Department of Health, and Health Information Network.

Substantive equality

WA Health contributes towards achieving substantive equality for all Western Australians by continuing to concentrate on the *Policy Framework for Substantive Equality* and adopt policies and implement initiatives that address the diverse needs and sensitivities of the communities in which it operates.

The Metropolitan Health Service has developed policies and implemented initiatives distinctive to their unique environment and that is appropriate and sensitive to cultural needs, are patient focussed, innovative, accessible and safe.

The North Metropolitan Health adopts a proactive approach to service delivery and best practice, and requires all policy to give due consideration to the impact of the policy on all Western Australians, specifically to ensure the new or reviewed policy promotes equality and awareness of the rights of diverse service users to achieve equitable outcomes.

The South Metropolitan Health Service continues to provide substantive equality in health care to all members of the community by caring for all patients with full respect to each patient's ethnic, cultural and religious needs. Implementation of initiatives, which included encouraging Aboriginal staff to participate on advisory groups and the provision of an Interpreting/ Translation service to persons with limited English, remain high priorities.

Programs such as the Child and Adolescent Health Service Aboriginal Cultural Learning Plan, whose purpose is *'To improve the health outcome of Aboriginal infants, children, young people and their families by embedding cultural learning in the delivery of health services',* promotes a workplace environment that enables cultural learning, sharing and acknowledges the diversity of Aboriginal people's cultures and practices.

Occupational safety, health and injury

All areas of the Metropolitan Health Service are committed to continuously improving the occupational safety, health and injury management systems in line with the *Occupational Safety and Health Act 1984* and the injury management requirements of the *Workers' Compensation and Injury Management Act 1981.*

Commitment to occupational safety and health, and injury management

The Metropolitan Health Service management will:

- comply with all relevant legislation and regulations, as well as the Department of Health policies, procedures and safe work procedures
- enhance the effectiveness of the occupational safety and health management system by consulting with employees and contractors on issues of health and safety
- improve occupational safety and health performance by establishing measurable objectives and targets
- undertake occupational safety and health risk management activities to adequately control risks to persons in the work environment
- provide adequate facilities to protect the health, safety and welfare of all employees
- provide, monitor and maintain safe systems of work for the use, handling, storage and transportation of plant, equipment and substances
- promote, train and support safety and health representatives to be a key safety resource
- provide information and supervision for all staff to enable them to work in a safe and healthy manner
- provide adequate resources, including finances and expertise, to facilitate the fulfillment of these responsibilities.

Compliance with occupational safety and health injury management

The Metropolitan Health Service is committed to ensuring the safety, health and welfare of its staff, volunteers, students, contractors and visitors. This is reflected in comprehensive injury management policies and services available to staff to assist in claims lodgement and processing, early intervention, return to work programs, and claims management. Staff are also provided training, instruction, and supervision as part of risk management programs to enable safe work practices and minimise risk of injury.

Employee consultation

The Metropolitan Health Service facilitates occupational safety and health management and consultation with staff by:

- establishment of occupational safety and health representatives and groups
- hazard/incident reporting and investigation systems
- routine workplace hazard inspections
- resolution of issues process
- implementation of regular audits, risk assessments and control measures to prevent incidents from occurring
- consultation with the workforce during regular reviews of safety related policies.

Employee rehabilitation

In the event of a work related injury or illness, the Metropolitan Health Service is committed to assisting injured workers to return to work as soon as medically appropriate. A case management approach is adopted to ensure that return to work outcomes of injured workers is optimised. This includes professional injury management staff assisting with the lodgement and management of workers' compensation claims, and access to appropriate alternative duties for employees on structured in-house rehabilitation programs.

Occupational safety and health assessment and performance indicators

During 2013–14, Metropolitan Health Service sites were independently audited in terms of workplace and industry standards. The findings and recommendations from these audits are currently being reviewed and action plans developed and/or implemented.

The Metropolitan Health Service's performance in relation to occupational safety, health and injury for 2013–14 is summarised in Table 39.

Table 39. **Metropolitan Health Service's occupational safety, health and injury performance for 2013–14**

	2013–14				
	North Metropolitan Health Service	South Metropolitan Health Service	Child and Adolescent Health Service	Dental Health Service	PathWest
Fatalities (number of deaths)	0	0	0	0	1
Lost time injury/diseases (LTI/D) incidence rate (rate per 100)	2.58	3.18	1.86	2.18	1.40
Lost time injury severity rate (rate per 100)	27.20	39.84	35.09	13.33	30.43
Percentage of injured workers returned to work within 26 weeks	77.1%	71.3%	93.0%	78.6%	92.3%
Percentage of managers trained in occupational safety, health and injury management responsibilities	67.3%	44.2%	61.5%	67.5%	67.2%

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Appendices

Appendix 1: Metropolitan Health Service addresses and locations

North Metropolitan Health Service

Street address:
Hospital Avenue, NEDLANDS WA 6009

Postal address:
Locked Bag 2012, NEDLANDS WA 6009

Phone: (08) 9346 3333
Fax: (08) 9346 3759
Email: scgh.webmaster@health.wa.gov.au
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 6009

Phone: (08) 9346 3333
Fax: (08) 9346 3759
Email: scgh.webmaster@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
Email: NMHS.PHACSQ@health.wa.gov.au
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 Kalamunda Health Service

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
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

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

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

PathWest Laboratory Medicine

Street address:
J Block, QEII Medical Centre
Hospital Avenue
NEDLANDS WA 6009

Postal address:
Locked Bag 2009
NEDLANDS WA 6009

Phone: (08) 9346 3000
Fax: (08) 9381 7594
Email: pathwest@health.wa.gov.au
Web: www.pathwest.com.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 subsidary of Ramsay Health Care

South Metropolitan Health Service

Street address:
16 Ogilvie Road, MT PLEASANT WA 6153

Postal address:
Locked Bag 8, CANNING BRIDGE WA 6153

Phone: (08) 9318 750
Fax: (08) 9318 7515
Web: www.southmetropolitan.health.wa.gov.au

Royal Perth Hospital – Wellington Street Campus

Street address:
197 Wellington Street
PERTH WA 6001

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

Royal Perth Hospital – Shenton Park Campus

Street and postal address:
6 Selby Street
SHENTON PARK WA 6008

Phone: (08) 9382 7171
Fax: (08) 9382 7351
Email: rph.general.enquiries@health.wa.gov.au
Web: www.rph.wa.gov.au

Bentley Hospital

Street address:
18-56 Mills Street
BENTLEY WA 6102

Postal address:
PO Box 158
BENTLEY WA 6982

Phone: (08) 9334 3666
Fax: (08) 9334 3711
Email: bl.enquires@health.wa.gov.au
Web: www.health.wa.gov.au/bhs

Fremantle Hospital

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@health.wa.gov.au
Web: www.fhhs.health.wa.gov.au

Kaleeya Hospital

Street address:
15 Wolsely Road (Cnr Station Rd)
EAST FREMANTLE WA 6158

Postal address:
PO Box 480
FREMANTLE WA 6959

Phone: (08) 9319 0300
Fax: (08) 9319 1958
Email: fhhs@health.wa.gov.au
Web: www.fhhs.health.wa.gov.au/services/kaleeya.aspx

Rottnest Island Nursing Post

Street address:
2 Abbott Street
ROTTNEST WA 6161

Postal address:
RINP, c/o Fremantle Hospital
PO Box 480
FREMANTLE WA 6959

Phone: (08) 9292 5030
Fax: (08) 9292 5121
Web: www.fhhs.health.wa.gov.au/services/rottnest

Armadale-Kelmscott Memorial Hospital

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.southmetropolitan.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.southmetropolitan.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

South Metropolitan Population Health

Street address:
Level 2, 7 Pakenham Street
FREMANTLE WA 6160

Postal address:
PO Box 546, FREMANTLE WA 6959
Phone: (08) 9431 0200
Fax: (08) 9431 0227
Web: www.smphu.health.wa.gov.au

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:
70 Hay Street
SUBIACO WA 6008

Postal address:
GPO Box D184
PERTH WA 6840

Phone: (08) 6389 5800
Fax: (08) 6389 5848
Email: pmh@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: pmh@health.wa.gov.au
Web: www.cahs.health.wa.gov.au

Appendix 2: Board and committee remuneration

Position	Name	Type of remuneration	2013–14 period of membership	Gross/actual remuneration
Armadale District Aboriginal Health Action Group				
Member	Gary Bennell	Per meeting	12 months	$540
Member	Gloria Bennell	Per meeting	12 months	$1,080
Member	Patricia Bennell	Per meeting	12 months	$270
Member	Norma Garllett	Per meeting	12 months	$90
Member	Allen Garlett	Per meeting	12 months	$90
Member	Edna Riley	Per meeting	12 months	$630
Member	Marian Kemp	Per meeting	12 months	$60
Member	Eunice Bynder	Per meeting	12 months	$1,080
Member	Theresa Miller	Per meeting	12 months	$90
Member	Chantel Yarran	Per meeting	12 months	$180
Member	Courtney Garlett	Per meeting	12 months	$180
Member	Christopher Stack	Per meeting	12 months	$450
Member	David Bilney	Per meeting	12 months	$180
Member	Amanda Yarran	Per meeting	12 months	$180
Member	Darian Garlett	Per meeting	12 months	$180
Member	Dianne Wynne	Per meeting	7 months	$690
Member	Cheryl French	Per meeting	12 months	$300
Member	Madge Hill	Per meeting	12 months	$660
Member	Glynis Yarran	Per meeting	12 months	$480
Member	Beatrice Yarran	Per meeting	12 months	$180
Member	Desma Collard	Per meeting	12 months	$150
Member	Raelene Hayward	Per meeting	7 months	$600
Member	Leon Hayward	Per meeting	7 months	$750
Member	Eric Waynne	Per meeting	7 months	$750
			Total:	**$9,840**
Armadale Health Service (AHS) Community Advisory Council				
Chair	Dorothy Harrison	Per meeting	12 months	$720
Deputy Chair	Julie Brown	Per meeting	12 months	$690
Secretary	Belinda Forte	Not eligible	Not applicable	$0
Member	Julie Hoey	Per meeting	12 months	$570
Member	Sam Youssef	Per meeting	12 months	$330
Member	John Hancock	Per meeting	12 months	$0
Member	Kerry Busby	Per meeting	9 months	$360
Member	Helen Abbott	Per meeting	4 months	$240
Member	Jan Stone	Per meeting	12 months	$0

Position	Name	Type of remuneration	2013–14 period of membership	Gross/actual remuneration
Armadale Health Service (AHS) Community Advisory Council (cont.)				
Member	John Kirkpatrick	Not eligible	Not applicable	$0
Member	Sheryl Little	Per meeting	12 months	$660
Member	Eric Wynne	Per meeting	2 months	$420
Member	Carey Buttfield	Per meeting	12 months	$360
Member	Margaret McRae	Per meeting	12 months	$240
			Total:	**$4,590**
Bentley District Aboriginal Health Action Group				
Member	Herman Eades	Per meeting	12 months	$150
Member	Janice McEwan	Per meeting	12 months	$1,200
Member	Doreen Nelson	Per meeting	12 months	$1,350
Member	Albert Knapp	Per meeting	12 months	$1,350
Member	Shirley Thorne	Per meeting	12 months	$1,260
Member	Shirley Voss	Per meeting	7 months	$1,200
Member	Ada Bolton	Per meeting	12 months	$1,410
Member	Bradley Hayward	Per meeting	7 months	$1,170
Member	Lorraine Belotti	Per meeting	12 months	$750
Member	Joanne Hayward	Per meeting	12 months	$570
			Total:	**$10,410**
Bentley Health Service Community Advisory Council				
Chair	Marilyn Carrigg	Per meeting	12 months	$360
Deputy Chair	Marie-Louise Matthews	Per meeting	12 months	$480
Deputy Chair	Michelle Wheaton	Per meeting	12 months	$540
Member	Linda Beresford	Per meeting	12 months	$480
Member	Alma Digweed	Per meeting	12 months	$540
Member/ Acting Chair	Roy Dobson	Per meeting	12 months	$540
Member	Colin Stevenson	Per meeting	12 months	$600
Member	Shirley Thorne	Per meeting	12 months	$300
Member	Cynthia Reilly	Per meeting	12 months	$600
Member	Felicity Graham	Per meeting	12 months	$240
Ex Officio Member	John Bartlett	Per meeting	12 months	$600
			Total:	**$5,280**
BreastScreen WA General Practitioner Advisory Committee				
Chair	Dr Eric Khong	Not eligible	Not applicable	$0
Member	Dr Liz Wylie	Not eligible	Not applicable	$0
Member	Dr Karen Moller	Per meeting	12 months	$480

Position	Name	Type of remuneration	2013–14 period of membership	Gross/actual remuneration
BreastScreen WA General Practitioner Advisory Committee (cont.)				
Member	Dr Angela Cooney	Per meeting	12 months	$720
Member	Dr Judy Galloway	Per meeting	12 months	$720
Member	Dr Alison Stubbs	Per meeting	12 months	$720
Member	Dr Jacquie Garton-Smith	Per meeting	12 months	$720
Member	Dr Crystal Cree	Per meeting	12 months	$480
Member	Dr Vicki Westoby	Per meeting	12 months	$480
			Total:	**$4,320**
Cardiovascular Health Network Executive Advisory Group				
Chair	Dr Jacquie Garton-Smith	Not eligible	Not applicable	$0
Deputy Chair	Dr Stephen Bloomer	Not eligible	Not applicable	$0
Member	Ass. Prof. Tom Briffa	Not eligible	Not applicable	$0
Member	Jille Burns	Not eligible	Not applicable	$0
Member	Craig Cheetham	Not eligible	Not applicable	$0
Member	Trevor Cherry	Not eligible	Not applicable	$0
Member	Lesley Gregory	Not eligible	Not applicable	$0
Member	Shirley Fitzthum	Not eligible	Not applicable	$0
Member	Dr Joseph Hung	Not eligible	Not applicable	$0
Member	Dr Frank Jones	Per meeting	12 months	$242
Member	Lorraine Linacre	Not eligible	Not applicable	$0
Member	Andrew Maiorana	Not eligible	Not applicable	$0
Member	Shelley McRae	Not eligible	Not applicable	$0
Member	Dr Tony Mylius	Not eligible	Not applicable	$0
Member	Lesley Nelson	Not eligible	Not applicable	$0
Member	Dr Paul Norman	Not eligible	Not applicable	$0
Member	John Powdrill	Per meeting	12 months	$120
Member	Dr Jamie Rankin	Not eligible	Not applicable	$0
Member	Julie Smith	Not eligible	Not applicable	$0
			Total:	**$362**
Child and Adolescent Health Service Governing Council				
Chair	Dr Rosanna Capolingua	Annual	12 months	$53,550
Deputy Chair	Adjunct Prof. Christopher McGowan	Annual	12 months	$32,130
Member	Brendan Ashdown	Annual	12 months	$24,097
Member	Dr Gervase Chaney	Not eligible	Not applicable	$0
Member	Prof. Gary Geelhoed	Not eligible	Not applicable	$0
Member	Amanda Magraith	Annual	12 months	$24,097
Member	Dr Dan McAullay	Annual	12 months	$24,097

Position	Name	Type of remuneration	2013–14 period of membership	Gross/actual remuneration
Child and Adolescent Health Service Governing Council (cont.)				
Member	Denys Pearce	Annual	12 months	$24,097
Ex-Officio Member	April Welsh	Annual	12 months	$3,000
			Total:	**$185,068**
Diabetes & Endocrine Health Network Executive Advisory Group				
Chair	Dr Scott Westover	Not eligible	Not applicable	$0
Chair	Prof. Tim Davis	Not eligible	Not applicable	$0
Lay person	Tim Benson	Per meeting	12 months	$120
Member	Bruce Campbell	Per meeting	12 months	$0
Member	Dr Richard Prince	Not eligible	Not applicable	$0
Member	Dr Gerry Fegan	Not eligible	Not applicable	$0
Member	Prof. Tim Jones	Not eligible	Not applicable	$0
Member	Dr Seng Khee Gan	Not eligible	Not applicable	$0
Member	Dr Chhaya Mehrotra	Not eligible	Not applicable	$0
Member	Denise Smith	Not eligible	Not applicable	$0
Member	Andrew Wagstaff	Not eligible	Not applicable	$0
Member	Helen Mitchell	Not eligible	Not applicable	$0
Member	Mel Robinson	Not eligible	Not applicable	$0
Member	Dr Rhonda Clifford	Not eligible	Not applicable	$0
Member	Genevieve Stone	Not eligible	Not applicable	$0
Member	Maria Orifici	Not eligible	Not applicable	$0
Member	Belinda Whitworth	Not eligible	Not applicable	$0
Member	Vivienne Duggin	Not eligible	Not applicable	$0
Member	Dr Alan Wright	Per meeting	12 months	$0
Member	Paul Hersey	Not eligible	Not applicable	$0
Member	Merinda March	Not eligible	Not applicable	$0
Member	Sophie McGough	Per meeting	12 months	$0
Member	Cara Westphal	Not eligible	Not applicable	$0
Member	Rachele Humbert	Not eligible	Not applicable	$0
Member	Dr Sean George	Not eligible	Not applicable	$0
			Total:	**$120**
Eating Disorders Program Consumer Advisory Groups				
Chair	Asha McAllister	Per meeting	4 months	$420
Deputy Chair	Linelle Fields	Per meeting	4 months	$180
Secretary	Ashleigh Hardcastle	Per meeting	4 months	$120
Member	Emily Wheeler	Per meeting	4 months	$600
Staff Member	Dawn Hopkins	Not eligible	Not applicable	$0

Position	Name	Type of remuneration	2013–14 period of membership	Gross/actual remuneration
Eating Disorders Program Consumer Advisory Groups (cont.)				
Staff Member	Ulli O'Sullivan	Not eligible	Not applicable	$0
			Total:	**$1,320**
Falls Prevention Health Network Executive Advisory Group				
Chair	Dr Nicholas Waldron	Not eligible	Not applicable	$0
Member	Phil Airey	Not eligible	Not applicable	$0
Member	Emily Anderson	Not eligible	Not applicable	$0
Member	Jenna Athans	Not eligible	Not applicable	$0
Member	Dr Erica Davison	Not eligible	Not applicable	$0
Member	Kathryn Devereux	Not eligible	Not applicable	$0
Member	Louise Mason	Not eligible	Not applicable	$0
Member	Ailsa Dinnes	Not eligible	Not applicable	$0
Member	Luke Hays	Not eligible	Not applicable	$0
Member	Dr Anne-Marie Hill	Not eligible	Not applicable	$0
Member	Su Kitchen	Not eligible	Not applicable	$0
Member	Dr Katherine Ingram	Not eligible	Not applicable	$0
Member	Dr Aru Moodley	Per meeting	12 months	$484
Member	Tony Petta	Not eligible	Not applicable	$0
Member	Marisa Skrzypek	Not eligible	Not applicable	$0
Member	Nola Todorovich	Not eligible	Not applicable	$0
Member	Kim Watkins	Per meeting	12 months	$0
Member	Elizabeth Solich	Per meeting	12 months	$60
			Total:	**$544**
Fiona Stanley Hospital Community and Consumer Advisory Council				
Chair	Piper Marsh	Per meeting	12 months	$600
Deputy Chair	Kelli Porter	Per meeting	12 months	$450
Member	Michelle Atkinson-de Garis	Per meeting	12 months	$450
Member	Nancy Pierce	Per meeting	12 months	$300
Member	Seamus Murphy	Per meeting	12 months	$450
Member	Bev Sinclair	Per meeting	12 months	$540
Member	Kerry Mace	Per meeting	12 months	$420
Member	Teresa Campbell	Per meeting	12 months	$450
Member	Margaret Walsh	Per meeting	12 months	$540
			Total:	**$4,200**
Fremantle District Aboriginal Health Action Group				
Member	Tova Calgaret	Per meeting	12 months	$660
Member	Sharon Calgaret	Per meeting	12 months	$1,170
Member	Tenika Calgaret	Per meeting	12 months	$1,020

Position	Name	Type of remuneration	2013–14 period of membership	Gross/actual remuneration
Fremantle District Aboriginal Health Action Group (cont.)				
Member	Dianne May	Per meeting	12 months	$1,200
Member	Anna Peck	Per meeting	12 months	$330
Member	Athol Thorne	Per meeting	12 months	$150
Member	Ivan Lyndon	Per meeting	12 months	$180
Member	Marjorie Newell	Per meeting	12 months	$1,110
Member	Howard Riley	Per meeting	12 months	$780
Member	Corina Abraham	Per meeting	12 months	$810
Member	Betty Ugle	Per meeting	12 months	$720
Member	Sealin Garlett	Per meeting	12 months	$270
Member	Glenda Morrison	Per meeting	12 months	$60
Member	Susan Pickett	Per meeting	12 months	$150
Member	Constance Moses	Per meeting	12 months	$240
Member	Blanche Quartermaine	Per meeting	4 months	$60
Member	Greg Turnbull	Per meeting	12 months	$120
			Total:	**$9,030**
Musculoskeletal Health Network Executive Advisory Group				
Chair	Ric Forlano	Not eligible	Not applicable	$0
Member	Kerryn Barton	Not eligible	Not applicable	$0
Member	Assoc. Prof. Kathy Briffa	Not eligible	Not applicable	$0
Member	Eng Soon Chew	Not eligible	Not applicable	$0
Member	Kathryn Devereux	Not eligible	Not applicable	$0
Member	Dr Jeff Hebert	Not eligible	Not applicable	$0
Member	Ben Horgan	Not eligible	Not applicable	$0
Member	Dr Helen Keen	Not eligible	Not applicable	$0
Member	Kerry Mace	Per meeting	12 months	$240
Member	Jean Mangharam	Not eligible	Not applicable	$0
Member	Helen Marsden	Not eligible	Not applicable	$0
Member	Yvonne Page	Per meeting	5 months	$0
Member	Prof. Stephan Schug	Not eligible	Not applicable	$0
Member	Robyn Timms	Not eligible	Not applicable	$0
Member	Dr James Williamson	Not eligible	Not applicable	$0
Member	Dr Greg Parkin-Smith	Not eligible	Not applicable	$0
Member	Prof. Johannes Nossent	Not eligible	Not applicable	$0
Member	Prof. Piers Yates	Not eligible	Not applicable	$0
Member	Dr Jim Codde	Not eligible	Not applicable	$0
Member	Maggie Crowe	Not eligible	Not applicable	$0
Member	Jane Churchill	Per meeting	12 months	$0

Position	Name	Type of remuneration	2013–14 period of membership	Gross/actual remuneration
Musculoskeletal Health Network Executive Advisory Group (cont.)				
Member	Dr Stephanie Davies	Not eligible	Not applicable	$0
			Total:	**$240**
North Metropolitan Health (NMHS) Community Advisory Council				
Chair	Tim Benson	Per meeting	12 months	$300
Deputy Chair	Alan Alford	Per meeting	12 months	$360
Member	Tom Benson	Per meeting	12 months	$180
Member	Jacquelin Carter	Per meeting	12 months	$300
Member	Theresa Ann McRae	Per meeting	12 months	$180
Member	Margaret Ryan	Per meeting	12 months	$360
Member	Ian Wright	Per meeting	12 months	$240
Member	Brian Stafford	Per meeting	12 months	$120
Member	Anne Cordingley	Per meeting	12 months	$0
			Total:	**$2,040**
North Metropolitan Health Service Governing Council				
Chair	Rob McDonald	Annual	12 months	$53,550
Deputy Chair	Adjunct Ass. Prof. Kim Gibson	Annual	12 months	$32,130
Member	Julian Henderson	Not eligible	Not applicable	$0
Member	Michael Levitt	Annual	12 months	$24,097
Member	Mary Jo Kroeber	Annual	12 months	$24,097
Member	Yvonne Parnell	Annual	12 months	$24,097
Member	Prof. Julie Quinlivan	Annual	12 months	$24,097
Member	Fiona Stanton	Annual	12 months	$24,097
Member	Prof. Simon Towler	Not eligible	Not applicable	$0
			Total:	**$206,165**
Osborne Park Hospital Community Advisory Council				
Chair	Joan Varian	Per meeting	12 months	$1,140
Deputy Chair	Tom Benson	Per meeting	12 months	$450
Member	Sharon Cooke	Per meeting	12 months	$240
Member	Suresh Rajan	Per meeting	12 months	$300
Member	Pam van Omme	Per meeting	12 months	$60
Member	Jane Robertson	Per meeting	12 months	$300
Resigned	Phil Samuell	Per meeting	12 months	$0
			Total:	**$2,490**
Peel District Aboriginal Health Action Group				
Member	Gloria Watkins	Per meeting	12 months	$480
Member	Mary Indich	Per meeting	12 months	$480

Position	Name	Type of remuneration	2013–14 period of membership	Gross/actual remuneration
Peel District Aboriginal Health Action Group (cont.)				
Member	Elsie Ugle	Per meeting	12 months	$630
Member	Ivy Bennell	Per meeting	12 months	$840
Member	Leslie Pickett	Per meeting	12 months	$240
Member	Theresa Hearne	Per meeting	5 months	$210
Member	Harry Nannup	Per meeting	12 months	$180
Member	Kayleen Bennell	Per meeting	12 months	$300
Member	Peter Woods	Per meeting	12 months	$120
Member	Robert Ugle	Per meeting	5 months	$210
Member	Leslie Jacobs	Per meeting	5 months	$270
Member	Sharree Kearing	Per meeting	5 months	$60
Member	Gloria Kearing	Per meeting	5 months	$60
Member	Narva Eades	Per meeting	12 months	$60
Member	Linda Quartermaine	Per meeting	5 months	$60
Member	Franklyn Nannup	Per meeting	12 months	$60
Member	Ruby Wallam	Per meeting	12 months	$60
			Total:	**$4,320**
Renal Health Network Executive Advisory Group				
Chair	Dr Harry Moody	Not eligible	Not applicable	$0
Deputy Chair	Dr Hemant Kulkarni	Not eligible	Not applicable	$0
Member	Dr Neil Boudville	Not eligible	Not applicable	$0
Member	Lynn Brown	Not eligible	Not applicable	$0
Member	Dr Aron Chakera	Not eligible	Not applicable	$0
Member	Dr Mike Civil	Per meeting	12 months	$726
Member	Evelyn Coral	Not eligible	Not applicable	$0
Member	Dr Rebecca Croke	Not eligible	Not applicable	$0
Member	Jenny Cutter	Not eligible	Not applicable	$0
Member	Lois Dear	Not eligible	Not applicable	$0
Member	Debbie Fortnum	Not eligible	Not applicable	$0
Member	Simone McMahon	Per meeting	12 months	$90
Member	Prof. Johan Rosman	Not eligible	Not applicable	$0
Member	Martyn Savage	Not eligible	Not applicable	$0
Member	Kerry Winsor	Not eligible	Not applicable	$0
Member	Dr Lauren Harris	Not eligible	Not applicable	$0
Member	Dr Stephen Wright	Not eligible	Not applicable	$0
Member	Vince Mazoue	Not eligible	Not applicable	$0
Total:				**$816**

Position	Name	Type of remuneration	2013–14 period of membership	Gross/actual remuneration
Respiratory Health Network Executive Advisory Group				
Chair	Assoc. Prof. Peter Kendall	Not eligible	Not applicable	$0
Lay person	Dr Jenni Ibrahim	Per meeting	12 months	$240
Member	Dr Jacquie Garton-Smith	Per meeting	12 months	$726
Member	Sharifa Dina	Not eligible	Not applicable	$0
Member	Dr Siobhain Mulrennan	Not eligible	Not applicable	$0
			Total:	**$966**
Rockingham General Hospital Community Advisory Council				
Chair	Jan Thair	Per meeting	12 months	$540
Member	Rosalie Cameron	Per meeting	12 months	$480
Member	Jane Churchill	Per meeting	12 months	$0
Member	Councillor Wendy Cooper	Per meeting	12 months	$480
Member	Suzanne Marshall	Per meeting	12 months	$360
Member	Betty McNeil	Per meeting	12 months	$0
Member	Colin Pitson	Per meeting	12 months	$0
Member	Councillor Joy Stewart	Per meeting	8 months	$0
Member	Councillor Matthew Whitefield	Per meeting	8 months	$0
Member	Sally Whyte	Per meeting	12 months	$0
Member	Kellie Wilson	Per meeting	12 months	$0
			Total:	**$1,860**
Rockingham General Hospital Medical Advisory Committee				
Chair	Dr Nick Prophet	Not eligible	Not applicable	$0
Member	Geraldine Carlton	Not eligible	Not applicable	$0
Member	Dr Helen Thomas	Not eligible	Not applicable	$0
Member	Dr Geoff Williamson	Not eligible	Not applicable	$0
Member	Dr Tehal Kooner	Not eligible	Not applicable	$0
Member	Dr Andrew Thompson	Not eligible	Not applicable	$0
Member	Dr Edward Pleydell-Bouverie	Not eligible	Not applicable	$0
Member	Dr Gordon Shymko	Not eligible	Not applicable	$0
Member	Dr Tim Patel	Not eligible	Not applicable	$0
Member	Dr Prasad Bheemasenachar	Not eligible	Not applicable	$0
Member	Dr Margarita Nicoletti	Not eligible	Not applicable	$0
Member	Dr Sunanda Gargeswari	Not eligible	Not applicable	$0
Member	Dr Murali Narayanan	Not eligible	Not applicable	$0
Member	Dr Raj Malvathu	Not eligible	Not applicable	$0

Position	Name	Type of remuneration	2013–14 period of membership	Gross/actual remuneration
Rockingham General Hospital Medical Advisory Committee (cont.)				
Member	Dr Peter Wallace	Not eligible	Not applicable	$0
Member	Dr Francis Loutsky	Not eligible	Not applicable	$0
Member	Dr Michael Wallace	Not eligible	Not applicable	$0
Member	Dr Charles Russell-Smith	Not eligible	Not applicable	$0
Member	Dr Baskar Mandal	Not eligible	Not applicable	$0
Member	Dr Ashiela narang	Not eligible	Not applicable	$0
Member	Dr Lisa Gallagher	Not eligible	Not applicable	$0
Member	Dr Mat Ickeringill	Not eligible	Not applicable	$0
			Total:	**$0**
Rockingham Kwinana Aboriginal District Health Action Group				
Member	Doris Getta	Per meeting	12 months	$1,230
Member	Yvonne Winmar	Per meeting	11 months	$1,260
Member	Theresa Walley	Per meeting	12 months	$930
Member	Michelle Sultan	Per meeting	6 months	$810
Member	Lindsay Calyun	Per meeting	12 months	$720
Member	Benita Indich	Per meeting	12 months	$720
Member	Helen Kickett	Per meeting	12 months	$750
Member	Marianne Mckay	Per meeting	12 months	$180
Member	Janet Hansen	Per meeting	8 months	$690
Member	Vanita Walley	Per meeting	12 months	$270
Member	Melanie Garlett	Per meeting	5 months	$150
			Total:	**$7,710**
Royal Perth Hospital Animal Ethics Committee				
Chair	Prof. Kevin Croft	Sessional	8 months	$20,940
Deputy Chair and Category A (Vet) member	Assoc. Prof. Len Cullen	Per meeting	8 months	$1,000
Secretary	Dr Linda Manning	Not eligible	Not applicable	$0
Category A (Vet)	Dr Tim Hyndman	Per meeting	8 months	$1,000
Category B (Research)	Dr Anne Barden	Per meeting	8 months	$800
Category B (Research)	Dr Jacky Bentel	Not eligible	Not applicable	$0
Category C (Animal welfare)	Mr Noel Smith	Per meeting	8 months	$1,200

Position	Name	Type of remuneration	2013–14 period of membership	Gross/actual remuneration
Royal Perth Hospital Animal Ethics Committee (cont.)				
Category C (Animal welfare)	Mr Steve Vanstan	Per meeting	8 months	$1,000
Category D (Lay member)	Mr Vern Ferdinands	Per meeting	8 months	$800
Category D (Lay member)	Mr Mike Field	Per meeting	8 months	$1,000
Category D (Lay member)	Dr Pam Garrett	Per meeting	9 months	$400
Category E (Technician in charge)	Mr Nicholas Grainger	Not eligible	Not applicable	$0
Invited	Dr Malcolm Lawson	Not eligible	Not applicable	$0
			Total:	**$28,140**
Royal Perth Hospital Community Advisory Council				
Member	Margaret Ryan	Per meeting	12 months	$720
Member	Kenneth Quick	Per meeting	12 months	$480
Member	Margaret Kyi-Flynn	Per meeting	12 months	$240
Member	Mary Ward	Per meeting	10 months	$420
Member	Margaret Walsh	Per meeting	12 months	$480
Member	Patricia Dagg	Per meeting	12 months	$540
Member	Robert Matthews	Per meeting	12 months	$720
			Total:	**$3,600**
South Metropolitan Area Aboriginal Health Action Group				
Member	Doreen Nelson	Per meeting	12 months	$450
Member	Albert Knapp	Per meeting	12 months	$450
Member	Eunice Bynder	Per meeting	12 months	$150
Member	Madge Hill	Per meeting	12 months	$150
Member	Sharon Calgarett	Per meeting	12 months	$150
Member	Michelle Sultan	Per meeting	12 months	$150
Member	Eric Wynne	Per meeting	7 months	$300
Member	Leon Hayward	Per meeting	7 months	$300
Member	Connie Moses	Per meeting	7 months	$300
Member	Janet Hansen	Per meeting	7 months	$300
Member	Yvonne Winmar	Per meeting	11 months	$300

Position	Name	Type of remuneration	2013–14 period of membership	Gross/actual remuneration
South Metropolitan Area Aboriginal Health Action Group (cont.)				
Member	Howard Riley	Per meeting	12 months	$300
			Total:	**$3,300**
South Metropolitan Area Health Service Consumer Advisory Council				
Chair	Frank Daly	Not eligible	Not applicable	$0
Deputy Chair	Carol Saunders	Not eligible	Not applicable	$0
Secretary	Vanessa Macdonald	Not eligible	Not applicable	$0
Coordinator	Joanne Clarke	Not eligible	Not applicable	$0
Member	Marilyn Carrigg	Per meeting	12 months	$315
Member	Roy Dobson	Per meeting	6 months	$75
Member	Dorothy Harrison	Per meeting	12 months	$435
Member	Julie Brown	Per meeting	12 months	$120
Member	Richard Hill	Per meeting	12 months	$315
Member	Sharon Kenny	Per meeting	12 months	$180
Member	Piper Marsh	Per meeting	12 months	$255
Member	Jacqueline Matheron	Per meeting	12 months	$60
Member	Juliet Mugambwa	Per meeting	12 months	$300
Member	Nancy Pierce	Per meeting	12 months	$300
Member	Jan Thair	Per meeting	12 months	$360
Member	Lyn Williamson	Per meeting	6 months	$120
Member	Eric Wynne (JP)	Per meeting	6 months	$120
Member	Petrina Lawrence	Not eligible	Not applicable	$0
Member	Peta Wotton	Not eligible	Not applicable	$0
Member	Mary Ward	Not eligible	Not applicable	$0
Member	Prof. Fiona Woods	Not eligible	Not applicable	$0
Member	Mitch Messer	Not eligible	Not applicable	$0
Ex Officio	Louise Ford	Not eligible	Not applicable	$0
Ex Officio	Stephanie Fewster	Not eligible	Not applicable	$0
Ex Officio	Michelle Dillon	Not eligible	Not applicable	$0
			Total:	**$2,955**
South Metropolitan Health Service Governing Council				
Chair	Adjunct Assoc. Prof. Robyn Collins	Annual	12 months	$53,550
Deputy Chair	Mr David Rowe	Annual	12 months	$31,460
Member	Dr Margaret Crowley	Annual	12 months	$24,097
Member	Mr Richard Cullen	Annual	12 months	$24,097
Member	Dr Vivienne Manessis	Not eligible	Not applicable	$0
Member	Mr Mitch Messer	Annual	12 months	$24,097

Position	Name	Type of remuneration	2013–14 period of membership	Gross/actual remuneration
South Metropolitan Health Service Governing Council (cont.)				
Member	Dr Marcus Tan	Annual	12 months	$24,097
Member	Prof. Fiona Wood	Not eligible	Not applicable	$0
Ex-Officio Member	Prof. Frank Daly	Not eligible	Not applicable	$0
			Total:	**$181,398**
South Metropolitan Mental Health Advisory Group (SuMMAt)				
Chair	Peta Wootton	Not eligible	Not applicable	$0
Deputy Chair	Mary Ward	Per meeting	12 months	$0
Acting Chair	Colin Stevenson	Per meeting	12 months	$0
Member	Alain Schoonens	Not eligible	Not applicable	$0
Member	Eileen Allison	Not eligible	Not applicable	$0
Member	Dr Steve Baily	Not eligible	Not applicable	$0
Member	Maureen Burke	Per meeting	12 months	$0
Member	Tammy Carleo	Not eligible	Not applicable	$0
Member	Kay deBrett	Per meeting	12 months	$0
Member	Paul Fitzgerald	Not eligible	Not applicable	$0
Member	Maria Gaglia	Per meeting	12 months	$330
Member	Carmel Harrington	Not eligible	Not applicable	$0
Member	Sandra Harris	Not eligible	Not applicable	$0
Member	Juliana Hussain	Not eligible	Not applicable	$0
Member	Rohan Jayawardene	Not eligible	Not applicable	$0
Member	Marina Korica	Not eligible	Not applicable	$0
Member	Michael McCrystal	Not eligible	Not applicable	$0
Member	Leanne Mirabella	Not eligible	Not applicable	$0
Member	Kathryn Moorey	Not eligible	Not applicable	$0
Member	Gwen Nuth	Not eligible	Not applicable	$0
Member	Cassie Endris	Per meeting	12 months	$210
Member	Mark Pestell	Not eligible	Not applicable	$0
Member	Sushma Shrestha	Not eligible	Not applicable	$0
Member	Leanne Sultan	Not eligible	Not applicable	$0
Member	Petra Elias	Not eligible	Not applicable	$0
Member	Vivian Bradley	Not eligible	Not applicable	$0
Member	Penny Tucker	Not eligible	Not applicable	$0
Member	Amy Van Leeuwin	Not eligible	Not applicable	$0
Member	SiewHo Yeak	Not eligible	Not applicable	$0
			Total:	**$540**

Position	Name	Type of remuneration	2013–14 period of membership	Gross/actual remuneration
Western Australian Child and Youth Health Network Executive Advisory Group				
Chair	Kate Gatti	Not eligible	Not applicable	$0
Member	Kerryn Barton	Not eligible	Not applicable	$0
Member	Mark Crake	Not eligible	Not applicable	$0
Member	Korene Dusting	Per meeting	12 months	$60
Member	Karen Edmond	Not eligible	Not applicable	$0
Member	Elaine Bennett	Not eligible	Not applicable	$0
Member	Denese Griffin	Not eligible	Not applicable	$0
Member	Cheryl Hayward	Not eligible	Not applicable	$0
Member	Tanyana Jackiewicz	Not eligible	Not applicable	$0
Member	Wendy Langford	Per meeting	12 months	$0
Member	Jenny Mace	Not eligible	Not applicable	$0
Member	Mel Robinson	Not eligible	Not applicable	$0
Member	Caron Molster	Not eligible	Not applicable	$0
Member	Dr Trevor Parry	Not eligible	Not applicable	$0
Member	Sue Peter	Not eligible	Not applicable	$0
Member	Christa Riegler	Not eligible	Not applicable	$0
Member	Debra Rose	Not eligible	Not applicable	$0
Member	Judy Walsh	Not eligible	Not applicable	$0
Member	Adrienne Wills	Not eligible	Not applicable	$0
Member	Dr Geoffrey Williamson	Not eligible	Not applicable	$0
			Total:	**$60**
Women's and Newborns' Health Network Executive Advisory Group				
Chair	Dr Janet Hornbuckle	Not eligible	Not applicable	$0
Chair	Assoc. Prof. Graeme Boardley	Not eligible	Not applicable	$0
Member	Leanda Verrier	Not eligible	Not applicable	$0
Member	Terri Barrett	Not eligible	Not applicable	$0
Member	Dr Peter Kell	Not eligible	Not applicable	$0
Member	Janice Butt	Not eligible	Not applicable	$0
Member	Sue Somerville	Not eligible	Not applicable	$0
Member	Jenny O'Callaghan	Not eligible	Not applicable	$0
Member	Hayley Sherratt	Not eligible	Not applicable	$0
Member	Jan Ryan	Not eligible	Not applicable	$0
Member	Susan Bradshaw	Not eligible	Not applicable	$0
Member	Heather Woods	Not eligible	Not applicable	$0
Member	Selena Knowles	Not eligible	Not applicable	$0
Member	Kate Reynolds	Not eligible	Not applicable	$0

Position	Name	Type of remuneration	2013–14 period of membership	Gross/actual remuneration
Women's and Newborns' Health Network Executive Advisory Group				
Member	Dr Sara Armitage	Not eligible	Not applicable	$0
Member	Dr Richard King	Not eligible	Not applicable	$0
Member	Tracy Martin	Not eligible	Not applicable	$0
Member	Prof. Helen Leonard	Not eligible	Not applicable	$0
Member	Karla Lister	Not eligible	Not applicable	$0
Member	Pippa Vines	Not eligible	Not applicable	$0
Member	Jennifer White	Not eligible	Not applicable	$0
Member	Melanie Robinson	Not eligible	Not applicable	$0
Member	Etwell Mari	Not eligible	Not applicable	$0
Lay person	Bev Sinclair	Per meeting	6 months	$60
			Total:	**$60**
Women's and Newborns' Health Service Community Advisory Committee (formerly King Edward Memorial Hospital)				
Co-Chair	Melanie Gregory	Per meeting	12 months	$480
Co-Chair	Pip Brennan	Per meeting	12 months	$420
Deputy Chair	Michelle Atkinson-de Garis	Per meeting	12 months	$420
Secretary	Robyn Kerr	Not eligible	Not applicable	$0
Member	Tracy Robertson	Not eligible	Not applicable	$0
Member	Jody Blake	Per meeting	12 months	$420
Member	Ann McRae	Per meeting	12 months	$360
Member	Sonja Whimp	Per meeting	12 months	$480
Member	Jaime Yallup Farrant	Per meeting	12 months	$360
Member	Leanne Treen	Per meeting	12 months	$120
Member	Ann Betts	Per meeting	12 months	$120
Member	Maryam Aghamohammadi	Per meeting	12 months	$420
Member	Oriel Green	Per meeting	12 months	$240
Member	Nicole Woods	Per meeting	12 months	$120
			Total:	**$3,960**

Notes:

1. 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.
2. Remuneration amounts can vary depending on the type of remuneration, the number of meetings attended, and whether a member submitted a remuneration claim.
3. 'Period of membership' is defined as the period (in months) that an individual was a member of a board/committee during the 2013–14 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'.

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