Government of **Western Australia**
North Metropolitan Health Service

ANNUAL REPORT 2018













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Statement of compliance

For year ended 30 June 2018

Hon. Mr Roger Cook MLA
Deputy Premier; Minister for Health; Mental Health

In accordance with section 63 of the *Financial Management Act 2006*, we hereby submit for your information and presentation to Parliament, the Annual Report of the North Metropolitan Health Service for the financial year ended 30 June 2018.

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

David Forbes
Acting Board Chair

North Metropolitan
Health Service
18 September 2018

Robyn Lawrence
Chief Executive

North Metropolitan
Health Service
18 September 2018

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Foreword

The *North Metropolitan Health Service Annual Report 2018* is presented as a celebration of the achievements of our staff in delivering excellence in health care for our community. We are extremely proud of the ongoing commitment of our team to safe, high-quality health care for the people of the North Metropolitan Region.

This year's *Annual Report* has involved an unprecedented level of engagement with staff, which appropriately reflects a year of enhanced engagement with all stakeholders. 2017/18 has seen an increased focus on transparency between our leadership and clinicians, with more staff forums and team presentations, and prioritisation of our patients' experiences of care and how we can improve their journeys. With a range of mechanisms to collect patient feedback, continued improvement of patient experience has been and will continue to be a major priority.

We are extremely proud of our team's ongoing commitment to safe, high-quality health care for the people of the North Metropolitan Region.

The continued improvement of patient experience has been, and will continue to be, a major priority.

In addition, working more closely with clinicians and identifying more meaningful ways to engage with our workforce have been at the forefront of our minds, particularly for the Women and Newborn Health Service (WNHS), which includes King Edward Memorial Hospital (KEMH). Through the Clinical Engagement Project, KEMH has worked hard and committed itself to listening and learning from the staff in areas of better patient safety and quality, improving and redesigning elements of the workforce, and reviewing and identifying infrastructure needs to ensure a safe place for patients and staff.

There have been several significant challenges this year. Extensive preparations were required for the separation of PathWest from NMHS and the establishment of it as a health service provider (HSP) in its own right at the end of this financial year. Further, the successful opening of Perth Children's Hospital was supported by NMHS's facilities management and support services, which have now assumed responsibility for service delivery at the new hospital under a shared service arrangement with the Child and Adolescent Health Service (CAHS).

Significant work was undertaken in identifying the allocation of resources in the most efficient and financially responsible way to meet the ever-present challenge of sustainably delivering services faced with high demand and rising costs.

The financial year close marks the end of our second-year transitioning to a statutory authority in which NMHS has experienced changes in our Executive and Board. Our gratitude is extended to all those who have contributed to the Health Service in a leadership capacity.

A new Board and Chief Executive will be welcomed in 2018/19 to provide leadership and support to the Health Service's 10 000-strong workforce dedicated to enhanced, sustainable, best-practice patient care.

Acknowledging and celebrating our diversity

NMHS continues to promote our vision of *Excellence in health care for our community*. We strive for safe, high-quality patient care and a committed workforce that is able to demonstrate our values in every aspect of care to our patients, and services to our community. Our values of Care, Respect, Excellence, Equity, Integrity, Teamwork and Leadership are at the core of our services to the community.

To live our vision and demonstrate our values, we embrace workforce equity and diversity as a source of strength. With just under half of our workforce born overseas, our diversity allows greater understanding of each other, improves the way in which we work with our colleagues and allows us to learn from and support our patients and community.

For our organisation, this diversity allows us to incorporate a wide variety of capabilities, ideas and insights from people of different backgrounds and experiences into our decision-making, problem-solving, policy development and service delivery.

Being diverse and inclusive creates a more engaging and productive workplace, facilitates greater innovation, positions us to better understand our patients' needs, and empowers us to attract the best talent.

Our diverse workforce challenges us to think about how all employees are responsible for embracing inclusiveness and equity within the workplace, free from discrimination and harassment.

Aboriginal Hospital Liaison Officer making a difference

Our Aboriginal Hospital Liaison Officer (AHLO) Program is one of the ways that our organisation is working to provide culturally secure health services. The program has received positive feedback from Aboriginal patients through the year. The AHLO provides cultural support to Aboriginal patients during their hospital stay, and provides a link between the hospital and other Indigenous community resources.

Aboriginal health and employment matters to our health services

Our Health Service covers almost 1000 square kilometres and provides public health services to almost 729 000 people across the Perth metropolitan area, of which about 7500 (1.2 per cent) are Aboriginal[1]. We recognise, respect and value Aboriginal cultures and work progressively towards delivering culturally secure health services.

Our Reconciliation Action Plan 2016–2019 is designed to assist with reducing the Indigenous life expectancy gap and increase access to health services that are culturally safe and welcoming for Aboriginal communities. It reflects our commitment to working in genuine partnerships with Aboriginal communities to support plans to improve the delivery of services and programs for Aboriginal people.

Commitment to Aboriginal health

Our Aboriginal Cultural Advisory Group comprises Aboriginal community members from a range of cultural and language groups across Western Australia and provides advice and guidance to our staff through their experience of accessing healthcare services across the system.

The members work to improve the access and equity of our services to Aboriginal patients and the Aboriginal community living in the north metropolitan area. They provide perspectives on Aboriginal cultural matters and provide feedback to the Aboriginal community members in the region through community forums, networks, media and printed materials.

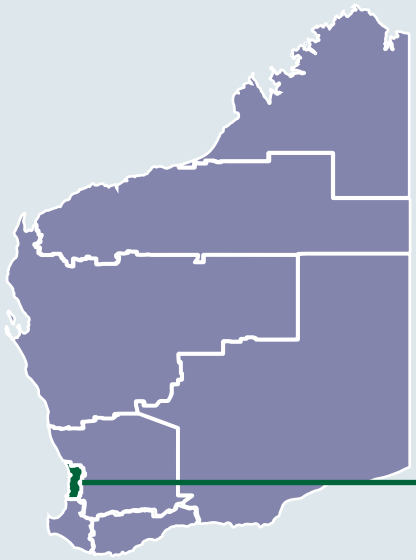
In 2017/18 the advisory group supported specific program design and development in the areas of sexual health research within the Aboriginal community, the Aboriginal patient experience, and ways of working with Aboriginal patients at Sir Charles Gairdner Hospital (SCGH) who are identified as being homeless.

Back row (from left): Director Aboriginal Health Cheryl Smith, Mrs Kathleen Farrell and Mrs Vivienne Weir
Front row: Mrs Barbara McGillivray, Mrs Margaret Jackson (dec.), Mrs Gertrude Taylor and Mrs Irene Nannup

Building a sustainable Aboriginal health workforce is progressing as we identify and develop career pathways and employment opportunities that assist in increasing the number of Aboriginal staff in our Health Service.

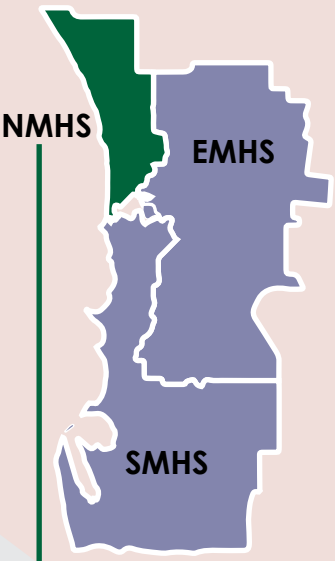
[1] The use of the term 'Aboriginal' within this document refers to Australians of both Aboriginal and Torres Strait Islander people.

NMHS map

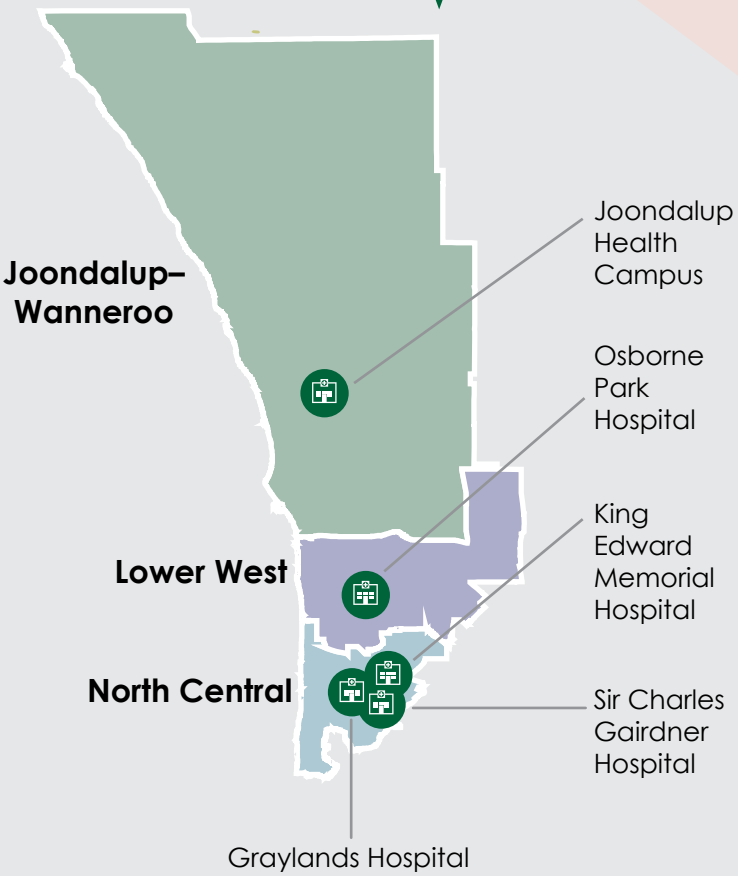


Western Australia

Metropolitan catchments



Health districts and hospitals



Stats and facts

993
square kilometres

10
Local government areas

729 000
population

37%
born overseas

5
hospitals

10 600
employees

Overview

Who we are

NMHS is a statutory authority established on 1 July 2016 and is governed by NMHS Board under s. 32 of the *Health Services Act 2016 (WA)*. The Board is responsible to the Minister for Health and the Minister for Mental Health.

Our Health Service has 10 600 staff and an annual budget of more than $2 billion. Our hospital network comprises tertiary, specialist and general hospitals including:

Sir Charles Gairdner Osborne Park Health Care Group

- SCGH 609-bed tertiary and teaching hospital
- Osborne Park Hospital (OPH) 205-bed general hospital

SCGH, as part of the Sir Charles Gairdner Osborne Park Health Care Group (SCGOPHCG), is one of Australia's leading teaching tertiary hospitals that provides a comprehensive range of clinical services to adults. It has more than 600 beds and employs 5500 staff who treat over 420 000 patients every year. Located at the Queen Elizabeth II Medical Centre, it is also home to WA's only comprehensive cancer centre – the largest cancer treatment centre in the State, and is WA's principal hospital for neurosurgery and liver transplant services. SCGH also plays a critical role in the research hub at the QEII MC site.

Established in 1962, OPH is part of the SCGOPHCG. As a general hospital, it provides maternity services, a range of surgical services and procedures, and rehabilitation and aged care services for the north metropolitan suburbs.

Mental Health, Public Health and Dental Services

- Graylands Campus 174-bed tertiary psychiatric and teaching hospital
- SCGH Mental Health Services 54 beds across a range of services

NMHS provides a comprehensive range of mental health services that are delivered by hospitals on the Graylands Health Campus and at the QEII Medical Centre, and in partnership with community health centres. Graylands Health Campus accommodates Graylands Hospital, the State's largest and only public stand-alone psychiatric teaching hospital that provides acute care, treatment and rehabilitation for adults. Co located are the Selby Older Adult Centre, and the Frankland Centre, which is a forensic maximum-secured inpatient facility. SCGH Mental Health Services comprise a Mental Health Unit, Hospital in the Home and neuroscience Services, and a Mental Health Observation Area (MHOA). Specialised care is provided by interdisciplinary teams, with care being person-centred to enhance the wellbeing and safety of the individual as well as the community.

Public Health and Ambulatory Care (PHAC) provides services and programs that are delivered in a range of settings (including the home, community centres and clinics) and in collaboration with hospital and community-based sectors including Aboriginal Health, Ambulatory Care Programs and Public Health Programs (Communicable Disease Control and Health Promotion). PHAC also provides a range of statewide services, including the WA Tuberculosis Control Program, Humanitarian Entrant Health Service and Dental Health Services.

Dental Health Services is the largest public dental service in WA, funded by the State Government. It provides oral health services to children aged 5 to 16 through the School Dental Service, general and emergency dental care for eligible people through metropolitan and country clinics, and specialist dental services to residents in aged care, corrective services facilities and eligible inpatients.

Women and Newborn Health Service

- KEMH 252-bed women's and neonatal tertiary and teaching hospital

WNHS incorporates KEMH and other women's health services. KEMH, which treated its first patients in 1916, is the State's largest maternity hospital and the only referral centre for complex pregnancies and extremely preterm babies in WA. Today, there are just under 6000 births at the hospital each year. KEMH is also a tertiary teaching facility that delivers specialised maternity, neonatology, gynaecology, and perinatal mental health services. It provides care annually for about 2000 preterm babies and 5000 women with gynaecological conditions – from urological and cancer-related problems to sexually transmitted diseases and reproductive disorders. In addition, WNHS provides a number of statewide programs and services, including the Statewide Obstetric Support Unit, Genetic Services WA, Newborn Emergency Transport Service, the WA Cervical Cancer Screening Program, BreastScreen WA, Women's Health Strategy and Programs, Sexual Assault Resource Centre and the Mother and Baby Unit. KEMH also provides care across the metropolitan area through the Community Midwifery Program.

PathWest

Through PathWest, we are the public pathology provider for WA. We provide a full range of diagnostic and laboratory medicine services 24 hours a day, seven days a week. Our services are provided at five tertiary teaching hospital laboratories, 23 branch laboratories and 56 collection centres. We also provide forensic services and are heavily involved in research. Our pathology staff are based at metropolitan and country locations throughout WA.

Joondalup Health Campus

- Joondalup Health Campus (JHC) 514 public-bed and 146 private-bed hospital

NMHS also provides a comprehensive range of services to public patients at a general hospital located at JHC through its public-private partnership (PPP) with Ramsay Health Care.

Vision

Excellence in healthcare for our community

Mission

To improve, promote and protect the health and wellbeing of our patients, population and community

Strategies

1. Strive for better patient health outcomes by **continuously improving clinical excellence**
2. Further develop centres of excellence to retain a strong **teaching, training, research and innovation** focus
3. **Strengthen our engagement and partnership** with patients, carers, staff and our community
4. Enable, **empower and engage our workforce**
5. Enhance our clinical services through **professional and efficient corporate support**

How we made a difference

Underpinned by our vision, mission and values, NMHS makes a difference through the five core strategies of our Strategic Plan 2017–2021

How we made a difference – at a glance

175 022
people presented to emergency department

10 313
births

78 376
patients underwent elective surgery

708 860
outpatient appointments provided

73
transplant patients (53 kidney and 20 liver)

37 459
Poisons Information Centre callers

20 948
cancer patients received treatment

15 584
mental health patients cared for

166 587
School Dental Service patients

293 999 occasions of service (visits and screenings) to individuals

186 514
patients admitted to our wards

Highlights: Core Strategy 1

Strive for better patient health outcomes by **continuously improving clinical excellence**

We will reform the way health care is delivered across NMHS, in line with the WA Health Clinical Services Framework 2014–2024 and the WA Health Plan that will be developed as an outcome of the Sustainable Health Review. This will include fostering innovation and partnerships to support alternative models of care, developing capacity and capability to ensure patients receive care closer to home, and enhancing partnerships with regional, community and primary healthcare.

Delivering telehealth

4997

Total number of outpatient occasions of service, an increase of

50%

from last year

Achieving accreditation in 2018

- **WNHS**
- **Dental Health Services**
- **OPH**

Delivering safe, high-quality and patient-centred care assessed against the 10 National Safety and Quality Health Service Standards.

Providing interpreter services

Service used over

70 000

times this year

76% outpatients

24% inpatients

Telehealth

Telehealth improves clinical excellence by allowing us to deliver health care over a distance using videoconferencing or other communications technology. It supports clinical coordination and collaboration among clinicians, irrespective of where the patients live. Videoconferencing facilities are available at all our hospitals and community facilities in NMHS area and serve patients across the State.

Telehealth goes from strength to strength

SCGH has purchased a range of telehealth equipment that has seen 56 outpatient consultation rooms fitted with webcam devices. The installation will help more of the hospital's rural patients access outpatient services closer to home.

> "Desktop equipment has helped with accessibility and efficiency for clinicians as they no longer have to leave their clinic and go down the hall to the 'Telehealth room' for an appointment," said NMHS Telehealth Manager Tania Orr. "When it's a country patient's turn, the clinician just connects using their office computer, which is set up for telehealth with a high-definition monitor and camera."

Telehealth enables patient-centred care

In his work for the WA Adult Epilepsy Service, Dr Nicholas Lawn sees patients from around the State, and says the expanding use of videoconferencing technology ensures clinicians offer patient-centred care.

> "Telehealth enables me to bring the epilepsy clinic to the bush.

> "Travelling to Perth is a major and highly expensive undertaking for both the patient and family members, often requiring several days off work, but with Telehealth they can just pop into their local hospital, and sometimes it can even be done from home.

> "Telehealth provides patients a reprieve from often-difficult travel, without compromising patient care," he said. "This is crucial in epilepsy as many patients cannot drive."

Launch of mesh clinic

KEMH launched a specialist mesh clinic in October 2017 in collaboration with patient groups, the Health Consumers' Council and the Pelvic Mesh Support Group. Pelvic mesh is a woven synthetic netting implanted into the pelvis for a variety of conditions, usually pelvic organ prolapse and stress urinary incontinence. Most women have a good outcome from treatment using mesh; however, some women have experienced complications. The new service strives to provide a genuine multidisciplinary approach and treatment options, with this service being deemed essential for the women of WA.

Adult Migrant English Program – Health Literacy Package

A Health Literacy Package has been developed to deliver positive lifestyle messages to new adult migrants when they attend English classes at North Metropolitan TAFE. Evaluation of the program showed that students possessed increased knowledge of healthy lifestyles as a result.

Patient Experience Survey for CaLD Patients

With a higher proportion of overseas-born people calling WA home (and with more than one-third of the migrant population settling in NMHS catchment area), NMHS, in partnership with community members, has developed an electronic survey tool to capture patient experience from CaLD patients. The feedback is supporting our health professionals to deliver culturally responsive and appropriate health care.

Accreditation

Embedding safety and quality through accreditation is an essential process to ensure safety and clinical excellence. The Australian Council on Healthcare Standards (ACHS) provides an independent evaluation of healthcare organisations throughout Australia. This nationally consistent and uniform assessment is based on the 10 National Safety and Quality Health Service (NSQHS) Standards and the National Standards for Mental Health Services (NSMHS) developed by the Australian Commission on Safety and Quality in Health Care.

Interpreter services

Interpreter services improve patient outcomes and SCGH is one of the hospitals in our Health Service that provides services to a culturally and linguistically diverse (CaLD) patient population. To meet the needs of non-English speaking patients, the hospital provides interpreters and, where required, translation of health information into English or designated languages.

New psychology service gets tick of approval and improves patient outcomes

A new clinical psychology consultation service at Sir Charles Gairdner Mental Health Observation Area has received overwhelmingly positive feedback from patients.

> "Patients have said they felt heard and understood and that they have been able to talk about and work on what they needed,' said Kate Harwood, Acting Senior Clinical Psychologist."

Highlights: Core Strategy 2

Further develop centres of excellence to retain a strong **teaching, training, research and innovation** focus

We will work in partnership with other agencies to ensure that our teaching, training, research and innovation programs are focused on improving patient care and outcomes, and are informing clinical practice.

Across our health service, committed and dedicated staff are working in clinical and translational research, and on innovative programs that contribute to local, national and international advances in health care.

In addition, we continue to offer significant teaching and training opportunities for our staff including management and leadership programs; new graduates of clinical backgrounds such as graduate nurses, junior doctors and allied health professional as well as trainees from the more traditional corporate and trade professions.

Advancing training

Delivering nationally recognised training

35 graduates
Diploma of Leadership and Management

33 graduates
Certificate III Pathology Collection

12 graduates
Graduate Certificate in Infection Prevention and Control

Supporting centre of research exellence

407
researchers papers published

1108
active research projects

Developing leaders and managers

"I've already gained valuable skills that have helped me in my current role and I am looking forward to contributing further to the community".

Brock Delfante
Pharmacist, SCGH and Trainee Board Director – Community Vision

Our future leaders

Thirty-five Diploma of Leadership and Management graduates celebrated at a graduation ceremony in December 2017. Learning and Development Workforce Manager John Ward said: "Participants bring a richness to the program that is shared with colleagues as they progress through diverse topics."

Sara Tilley, from SCGH, was awarded the prize for the most outstanding student of the year. "The course included class discussion, group work and assessable assignments that were relevant and applicable in my role as a Nurse Manager," Sara said. "The topics are applicable to all areas of the health system, not just nursing."

Delivering nationally recognised training

Delivering nationally recognised training is a key strength of our Health Service. As a registered training organisation (RTO) for 15 years, NMHS is uniquely placed to deliver and assess nationally recognised qualifications. Our Health Service places great importance on continuous development of our people. These programs provide opportunities and experiences for people to enhance their capabilities, knowledge and skills as well as to earn a formal qualification. This in turn strengthens our organisation's ability to innovate and improve the quality of our services.

Developing and enabling new leaders

Developing and enabling new leaders in the Health Service is critical to the sustainability and future of our organisation. Recognising emerging leaders is a key to healthy governance in our complex Health Service and system.

Relishing research

The Engaging iN Research program was again offered in 2018 by SCGH Centres for Nursing Research and Nursing Education. It aims to advance a culture of enquiry and evidence-based healthcare practice using an interprofessional approach. The eight-month program attracts nurses, midwives and occupational therapists from across the Health Service, and includes research methodology and critique, knowledge translation and presentation skills. Participants lead a quality improvement project and present their results during SCGOPHCG Research Week.

Progressing towards a centre of excellence

Progressing towards a centre of excellence includes an array of research into clinical, population health and health services. Our Health Service recognises the integral role that quality interprofessional research and innovation have in improving the wellbeing of patients, consumers and the community. Coupled with greater focus on improved governance of research ethics, our Health Service is working to improve systems and enhance our research capability and capacity.

Coconut oil is the key

A research initiative aimed at improving the skin integrity of preterm babies was so successful that it featured in a special edition of the ABC *Catalyst* program broadcast in March 2018.

Researchers at KEMH Neonatal Intensive Care Unit (NICU) conducted a randomised controlled trial that involved applying coconut oil to preterm babies.

The results showed that babies who received coconut oil had far better skin compared to those who didn't and, as a result, health professionals from NICU are now applying coconut oil to the skin of all babies born under 30 weeks' gestation as part of routine care.

Research-focused and patient-centred

The Dental Health Research and Evaluation Unit is collaborating in a randomised controlled trial to see whether an early childhood oral health promotion reduces the occurrence of tooth decay and obesity.

In partnership with the CAHS and WA Country Health Services (WACHS), the study is partly funded by the National Health and Medical Research Council (NHMRC) Project Grants Scheme. Findings will be presented at the International Association for Dental Research Conference in July 2018.

Clozapine monitoring trial

As patients prescribed the antipsychotic medication clozapine are prone to physical problems that require regular monitoring, a project was initiated to improve their overall health.

As a result, a Clozapine Nurse role was created to monitor a range of factors including the safety of clozapine doses, monitoring of blood tests and side effects, and checking heart rate, blood pressure and weight.

Worldwide study captures information from a Kununurra family

Since 2014, the Neurosciences Unit (NSU) has been involved in a worldwide study sponsored by the Cure Huntington's Disease Initiative Foundation that aims to develop new, effective treatments for the inherited brain disorder Huntington's disease. An Aboriginal family, based in Kununurra and with at least 61 family members, is eligible to participate in the study. A mobile clinic has been established so the family don't have to travel to Perth for specialist neurology and research visits.

Research that improves services to patients for better patient care

Our researchers have been leading initiatives to develop new resources critical to establishing personalised medicine. "The Medical Research Future Fund has funded a review of biobanks, which are large collections of biological materials and data for use in health and medical research," said Dr Aron Chakera, Director Research, SCGOPHCG.

Highlights: Core Strategy 3

Strengthen our engagement and partnership with patients, carers, staff and our community

We will ensure that our patients, carers, employees and our community are involved in the decision-making process and the planning, delivery, improvement and evaluation of our services.

Strengthening our engagement and partnerships has progressed in the past year. Our Health Service is starting to see some early achievements in areas of the patient experience, increasing clinical engagement and embracing consumers through a variety of mechanisms, including the survey tool Patient Opinion and social media.

Valuing the patient experience

Patient Opinion implemented

76 opinions
(29% complaints)

Patient satisfaction

4253 responses
(9% complaints)

Embracing consumers through social media

Social media platforms launched in March 2018

320 likes Facebook

37 posts

64 followers

Strengthening clinical engagement

- Board Clinical Advisory Council
- WNHS Clinical Engagement Project
- Mental health information packs for GPs
- Promotion of multidisciplinary team care

School Dental Service trials a children's feedback tool

In 2017/18 our School Dental Service tested a children's feedback tool using smiley faces to gauge their satisfaction rather than traditional responses from parents or guardians completing a standard survey.

The form asked children to rate how their visit made them feel. They were asked further questions about the 'best thing' and 'worst thing' about their visit and how the clinic could improve. Receiving good news about their teeth, encountering lovely staff and getting teeth cleaned were the top three best things children liked. The top two worst things were dental tools and the taste of the filling.

Listening and responding to patient experiences

Listening and responding to patient experiences are integral to our Health Service. Multiple approaches are being used to gain feedback on patient experiences, including Patient Opinion and measuring patient satisfaction through complaints and compliments received about our service. A strong focus on improving each patient's experience and satisfaction with care is imperative to a safe, high-quality health service. Patients are best placed to provide insight regarding their health care, and their experiences provide valuable information for improved and innovative design, planning, delivery and evaluation of health systems.

Thanks team!

> My experience of every single member of staff at Charlie's was amazing and their kindness, care, professionalism and competence was extraordinary.
> – Bernadette Brady

Anita's story

Our Health Service provides support and connects patients to services provided by other agencies. This is particularly important for patients with mental health conditions. START Court is one of these programs. It is a Mental Health Court Diversion and Support program that offers a solution-focussed response for people with mental health conditions who appear before the Magistrates Court. The program aims to provide holistic support to address underlying causes of offending behaviour.

Anita (consent provided for use of her real name) was one of our patients who was connected into the START Court program. A mother of two, Anita, aged 28, was living with her parents at the time of her presentation to the START Court. Anita had previous experiences of domestic violence, homelessness, financial hardship and self-reported diagnoses of post-traumatic stress disorder and depression. During her involvement, Anita participated in a range of programs and found the necessary support to overcome her obstacles. Anita is now employed full-time and has built firm trust and responsibility with her employer. She has regained her health and her family relationships and newfound friendships are strong.

> “Imagine my surprise when I looked up to see a large build-up of dirt and dust on the ceiling and around the sprinkler head. It looked like no one had bothered to clean or do anything for many months (if not longer). The ceiling tiles in one corner of the room have paper towels wedged under them to stop them vibrating.
> – courtesy of anonymous patient on Patient Opinion (October 2017)”

This matter was promptly investigated by our facilities management staff and the room was subsequently cleaned. Further, an audit of the ward was undertaken and the ward cleaning schedule and task list were updated.

Patient Opinion

This year, our Health Service subscribed to Patient Opinion, an online platform that enables patients, family and carers to anonymously share their experiences of our care. The feedback provides an opportunity for our Health Service to respond and introduce improvements to services.

Receiving feedback from patients through our complaints and compliments system is important because it assists us to continually improve and remain responsive to the people that use our service, their families and their carers. It also lets us know when we get it right and where we need to improve. Feedback may be verbal or in writing (via letter, email or standard form), and it may be provided anonymously.

Every year and throughout the year since 1997, the Patient Evaluation of Health Services surveys thousands of patients and asks them about their satisfaction in the WA health system. Patients are asked to rank seven aspects of health care from most to least important, and asked specific questions about their experience and satisfaction during their hospital stay.

In addition, SCGH and OPH contract an organisation to undertake inpatient and outpatient patient experience surveys. The survey, which is sent out to patients two weeks after they have been discharged home, seeks feedback on a range of measures about the care they have received.

Community Advisory Councils (CACs) exist at SCGH, OPH, WNHS and NMHS Mental Health. They reflect broad representation from our community to represent the interests of patients, carers and visitors to our sites. Matters discussed vary widely and include Hospital Service improvement, policies and procedures, in addition to access and communication.

This year, WNHS CAC reported its most productive year ever, contributing their consumer perspective to a number of policies and document reviews. They conducted their first member satisfaction survey and responses were positive about member involvement. The survey resulted in the start of a ‘buddy system’ for new CAC members, out-of-session coffee mornings to improve cohesiveness, inclusion of a ‘topical issue’ agenda item at meetings, and agreement to conduct the survey annually.

OPH CAC also had a very busy year. Among the highlights was the ‘Getting to Know You Program’, which was formed in response to patient feedback.

Getting to Know You

The Getting to Know You program was launched at OPH to enhance the patient's experience in hospital during rehabilitation. As part of this initiative, a particular activity program was introduced that appealed to the patient's interest and hobbies including art and craft sessions, gardening, music, drama and movie afternoons. A program like this allows patients to connect with each other, which increases their general wellbeing and approach to rehabilitation. Ruby, the therapy dog, has been a great hit with patients.

Youth Hospital In the Home

The Youth Hospital in The Home (YHiTH) service – the first of its kind in Australia – was established in March 2017 to provide daily mental health care in a young patient's home that would otherwise be delivered in a hospital environment.

Located at the Graylands Hospital campus, YHiTH clinicians make daily visits to the patient's home and work in partnership with them and their families or carers for about 14 days to provide intensive support, education and guidance.

The quality improvement project, which has received overwhelmingly positive feedback from families and carers, concentrates on providing families with the skills and knowledge to better support their loved ones.

Making a difference through music

The sound of music was heard at SCGH when patients and staff were greeted by a group of musicians from the WA Charity Orchestra, who performed at Watling Walk and the Cancer Centre.

Huge thanks to volunteers

During the reporting year, SCGH Auxiliary provided funding for a range of equipment to improve inpatient recovery and comfort.

Patients have benefited from purchases including bariatric commode chairs, seat walkers, 'tilt in space' wheelchairs and 'duogel' contour and memory cushions, which reduce the risk of pressure areas and enable patients to sit out of bed as part of their recovery process.

The auxiliary raises funds through their efforts in the G and E block shops, in addition to their 'lolly trolley'.

Social media

Social media has transformed the way we, as consumers, receive information and interact with individuals and organisations. Its use as a key communication tool is now common practice for many public sector agencies and is steadily being incorporated into our Health Service. This year, we launched accounts with Facebook, Twitter and Instagram. Through social networking, we are increasing awareness and access to our key programs and initiatives, and helping to encourage two-way communication between our staff, patients and their families and carers.

Multidisciplinary approach to treatment of acquired brain injury

Acquired brain injury (ABI) occurs when a sudden external, physical assault damages the brain. It is one of the most common causes of disability and death in adults. Patients at our Health Service with ABI receive a range of treatments – clinical psychology, occupational therapy, physiotherapy, social work and speech pathology – to achieve the maximum recovery possible and increase their likelihood of independent living in the future.

Increasing engagement with clinical staff

Increasing engagement with clinical staff is integral to ensuring patients receive safe, high-quality care. Our Health Service has worked hard to improve engagement through both formal and informal mechanisms. These have included the establishment of the Clinical Advisory Council, which reports to the Board, working through our health sites with clinicians, particularly in WNHS's Clinical Engagement Project, and with allied health staff and general practitioners.

Patient compliment

"I can't speak highly enough of the staff at KEMH. I felt so supported and empowered as a result of gaining access to all the professional services on offer at the hospital. I also felt lucky to have such strong woman professionals supporting my labour and newborn baby. – Kirby"

Learning to engage with clinicians

Members of NMHS Business Information and Performance Directorate met with international health economic and policy expert Stephen Duckett.

From left: Wendy Wen, Pammy Yeoh, Michael Campbell, Stephen Duckett, Brendon McMullen and Kavitha Gunaseelan

Highlights: Core Strategy 4

Enable, **empower and engage our workforce**

We will ensure that we have a high-performing workforce, one that has the skills and knowledge to continuously deliver innovative services. We will support them to ensure patient-centred care is provided every day.

NMHS has a large, diverse workforce that delivers health care. With a workforce of about 10 600 to serve 729 000 people and a payroll of almost $50 million each fortnight, our workforce prides themselves on delivering safe, high-quality services and health care to the community.

Enabling Aboriginal people and patients

- Increasing Aboriginal employment opportunities and outcomes
- Delivering Aboriginal Cultural Awareness programs
- Fostering leadership opportunities for our Aboriginal staff

Supporting junior doctors health and wellbeing

- Welfare advocate program
- Mindfulness workshops and sessions
- Clinical Debriefing Program

Celebrating staff achievements in health care

71 staff
recognised at local / State level

35 national awards
and acknowledgements

5 international achievements

3 staff
recognised in Queen's Birthday 2018 Honours

Member of the Order of Australia

Three of our staff were awarded a Member of the Order of Australia (AM) for their service to medicine:

Dr Roger Goucke: Director, WA Statewide Pain Service, SCGH, in the field of pain management as a clinician, academic and mentor, and to professional societies.

Dr David Hillman: Consultant, Department of Pulmonary Physiology and Sleep Medicine, SCGH, as an anaesthesiologist and physician, medical research into sleep disorders, and to professional organisations.

Dr Dominic Spagnolo: Consultant Anatomical Pathologist, PathWest, particularly in the field of pathology, as a clinician, and to medical education as a researcher and author.

Theatre Win

SCGH was a winner at the WA Health Excellence Awards. The workforce initiative to 'Improve Service Delivery and Theatre Efficiency Reform Program' was designed to improve access to surgical services, timelines of care and theatre efficiency, improve safety and quality outcomes for patients and patient experience as well as enhance staff satisfaction.

Committed to Aboriginal employment initiatives

Our Health Service offered several employment initiatives that led to extra jobs for Aboriginal people with us in 2017/18. These included participants in the WA Public Sector Commission Aboriginal Traineeship Program, Dental Clinical Assistant sponsorships and phlebotomy scholarships.

The Dental Clinical Assistant program enjoyed great success with all five recipients of scholarships completing their Certificate IV and being employed at various clinic locations through the metropolitan area.

Workforce Consultant Aboriginal Employment, Pearl Clarkson, continues to work on ways to attract, appoint and retain Aboriginal people in our workforce and to assist our Health Service in becoming one that is culturally secure.

Thank you to long-serving staff from OPH

'Thank you to the nine staff at OPH for their dedication and service to our Health Service. Coming from both clinical and corporate services, four of our staff have provided over 40 years of service, while another five have dedicated more than 35 years to the hospital.' – Lorraine Beatty, Acting Co-Director of Nursing

Highlights: Core Strategy 5

Enhance our clinical services through
professional and efficient corporate support

We will ensure that our corporate services (non-clinical services) are accountable, supportive and responsive to our clinical services. Where necessary, we will develop new skills and put the required systems in place to ensure we meet our obligations as a new statutory authority within the *Health Services Act 2016*. We will also implement a rigorous change program to embed a wide range of reforms in corporate services such as finance, workforce management, audit and risk and statutory reporting.

As in any large organisation, a significant proportion of the workforce is dedicated to providing corporate support through a comprehensive set of services and functions. Corporate support is integral to our clinical staff delivering safe, high-quality care, providing strategic direction and to fulfilling our corporate and statutory obligations as a public sector agency.

Enhancing audit and risk capabilities

15
internal and external audits completed

- new enterprise risk management system implemented
- eLearning risk management training launched

Advancing corporate governance

80%
of local policies reviewed and current

80%
of facility asset condition audit complete

- Sustainable service reform progressed

Empowering clinical decision-making

- New business intelligence tools developed

80%
tools published and available

Women in Leadership

Director and Consultant Clinical Neuropsychologist of NSU, Rachel Zombor, was selected as one of 80 women to be part of the 2017/18 Homeward Bound team, which saw her take part in an international leadership initiative for women in science.

Rachel returned to NMHS with enhanced leadership capability, a well-stocked toolbox and a worldwide network of passionate and talented female leaders.

In our Health Service, three core business areas provide services to enable good patient care:

Business and Performance which provides support in areas of workforce and human resources, finance business support, business information and performance, clinical planning, records management and integrity and ethics.

Procurement, Contract Management and Infrastructure which works closely with the Department of Health and other government organisations in areas of procurement, contract management and health infrastructure development.

Safety, Quality, Governance and Consumer Engagement which, like those who deliver frontline care in our Health Service, puts patients front and centre. The focus is on supporting clinical staff and safety and quality teams to deliver safe, high-quality care now and into the future.

Intraoperative Magnetic Resonance Imaging Service

Named after Clinical Professor Neville Knuckey, the Intraoperative Magnetic Resonance Imaging (IOMRI) suite has modern integrated operating theatres fitted with audiovisual systems to help image guidance during complex neurosurgery. IOMRI is considered more sensitive than other imaging techniques at identifying structures within the brain and brain tumours with real-time imaging during a surgical procedure. The establishment of an IOMRI service brings SCGH in line with comparable service models offered interstate and worldwide.

Short Stay Unit relocated to make way for improved service

A small opening ceremony was held in July 2017 for everyone involved in the relocation of SCGH's short stay and day procedure units to a new facility in E Block. Clinical staff and patients were involved in the early design stages to ensure the new space is both functional and practical for staff and patients.

KEMH's Chief Sonographer sweeps annual awards

KEMH's Chief Sonographer Michelle Pedretti was named national Sonographer of the Year and collected a further two awards at the Australian Sonographers Association's 2017 Awards of Excellence.

Ultrasound excellence

The OPH Radiology Department purchased two new ultrasound units in March 2018 as part of our Medical Equipment Replacement Program, significantly improving clinical performance and enhancing patient outcomes.

Learning from clinical incidents and promoting safety and quality

Few would dispute that delivering health care in 2018 has become the art of managing extreme complexity. Our staff strive to provide safe, high-quality care at all times, which is what the community expects and deserves. However, even enhanced by technology, we are not all powerful. It is regrettable that errors do occur and it is recognised that these errors may have serious consequences for those in our care.

A clinical incident is any unplanned event which causes, or has the potential to cause, harm to a patient. NMHS encourages a transparent approach to reporting of clinical incidents by staff. The process of investigating and learning from such incidents is fundamental to protecting our patients from harm, current and future. Investigation results in recommendations and actions that aim to prevent repeat incidents and to make our healthcare system safer for all.

Our investigation process aligns with the WA Clinical Incident Management Policy and the WA Open Disclosure Policy. Open disclosure ensures that communication with the patient, their family and carers is undertaken in an open and timely manner.

When serious errors are identified, they are given a Severity Assessment Code (SAC) rating of SAC1. There were 116 SAC1 incidents reported by NMHS and 38 reported by Joondalup Health Campus (JHC – publicly-funded activity) staff during 2017/18 (Table 1). At the time of reporting, 18 (16 NMHS; 2 JHC) incidents were still under investigation and 56 (47 NMHS; 9 JHC) incidents had been declassified as the health care provided was ultimately determined not to have been a factor in the poor outcome of the patient.

Of the 98 (69 NMHS; 29 JHC) remaining incidents, health care was identified as contributing to the poor patient outcome. Regrettably, 33 (21 NMHS; 12 JHC) patients died and 57 (40 NMHS; 17 JHC) experienced serious harm while in our care. It is clear that the reporting of clinical incidents, whether they result in harm or not, is vital to improving patient safety.

Table 1: NMHS SAC1 clinical incidents reported 2017/18

SAC1 clinical incident	NMHS	JHC (publicly-funded activity)
Total reported	**116**	**38**
Declassified*	**47 (41%)**	**9 (24%)**
Investigation completed	53	27
Investigation in progress	16	2
Completed + SAC1 investigations in progress	**69 (59%)**	**29 (76%)**
Outcome of completed + SAC1 in progress		
Death	21 (30%)	12 (41%)
Serious harm	40 (58%)	17 (59%)
Moderate harm	0	0
Minor harm	1 (2%)	0
No harm	7 (10%)	0

* Declassification of a reported SAC1 clinical incident may occur following thorough investigation if it is identified that no healthcare causative factors contributed to the incident. Declassification requests are reviewed by two Department of Health senior clinicians who have extensive experience in the area of safety and quality in health care. Declassification means that the event is no longer considered a clinical incident.

Examples of SAC1 clinical incidents reported by our staff include delays in responding to the deterioration of patients, mental health patients who have an unexplained death (despite recent contact and assessment by our services), infections acquired in hospital, falls resulting in fractures, and a medication error resulting in the death of a patient.

Clinical incidents where our patients suffered no harm were also investigated, particularly those incidents that were considered 'near misses' with the potential for harm. There are still important lessons to be learned from near-miss clinical incidents.

Our Health Service recognises that serious clinical incidents are distressing for patients, their families and carers, as well as for staff, and appropriate support should be provided to all involved. We will continue to strive to improve patient safety, with staff playing a key role in reporting and participating in the investigation of clinical incidents.

An example of good safety and quality – hand hygiene

Good hand hygiene (washing or decontaminating hands with soap and water or an alcohol-based hand rub) is an important part of good patient care and significantly reduces hospital-acquired infections.

The estimated hand hygiene rate for a hospital is a measure of how often hand hygiene is correctly performed (as a percentage). The data are derived from audits of hand hygiene 'moments' conducted up to three times a year. Hospitals must achieve a minimum national benchmark of 80 per cent.

Figure 1 shows the hand hygiene compliance rate of NMHS hospital sites and JHC over three audits conducted between April 2017 and March 2018.

All NMHS hospitals and JHC continue to achieve greater than 80 per cent hand hygiene compliance, that is, they meet or exceed the national benchmark.

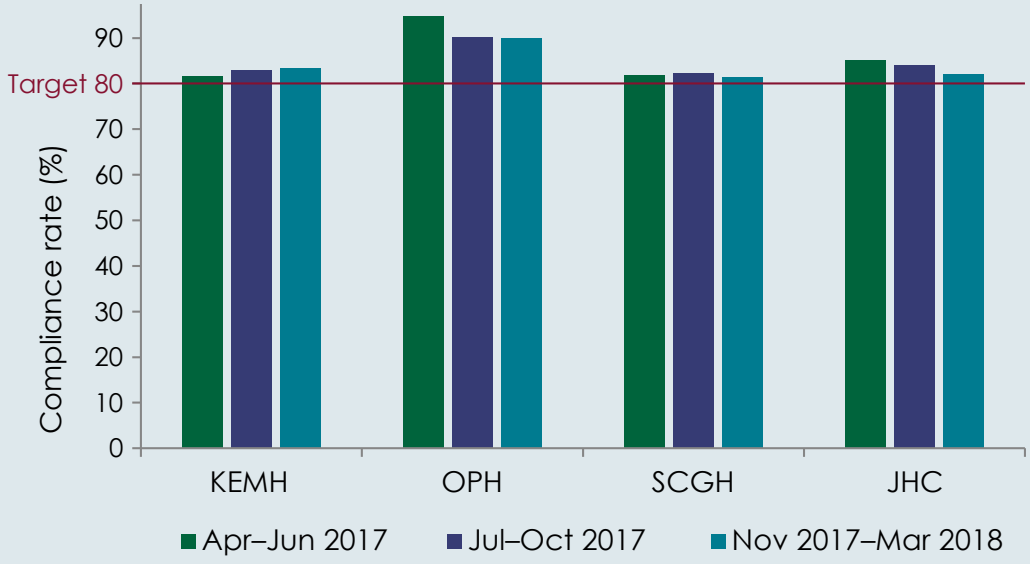


Figure 1 **Hand hygiene compliance rates, April 2017 to March 2018, by hospital**

Governance

Enabling legislation

NMHS was established as a HSP governed by a Board and Chief Executive in the Health Services (Health Service Provider) Order 2016 made by the Minister for Health under s. 32 of the *Health Services Act 2016*.

NMHS is responsible to the Minister for Health and the Chief Executive Officer of the Department of Health (System Manager) for the efficient and effective management of the organisation.

Accountable authority

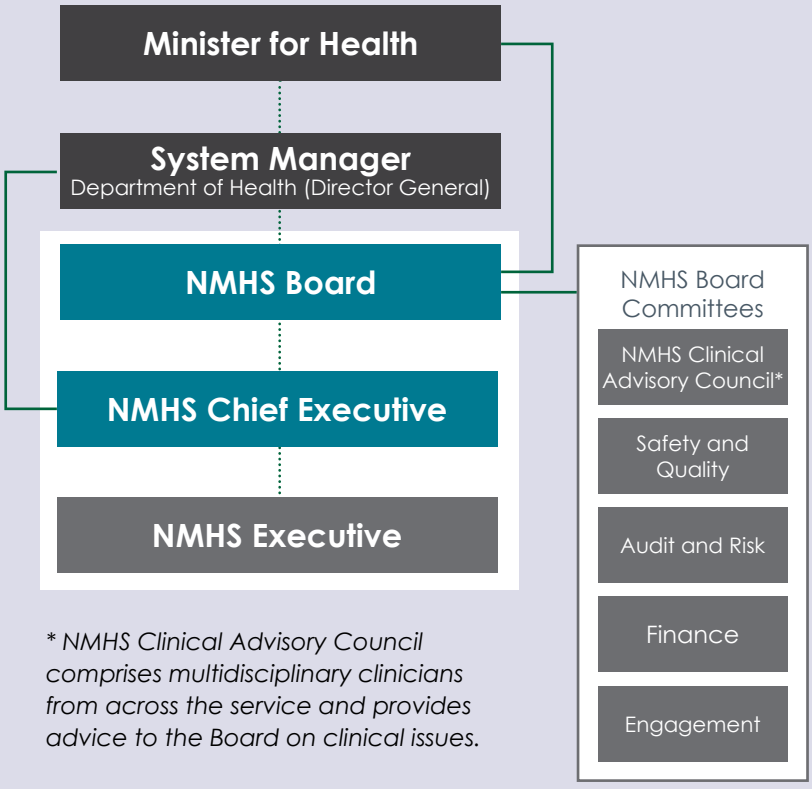
NMHS Board Chair, Professor Bryant Stokes AM, was the accountable authority for 2017/18.

Board of Authority

Under s. 34 of the *Health Services Act 2016*, the Board is responsible for the stewardship of the health service, including the governance of all aspects of service delivery and financial performance, and is responsible for setting the strategic and operational direction within the scope of policy frameworks set by the Department of Health.

Board members are appointed for up to a three-year period by the Minister for Health. A member is eligible for reappointment but cannot hold office for more than nine consecutive years. Members are appointed according to their expertise and experience in areas relevant to NMHS's activities.

Our governance structure



** NMHS Clinical Advisory Council comprises multidisciplinary clinicians from across the service and provides advice to the Board on clinical issues.*

Board profiles

Professor Bryant Stokes AM

Board Chair

Professor Bryant Stokes AM is a highly distinguished neurosurgeon with three professorships at WA universities and is a former Acting Director General of WA Health.

Professor Stokes was awarded a Member of the Order of Australia in 2001. With extensive experience at a senior executive level in WA Health, he brings strong leadership and governance skills to NMHS Board.

Professor Stokes resigned 30 June 2018.

Associate Professor Rosanna Capolingua

Deputy Board Chair
Chair, NMHS Board Safety and Quality Committee

Associate Professor Rosanna Capolingua is a highly qualified and experienced clinician, and currently the Director of GP Liaison at St John of God Health Care (SJGHC) Subiaco Hospital.

Chair of the former CAHS Governing Council, Associate Professor Capolingua has served on many health boards and committees and is currently Chair of the WA Immunisation Strategy Committee, Board Member of SJGHC and was State Councillor for the Australian Medical Association until December 2017. She was also a Member of the Board of Governors of the University of Notre Dame.

Professor Capolingua resigned 20 June 2018.

Dr Margaret Crowley

Chair, NMHS Board Engagement Committee

Dr Margaret Crowley has extensive experience as a Chief Executive Officer in the community sector and held senior executive positions in federal and state governments and universities.

Dr Crowley has held numerous board positions, including as a member of the WA Board of the Nursing and Midwifery Board of Australia, the Lions Eye Institute and the South Metropolitan Health Service (SMHS) Governing Council.

Dr Crowley completed her tenure 30 June 2018.

Dr Felicity Jefferies

Dr Felicity Jefferies has over 30 years' experience as a medical practitioner, working in both metropolitan and rural settings, and over 10 years' experience as a member of the Medical Board of Western Australia.

Dr Jefferies has a focus on ensuring consistent standards of quality and safety of medical services and a background in rural workforce development, including as an inaugural member of Health Workforce Australia and a life member of Rural Health West.

Dr Jefferies resigned on 1 March 2018.

Ms Michele Kosky AM

Ms Michele Kosky AM brings a depth of experience and understanding of the patient and carer perspective from recent positions as Executive Director of the Health Consumers' Council of WA and as Deputy Chair of the Mental Health Law Centre.

Ms Kosky was awarded a Member of the Order of Australia in 2009 for her service to the community. She has considerable experience on consumer advisory councils and on the Australian Commission on Quality and Safety in Health Care in the development of the current accreditation standards.

Ms Kosky completed her tenure 30 June 2018.

Mr Geoff Mather

Mr Geoff Mather is Group Chief Financial Officer at the Royal Automobile Club of WA and has extensive experience in accounting, insurance, financial services, strategy, governance and operations.

Mr Mather has a keen interest in retirement, aged care and education, and was formerly a non-executive director at Amana Living, an Anglican agency specialising in aged care, retirement living, where he also served as Chair of the Investment Committee and member of the Audit and Risk Committee.

Mr Mather completed his tenure 30 June 2018.

Mr Graham McHarrie

Chair, NMHS Board Finance Committee

Mr Graham McHarrie has extensive professional experience as a Chartered Accountant with widespread experience in the disability services sector. A former partner of Deloitte, Mr McHarrie is currently Chair of Rocky Bay Inc. where he has served as a board member.

Mr McHarrie also served as a board member of the International Centre for Radio Astronomy Research and is a former member of the Council of Edith Cowan University (ECU).

Mr McHarrie resigned effective 30 June 2018.

Ms Maria Saraceni

Chair, NMHS Board Audit and Risk Committee

Ms Maria Saraceni is a barrister practising in regulatory and compliance law, with a focus on occupational safety and health and employment/ industrial relations. A former partner of Norton Rose and Jackson McDonald Lawyers, she is currently an Adjunct Professor at the Murdoch University School of Law.

Ms Saraceni has served on numerous boards and committees, including two terms as President of the Law Society of WA and Director of the Law Council, Chair of the Women's Advisory Council in WA, President of the Ethnic Communities Council of WA, Director of the Federation of Ethnic Communities Councils of Australia and a Member of the SBS Community Advisory Council.

Ms Saraceni resigned effective 30 June 2018.

Professor Rhonda Marriot

Professor Rhonda Marriott was born in Derby, WA, and is a descendent of the Kimberley Nyikina Aboriginal people. She has extensive experience in the professions of nursing and midwifery in both clinical and academic roles, celebrating 50 years of being a nurse and 28 years of being an academic in 2017.

Professor Marriott is a senior researcher with expertise in Aboriginal maternal and child health matters. As a leader in her field, she has been invited to contribute to many professional forums and conferences and brings a depth of knowledge to NMHS.

Dr Marriott resigned 28 March 2018.

Professor Grant Waterer

Professor Grant Waterer is a consultant respiratory physician who has developed a successful academic career with major international roles, and is a Doctor of Philosophy of Medicine.

Currently Medical Co-Director of Royal Perth Hospital and Professor of Medicine at The University of Western Australia (UWA), Professor Waterer has over 20 years' experience in various clinical and medical administrative positions.

Professor Waterer completed his tenure 30 June 2018.

Our organisational structure

Angela Kelly
A/Chief Executive
North Metropolitan Health Service

Graeme Boardley
A/Executive Director
Women and Newborn Health Service

Functions

- BreastScreen WA
- Community Midwifery Program
- Genetic Services and Familial Cancer Program of WA
- King Edward Memorial Hospital
- Newborn Emergency Transport Service WA
- Perinatal Mental Health
- Sexual Assault Resource Centre
- Statewide Obstetric Support Unit
- WA Cervical Cancer Prevention Program
- WA Register of Developmental Anomalies
- Women's Health Clinical Support Programs

Tanya Adair
A/Executive Director
Procurement, Infrastructure and Contract Management

Functions

- Facilities Management
- Fleet Management
- Mail
- Metropolitan Parking
- Public Private Partnership Joondalup Health Campus
- Procurement, Contract Management and Leasing
- Security
- Strategic Asset Planning and Delivery
- Telecommunications

Dr Theresa Marshall
Executive Director
Safety, Quality, Governance and Consumer Engagement

Functions

- Audit and Risk Management
- Clinical Governance
- Community and Stakeholder Engagement
- Corporate Governance
- Intellectual Property
- Medico Legal Services
- Safety and Quality

Penny Fielding
Executive Director
Business and Performance

Functions

- Business Information and Performance
- Clinical Planning (and Telehealth Service)
- Data Stewardship and Governance
- Finance
- Integrity and Ethics
- Records Management
- Workforce

Ros Elmes
A/Executive Director
Mental Health, Public Health and Dental Services

Functions

- Aboriginal Health Stratergy
- Area Mental Health Services
- Dental Health Services
- DonateLife WA
- Public Health
- State Head Injury Unit

Tony Dolan
A/Executive Director
Sir Charles Gairdner Osborne Park Health Care Group

Functions

- Comprehensive Cancer Centre
- Osborne Park Hospital
- Sir Charles Gairdner Hospital
- WA Poisons Information Centre

Dr Karen Murphy
Executive Director
Medical Services

Functions

- Medical Education and Research
- Medical Governance
- Medical Workforce

Marie Slater
A/Executive Director
Nursing and Midwifery Services

Functions

- Nursing and Midwifery Medical Equipment Replacement Program
- Nursing Education and Research
- Nursing Governance
- Patient Support Services

Silvano Palladino
Executive Director
PathWest

Functions

- Corporate Governance
- Contract Management
- Finance
- Performance
- Statewide Pathology Services
- Workforce

Performance management framework

Outcome-based management framework

The outcome-based management (OBM) framework is a Department of Treasury mandatory requirement for all State Government agencies.

The OBM framework describes how Outcomes, Services and Key Performance Indicators (KPIs) are used to measure WA health system performance towards the State Government goal of 'Strong communities, safe communities and supported families' and the WA Health agency goal of 'Delivery of safe, quality, financially sustainable and accountable health care for all Western Australians'. The KPIs of the OBM framework measure the effectiveness and efficiency of the services delivered against agreed State Government priorities and desired outcomes.

The key principles that underpin the OBM framework are:

Transparency:	transparent reporting of performance against agreed outcome targets.
Accountability:	clearly defined roles and responsibilities to achieve agreed outcome targets.
Recognition:	acknowledgment of performance against agreed outcome targets.
Consistency:	consistent systems to support the achievement of agreed outcome targets.
Integration:	integrated systems and policies to support the achievement of agreed outcome targets.

NMHS, as a HSP, is responsible for delivering and reporting against the following Outcomes and Services:

Outcome 1	Public hospital-based services that enable effective treatment and restorative health care for Western Australians.
Service 1	Public hospital admitted services
Service 2	Public hospital emergency services
Service 3	Public hospital non-admitted services
Service 4	Mental health services
Outcome 2	Prevention, health promotion and aged and continuing care services that help Western Australians to live healthy and safe lives
Service 6	Public and community health services
Service 7	Community dental health services
Note:	Aged and continuing care services (Service 5) are mainly provided by the Department of Health for the health system. NMHS provides Aged and continuing care services; however, no performance measures are reportable for this service as per the OBM framework.

Performance against these activities and outcomes are summarised in the Summary of KPI performance (Table 3), and described in detail in the Detailed information in support of KPIs.

Small steps to quality improvement

SCGH General Surgery Department has paved the way for the establishment of a quality improvement register that will reduce variations in outcomes and care following emergency laparotomy (operation for people with severe abdominal pain), which is associated with high mortality and morbidity.

Emergency surgery is a significant healthcare burden and constitutes between one-third and one-half of all general surgery admissions.

Information from the pilot study will be used to seek funding for a more detailed, multiyear quality improvement study that will be benchmarked against other international studies.

Geriatric Assessment Team

A trial was undertaken at SCGH with the aim of reducing time patients spend unnecessarily at the hospital.

Overall, the results of the Geriatric Assessment Team pilot have shown patients have been helped to 'receive the right care, in the right place, at the right time'.

Not only has this been beneficial for patients in terms of their overall experience, but the initiative has helped to align resources across SCGOPHCG, promoting greater financial sustainability.

Changes to OBM framework

To ensure currency and ongoing relevance as part of the WA Health Reform Program 2015–2020, WA Health implemented a revised and contemporary OBM framework for the WA health system as described above.

Shared responsibilities with other agencies

As part of the WA health system, NMHS works with other agencies to provide and fund health services to achieve the stated desired Outcomes as per the OBM framework.

Outcome-based management framework

Outcome 1

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

Effectiveness KPIs

Unplanned hospital readmissions of public hospital patients within 28 days for selected surgical procedures: (a) knee replacement; (b) hip replacement; (c) tonsillectomy and adenoidectomy; (d) hysterectomy; (e) prostatectomy; (f) cataract surgery; (g) appendectomy

Proportion of elective wait list patients waiting over boundary for reportable procedures (a) % Category 1 over 30 days (b) % Category 2 over 90 days (c) % Category 3 over 365 days

Hospital infection rates (Healthcare-associated Staphylococcus aureus bloodstream infections (HA-SABSI) per 10000 occupied bed-days in public hospitals)

Survival rates for sentinel conditions: stroke, acute myocardial infarction, fractured neck of femur

Percentage of admitted Aboriginal and non-Aboriginal patients who discharged against medical advice

Percentage of live-born term infants with an Apgar score of less than 7 at 5 minutes post-delivery

Rate of total hospital readmissions within 28 days to an acute designated mental health inpatient unit

Percentage of contacts with community-based public mental health non-admitted services within 7 days post discharge from an acute public mental health inpatient unit

Efficiency KPIs

Service 1 Public hospital admitted services
Average admitted cost per weighted activity unit

Service 2 Public hospital emergency services
Average Emergency Department cost per weighted activity unit

Service 3 Public hospital non-admitted services
Average non-admitted cost per weighted activity unit

Service 4 Mental health services
Average cost per bed-day in specialised mental health inpatient units
Average cost per treatment day of non-admitted care provided by public clinical mental health services

Outcome 2

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

Effectiveness KPIs

Participation rate of women aged 50 – 69 years who participate in breast screening

Percentage of (a) adults and (b) children who have a tooth re-treated within 6 months of receiving initial restorative dental treatment

Percentage of eligible school children who are enrolled in the School Dental Service program

Percentage of eligible people who accessed Dental Health Services

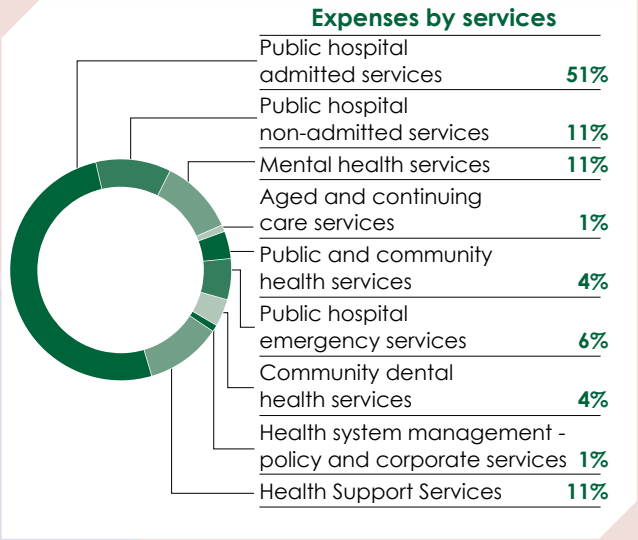
Efficiency KPIs

Service 6 Public and community health services
Average cost per person of delivering population health programs by population health units

Average cost per breast screening

Service 7 Community dental health services
Average cost per patient visit of WA Health-provided dental health programs for (a) school children and (b) socioeconomically disadvantaged adults

Agency performance

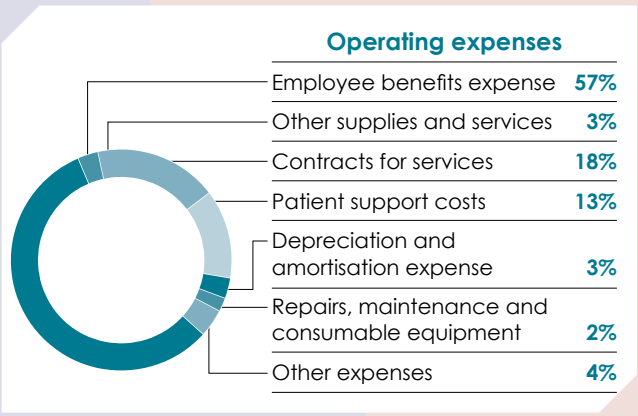


Report on operations

NMHS annual budget is contained within the approved Minister for Health *Financial Management Act 2006* s. 40 Estimates Annual Financial Statements, which were developed based on the initial (2017) Service Agreement.

In 2017/18 the total cost of providing State services and health services to NMHS community was $2.4 billion. Results for 2017/18 against agreed financial targets (based on Budget Statements) are presented in (Table 2).

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



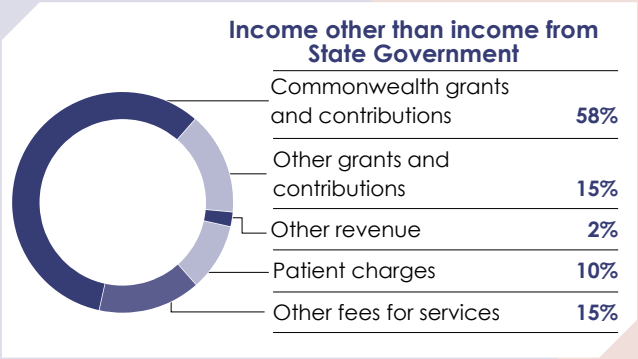


Table 2: Actual results versus budget targets, 2017/18

Financial targets	2017/18 Target[1] $000	2017/18 Actual $000	Variation[2] $000
Total cost of services (expense limit) (sourced from Statement of comprehensive income)	2,257,635	2,449,212	191,577
Net cost of services (sourced from Statement of comprehensive income)	1,219,196	1,286,722	67,526
Total equity (sourced from Statement of financial position)	2,041,907	1,967,636	(74,271)
Net increase / (decrease) in cash held (sourced from Statement of cash flows)	5,300	9,015	3,715
Approved salary expense level	(1,289,481)	(1,388,748)	(99,267

Data sources: Budget Strategy and Reporting:
(1) as per the 2017/18 section 40 Estimates Annual Financial Statements.
(2) explanations of variances are contained in Note 9.12 'Explanatory Statement' to the Financial Statements.

Summary of key performance indicators

KPIs assist NMHS 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. KPIs also provide a means to communicate to the community how NMHS is performing.

Table 3 provides a summary of our KPIs and variation from the 2017/18 targets.

Table 3: Actual results versus KPI targets

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

Performance indicator	2017/18 Actual (%)	2017/18 Target (%)	Variation (%)	Target met
Waiting times for emergency hospital care (proportion of ED patients seen within recommended times):				
Triage category 1 (2 minutes)	100.00	100	0.00	✓
Triage category 2 (10 minutes)	79.83	80	0.17	×
Triage category 3 (30 minutes)	43.14	75	31.86	×
Triage category 4 (60 minutes)	59.39	70	10.61	×
Triage category 5 (2 hours)	91.61	70	21.61	✓
Effectiveness KPI	**2017 Actual**	**2017 Target**	**Variation**	**Target met**
Unplanned hospital readmissions of public hospital patients within 28 days for selected surgical procedures				
Knee replacement	36.1	≤ 26.2	9.9	×
Hip replacement	21.3	≤ 17.2	4.1	×
Tonsillectomy and adenoidectomy	112.4	≤ 61.0	51.4	×
Hysterectomy	45.5	≤ 41.3	4.2	×
Prostatectomy	45.5	≤ 38.8	6.7	×
Cataract surgery	2.0	≤ 1.1	0.9	×
Appendectomy	18.4	≤ 32.9	14.5	✓

Table 3: Actual results versus KPI targets (continued)

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

Effectiveness KPI	2017/18 Actual (%)	2017/18 Target (%)	Variation	Target met
Proportion of elective wait list patients waiting over boundary for reportable procedures:				
Category 1 over 30 days	5.5	0	5.5	×
Category 2 over 90 days	7.3	0	7.3	×
Category 3 over 365 days	2.8	0	2.8	×
Effectiveness KPI	**2017 Actual**	**2017 Target**	**Variation**	**Target met**
Hospital infection rates (healthcare-associated *Staphylococcus aureus* bloodstream infections (HA-SABSI) per 10000 occupied bed-days in public hospitals)	0.71	≤1.0	0.29	✓
Survival rates for sentinel conditions	(%)	(%)	(%)	
Stroke				
0 to 49 years	93.5	94.3	0.8	×
50 to 59 years	91.8	92.4	0.6	×
60 to 69 years	92.0	92.8	0.8	×
70 to 79 years	91.2	89.5	1.7	✓
80+ years	86.1	80.9	5.2	✓
Acute myocardial infarction				
0 to 49 years	99.1	99.2	0.1	×
50 to 59 years	98.9	98.9	0.0	✓
60 to 69 years	96.9	98.1	1.2	×
70 to 79 years	96.6	96.1	0.5	✓
80+ years	91.6	91.7	0.1	×
Fractured neck of femur				
70 to 79 years	100.0	98.9	1.1	✓
80+ years	96.6	95.3	1.3	✓
Percentage of admitted Aboriginal and non-Aboriginal patients who discharged against medical advice				
Aboriginal	3.36	-	-	-
Non-Aboriginal	0.76	-	-	-
Total	0.83	≤ 0.77	0.06	×
Percentage of liveborn term infants with an Apgar score of less than 7, 5 minutes post-delivery	1.6	≤ 1.8	0.2	✓
Rate of total hospital readmissions within 28 days to an acute designated mental health inpatient unit	17.8	≤ 12	5.8	×
Percentage of contacts with community-based public mental health non-admitted services within 7 days post-discharge from an acute public mental health inpatient unit	66	≥ 75	9	×

Table 3: Actual results versus KPI targets (continued)

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

Efficiency KPI	2017 Actual ($)	2017 Target ($)	Variation ($)	Target met
Service 1 Public hospital admitted services				
Average admitted cost per weighted activity unit	7,087	7,285	198	✓
Service 2 Public hospital emergency services				
Average Emergency Department cost per weighted activity unit	6,095	7,043	948	✓
Service 3 Public hospital non-admitted services				
Average non-admitted cost per weighted activity unit	7,224	7,160	64	×
Service 4 Mental health services				
Average cost per bed-day in specialised mental health inpatient units	1,482	1417	65	×
Average cost per treatment day of non-admitted care provided by public clinical mental health services	465	483	18	✓

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

Effectiveness KPI	2017 Actual (%)	2017 Target (%)	Variation (%)	Target met
Participation rate of women aged 50 to 69 years in breast screening	56.0	≥ 70	14.0	×

Effectiveness KPI	2017/18 Actual (%)	2017/18 Target (%)	Variation (%)	Target met
Percentage of				
(a) adults	6.0	< 7.7	1.7	✓
(b) children	2.2	< 2.6	0.5	✓
who have a tooth re-treated within 6 months of receiving initial restorative dental treatment				
Percentage of eligible school children who are enrolled in the School Dental Service program	79	≥ 69	10	✓
Percentage of eligible people who accessed Dental Health Services	15	≥ 15	0	✓

Efficiency KPI	2017/18 Actual ($)	2017/18 Target ($)	Variation ($)	Target met
Service 6 Public and community health services				
Average cost per person of delivering population health programs by population health units	50	19	31	×
Average cost per breast screening	165	157	165	×
Service 7 Community dental health services				
Average cost per patient visit of WA Health-provided dental health programs for:				
(a) school children	198	208	10	✓
(b) socioeconomically disadvantaged adults	272	305	33	✓

Note: Actual results vs. KPIs (Table 3) are to be read in conjunction with detailed information on each KPI found in the Agency performance section of this report.

Detailed information in support of key performance indicators

The framework for the WA health system was updated comprehensively for 2017/18. Comparative results will not be reported for new or previously reported KPIs where there have been material changes in KPI definitions and cost allocation methodologies as per the OBM framework. The KPIs are prepared based on the latest available information.

Unplanned hospital readmissions of public hospital patients within 28 days for selected surgical procedures

WA Government Goal	Strong communities, safe communities and supported families
WA Health Goal	Delivery of safe, quality, financially sustainable and accountable health care for all Western Australians
Outcome 1	Public hospital-based services that enable effective treatment and restorative health care for Western Australians

Rationale

After a successful hospital stay, the most important task for WA public hospital patients and staff is preparing for a successful discharge home. Tracking the number of patients who experience unplanned readmissions to WA health system hospitals within 28 days for selected surgical procedures assists in assessing the quality of hospital services provided to the community. Unplanned readmissions are those readmissions where the principal diagnosis and readmission interval indicate that the readmission may be related to the care provided by the hospital in an index surgical episode of care. This indicator measures readmissions to any public hospital or as a public patient in contracted health entities. The indicator is reported at the facility where the initial admission occurred rather than the facility where the patient was readmitted.

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

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

Target

Maintained performance is demonstrated by a result below, or equal to, the target. Please see the targets for each condition in the results section (Table 4).

Results

In 2017 the rate of unplanned readmission within 28 days for appendectomy was below target (see Table 4). All other surgical procedure indicators for unplanned hospital readmissions within 28 days were above target. The number of readmission cases for all procedures was small and results should be interpreted with caution. For example, there were a total of 16 readmissions out of the 868 appendectomy cases and 28 readmissions out of the 249 tonsillectomy and adenoidectomy cases. Case reviews have identified that patients have received appropriate care and a number of readmissions were due to pre-existing conditions.

Table 4: Unplanned hospital readmissions within 28 days for selected surgical procedures (per 1000), 2017

Surgical procedure	2016 (per 1000)	2017 (per 1000)	2017 Target (per 1000)	Target met
Knee replacement	21.9	36.1	≤ 26.2	×
Hip replacement	16.5	21.3	≤ 17.2	×
Tonsillectomy and Adenoidectomy	142.9	112.4	≤ 61.0	×
Hysterectomy	34.9	45.5	≤ 41.3	×
Prostatectomy	48.1	45.5	≤ 38.8	×
Cataract surgery	3.6	2.0	≤ 1.1	×
Appendectomy	28.0	18.4	≤ 32.9	✓

Data source: Hospital Morbidity Data Collection.

Fall prevention

OPH hosted a free balance workshop for seniors during the reporting year, to help prevent falls. The workshop was open to Stirling residents and covered a range of balance exercises and strategies.

Proportion of elective wait list patients waiting over boundary for reportable procedures

WA Government Goal	Strong communities, safe communities and supported families
WA Health Goal	Delivery of safe, quality, financially sustainable and accountable health care for all Western Australians
Outcome 1	Public hospital-based services that enable effective treatment and restorative health care for Western Australians

Rationale

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

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

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

Reportable cases are defined as:

> All waiting list cases that are not listed on the Elective Services Wait List Data Collection (ESWLDC) Commonwealth Non-Reportable Procedures list. This list is consistent with the Australian Institute of Health and Welfare (AIHW) excluded procedures list. It also includes additional procedure codes that are intended to better reflect the procedures identified in the AIHW excluded procedures list.

Target

The 2017/18 target is 0 per cent. Performance is demonstrated by a result equal to the target.

Results

In 2017/18 all urgency categories for elective surgery wait list patients waiting over boundary were above target (see Table 5) due to challenges associated with increased demand on service and patient flow.

Table 5: Proportion of elective wait list patients waiting over boundary for reportable procedures, 2016/17 to 2017/18

Urgency category	2016/17 (%)	2017/18 (%)	Target (%)	Target met
Category 1 over 30 days	4.5	5.5	0	×
Category 2 over 90 days	6.6	7.3	0	×
Category 3 over 365 days	2.0	2.8	0	×

Data source: Elective Services Wait List Data Collection.

Hospital is stoked with stroke innovation

An innovative procedure for treating severe stroke victims is now curing hundreds of people in WA.

A team of specialist doctors based at SCGH is treating 'brain attacks' using a complex but minimally invasive surgical technique that allows patients to walk out of hospital the next day.

The unit, the first of its kind in Australasia, has treated about 700 patients this year, mostly for strokes but also for brain aneurysms and burst aneurysms.

SCGH performance in the Australian and New Zealand Hip Fracture Registry

Of the 28 hospitals that participated in the Australian and New Zealand Hip Fracture Registry during 2017, SCGH performed extremely well. The hospital scored highly against a range of criteria focused on improving patient care, reducing morbidity, hastening recovery and reducing length of stay.

Continuously improving clinical excellence

A multidisciplinary team at OPH has been able to reduce the hospital's endoscopy wait list significantly, from 3000 in January 2015 to 1215 in March 2018.

This dramatic reduction has been achieved year-on-year since 2015 through a multifaceted project involving an in-depth audit of the wait list, development of referral guidelines and a specific electronic GP referral form, in addition to improved clerical handling of referrals, and the development of an improved triage system.

Improvements in the management of the endoscopy wait list are expected to continue in the year ahead.

Hospital infection rates (healthcare-associated *Staphylococcus aureus* bloodstream infections (HA-SABSI) per 10 000 occupied bed-days in public hospitals)

WA Government Goal	Strong communities, safe communities and supported families
WA Health Goal	Delivery of safe, quality, financially sustainable and accountable health care for all Western Australians
Outcome 1	Public hospital-based services that enable effective treatment and restorative health care for Western Australians

Rationale

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

HA-SABSI are generally considered to be preventable adverse events associated with the provision of health care.

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

Target

The 2017 target is <1.0 per 10 000 occupied bed-days. Maintained performance is demonstrated by a result below, or equal to, the target.

Results

In 2017 hospital infection rates were below target (see Table 6). The target was met due to improved methodologies and initiatives, such as the implementation of a revised peripheral intravenous catheter assessment form and continual monitoring of HA-SABSI incidences using a multidisciplinary approach. These initiatives have contributed to enhanced outcomes.

Table 6: Healthcare-associated *Staphylococcus aureus* bloodstream infections (HA-SABSI) per 10000 occupied bed-days, 2017/18

	2017	Target (per 10000)	Target met
HA-SABSI per 10000 occupied bed-days	0.71	≤ 1.0	✓

Data source: Healthcare Infection Surveillance WA Data Collection (HISWA).

Midwives drive change

Two KEMH midwives were award recipients at the 2018 WA Nursing and Midwifery Excellence Awards.

Alison Jennings was bestowed the Excellence in Midwifery Award for her dedication to empowering women and ensuring they had the best birthing experience possible. Christian Wright received the Graduate Midwife of the Year Award

Responding appropriately to patient needs

After a 51-year-old Aboriginal woman presented at the SCGH emergency department in April 2018 with domestic violence injuries, her case was reviewed by several specialists.

The care she subsequently received was thorough and implemented by several agencies working in collaboration. They included the relevant Victim Support Unit, WA Police Force and the co-located Family Domestic Violence (FDV) Officer, in addition to the Department of Communities, Division of Child Protection and Family Support (Communities).

Pleasingly, the patient has not re-presented to ED since the intervention by all of the agencies involved.

Pregnant pause is all positive

Christian Wright – the first male midwife in the 25-year history of the Family Birth Centre at KEMH – assisted in the delivery of Sonya McQuire's two children – Archer and Imogen. Ms McQuire said he was an 'amazing' midwife and she was never uncomfortable about his gender.

Survival rates for sentinel conditions

WA Government Goal	Strong communities, safe communities and supported families
WA Health Goal	Delivery of safe, quality, financially sustainable and accountable health care for all Western Australians
Outcome 1	Public hospital-based services that enable effective treatment and restorative health care for Western Australians

Rationale

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 a 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 ED 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 including the diagnosis, the treatment given or procedure performed, age, comorbidities at the time of admission and complications that may have developed while the patient is in hospital.

Hospital survival indicators are considered screening tools to identify areas that may require further investigation.

Target

Maintained performance is demonstrated by a result below, or equal to, the target. Please see the targets for each condition in the results section (Table 7).

Australian first in heart treatment

A stent graft used in an Australian first at SCGH has revolutionised the way difficult aneurysms are treated.

The stent, still under clinical trials in the US, required approval from Australia's medical appliance watchdog before vascular surgeon Joe Hockley could insert it into the first patient's aorta.

> "Previously such an aneurysm required complex major surgery but now we do it with two cuts to the arteries in the groin," Dr Hockley said.

Results

In 2017 the survival rate for stroke was above target for patients in age groups cohort of 70 to 79 years and 80+ years (see Table 7); however, the survival rate was below target for patients in all other age groups. Survival rates are impacted by severity of disease on admission and patients with multiple comorbidities.

Table 7: Survival rate for stroke, by age group, 2016 to 2017

Age group (years)	2016 (%)	2017 (%)	2017 Target (%)	Target met
0 to 49	87.7	93.5	94.3	×
50 to 59	87.5	91.8	92.4	×
60 to 69	92.4	92.0	92.8	×
70 to 79	90.6	91.2	89.5	✓
80+	84.4	86.1	80.9	✓

Data source: Hospital Morbidity Data Collection.

Survival rates for patients with an acute myocardial infarction were equal to target for age group 50 to 59 years and above target for age group 70 to 79 years. Survival rate was below target for all other age groups (see Table 8). Survival rates are impacted by severity of disease on admission and elderly patients with multiple co-morbidities.

Table 8: Survival rate for acute myocardial infarction, by age group, 2016 to 2017

Age group (years)	2016 (%)	2017 (%)	2017 Target (%)	Target met
0 to 49	100.0	99.1	99.2	×
50 to 59	99.2	98.9	98.9	✓
60 to 69	97.9	96.9	98.1	×
70 to 79	93.3	96.6	96.1	✓
80+	90.1	91.6	91.7	×

Data source: Hospital Morbidity Data Collection.

The survival rate for patients with fractured neck of femur was above target for all age groups (see Table 9).

Table 9: Survival rate for fractured neck of femur, by age group, 2016 to 2017

Age group (years)	2016 (%)	2017 (%)	2017 Target (%)	Target met
70 to 79	93.8	100	98.9	✓
80+	97.4	96.6	95.3	✓

Data source: Hospital Morbidity Data Collection.

Percentage of admitted Aboriginal and non-Aboriginal patients who discharged against medical advice

WA Government Goal	Strong communities, safe communities and supported families
WA Health Goal	Delivery of safe, quality, financially sustainable and accountable health care for all Western Australians
Outcome 1	Public hospital-based services that enable effective treatment and restorative health care for Western Australians

Rationale

Patients who leave hospital against medical advice (also called DAMA or discharged against medical advice) have been found to cost the health system 50 per cent more than patients who are discharged by physicians.[2] Published data contend that high DAMA rates reflect the need for improved responses by the health system to the needs of patients and provide a measure of the safety, quality and cultural security of the services provided.

Monitoring this indicator will enable identification of performance improvement opportunities, as well as the collaborative and effective addressing of the underlying factors in achieving treatment outcomes.

Target

The 2017 target is ≤ 0.77 per cent. Maintained performance is demonstrated by a result below, or equal to, the target.

Results

In 2017 the percentage of admitted patients who discharged against medical advice was above target (see Table 10). To actively manage DAMA patients, NMHS has implemented initiatives to assess and engage high risk patients and their families as early as possible.

Table 10: Percentage of admitted Aboriginal and non-Aboriginal patients who discharged against medical advice, 2017

	2017 (%)	Target (%)	Target met
Aboriginal	3.36	-	-
Non-Aboriginal	0.76	-	-
Total	0.83	≤ 0.77	×

Data source: Hospital Morbidity Data Collection.

[2] Aliyu ZY. Discharge against medical advice: sociodemographic, clinical and financial perspectives. International journal of clinical practice 2002;56(5):325-27.

Percentage of liveborn term infants with an Apgar score of less than seven, five minutes post-delivery

WA Government Goal	Strong communities, safe communities and supported families
WA Health Goal	Delivery of safe, quality, financially sustainable and accountable health care for all Western Australians
Outcome 1	Public hospital-based services that enable effective treatment and restorative health care for Western Australians

Rationale

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

The Apgar score is an assessment of an infant's health at birth based on breathing, heart rate, colour, muscle tone and reflex irritability. An Apgar score is applied at one, five and possibly 10 minutes after delivery to determine how well the infant is adapting outside the mother's womb. Apgar scores range from zero to two for each condition with a maximum final total score of 10. The higher the Apgar score, the better the health of the newborn infant.

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

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

Target

The 2017 target for liveborn term infants with an Apgar score of less than seven, five minutes post-delivery is ≤ 1.8 per cent. Maintained performance is demonstrated by a result below, or equal to, the target.

Results

In 2017 the percentage of liveborn term infants with an Apgar score of less than seven at five minutes post-delivery was below target (see Table 11). Consistent evidence-based care across all sites has contributed to patient outcomes.

Table 11: Percentage of liveborn term infants with an Apgar score of less than seven, five minutes post-delivery, 2016 to 2017

Live births	2016 (%)	2017 (%)	Target (%)	Target met
Apgar Score < 7	1.6	1.6	≤ 1.8	✓

Data sources: Midwives Notification System; Birth Notification Dataset.

Rate of total hospital readmissions within 28 days to an acute designated mental health inpatient unit

WA Government Goal	Strong communities, safe communities and supported families
WA Health Goal	Delivery of safe, quality, financially sustainable and accountable health care for all Western Australians
Outcome 1	Public hospital-based services that enable effective treatment and restorative health care for Western Australians

Rationale

Readmission rate is considered to be a global performance measure as it potentially points to deficiencies in the functioning of the overall mental healthcare system.

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

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

Target

The 2017 target is ≤ 12 per cent readmissions within 28 days to an acute designated mental health inpatient unit. Maintained performance is demonstrated by a result below, or equal to, the target.

Results

In 2017 the rate of total hospital readmissions within 28 days to an acute designated mental health inpatient unit was above target (see Table 12). This indicator looks at total readmissions and it should be noted that some readmission cases are warranted as part of accepted best practice protocols. Strategies that have been implemented to appropriately manage this KPI include implementing admission efficiencies, having clearly defined roles between the Intensive Community Outreach teams and Hospital Extended Care Service, opening of the MHOA at JHC in late January 2018, and improving discharge reviews and data capture processes.

Results should be interpreted with caution due to data input systems and internal processes/ procedures being limited in their ability to capture correct data to comply with the definition of the KPI. An approach to ensure correct data capture is currently being implemented.

Table 12: Rate of total hospital readmissions within 28 days to the same hospital for a mental health condition, 2017

	2017 (%)	Target (%)	Target met
Readmission rate	17.8	≤ 12	×

Data source: Hospital Morbidity Data Collection.

Graylands Hospital Extended Care Service

A Positive Behaviour Support Framework has been implemented at Graylands Hospital Extended Care Service to provide specialised clinical and rehabilitation treatments to a targeted group of inpatients with major mental illnesses to support their return to living safely in the community.

Best care for babies

In the intensive care unit for babies (NICU) at KEMH, infants are physically separated from their parents and this often has an impact on the physical, psychological and emotional health of both the parents and the infants. In November 2017, the NICU rolled out FiCare, or Family Integrated Care, a program focused on empowering parents and encouraging them to become true partners in their infant's care, even when in the NICU. The improved confidence and skills of parents in FICare increases parental readiness for the transition from hospital to home, improves management abilities at home, and lowers parental anxiety.

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

WA Government Goal	Strong communities, safe communities and supported families
WA Health Goal	Delivery of safe, quality, financially sustainable and accountable health care for all Western Australians
Outcome 1	Public hospital-based services that enable effective treatment and restorative health care for Western Australians

Rationale

In 2014/15 4.0 million Australians (17.5%) were reported having a mental or behavioural condition[3]. Hence, it is crucial to ensure effective and appropriate care is provided not only in a hospital setting but also in the community.

Discharge from hospital is a critical transition point in the delivery of mental health care. People leaving hospital after an admission for an episode of mental illness have heightened levels of vulnerability and, without adequate follow-up, may relapse or be readmitted. This KPI measures the performance of the overall health system in providing continuity of mental health care.

A responsive community support system is essential for people leaving hospital after a psychiatric episode. Ongoing community support will help maintain the person's clinical and functional stability and reduce the need for readmission. Patients leaving hospital after a psychiatric admission with a formal discharge plan, involving linkages with public community-based services and support, are less likely to need avoidable readmission.

The standard underlying the measure is that continuity of care involves prompt community follow-up in the vulnerable period following discharge from hospital. Overall, the variation in post-discharge follow-up rates suggests important differences between mental health systems in terms of their practices.

Target

The 2017 target is ≥ 75 per cent. Maintained performance is demonstrated by a result above, or equal to, the target.

[3] National Health Survey 2014-15

Results

In 2017 the number of people contacted by a community-based mental health service within seven days of discharge was below target (see Table 13). During 2017 a range of strategies and processes, such as staff education and awareness training programs, were implemented to actively manage this indicator, resulting in a 13.2 per cent increase compared to the prior period (2016). Performance is being reviewed and monitored on an ongoing basis.

Table 13: Percentage of contacts with a community-based mental health non-admitted services within seven days post-discharge from public mental health inpatient unit, 2016 to 2017

	2016 (%)	2017 (%)	Target (%)	Target met
Post-admission community-based contact	52.9	66	≥ 75	×

Data sources: Mental Health Information System Data Collection; Hospital Morbidity Data Collection.

Focusing on in-home carer support

When a patient required a graduated reduction in outpatient electroconvulsive therapy over a seven-month period, a collaboration of interagency agreements and support ensured her optimum care.

The collaboration was designed to prevent the patient being admitted overnight in the Mental Health Unit for observation, as she wanted to return home following treatment. Pleasingly, feedback from everyone concerned has been extremely positive, with a number of recommendations being put forward to enable this new approach to be repeated in the future.

Helping babies to breathe easy

During the year, Associate Professor Jane Pillow and her colleagues at KEMH NICU conducted preclinical studies to determine the optimal settings for use of jet ventilators in preterm and term infants. As a result, more gentle and effective ventilator modes are now used in NICU.

Average admitted cost per weighted activity unit

WA Government Goal	Strong communities, safe communities and supported families
WA Health Goal	Delivery of safe, quality, financially sustainable and accountable health care for all Western Australians
Outcome 1	Public hospital-based services that enable effective treatment and restorative health care for Western Australians
Service 1	Public hospital admitted services

Rationale

This indicator is a measure of the cost per weighted activity unit compared with the health service provider's Health Service Allocation Price (HSAP) set each year in the WA Activity Based Funding (ABF) Operating Model.

The measure ensures that a consistent methodology is applied to calculating and then measuring the performance of HSPs against the funding they receive through the Government Budget Statement and subsequent Service Agreements and the activity delivered by each Hospital site (reported at an aggregated entity level). It is imperative that efficiency of this Service delivery is accurately monitored and reported.

Target

The 2017/18 target is $7,285 per weighted activity unit. Maintained performance is demonstrated by a result below, or equal to, the target.

Results

In 2017/18 the average admitted cost per weighted activity unit was below target (see Table 14).

Table 14: Average admitted cost per weighted activity unit, 2017/18

	2017/18 ($)	Target ($)	Target met
Average cost	7,087	7,285	✓

Note: This efficiency KPI target, set in 2017/18 Budget Paper 2, did not include Teaching, Training and Research (TT&R) Programs and PathWest resources received free of charge (RRFoC) (excluding direct charges to HSPs captured under the existing fee for service model). The requirement for TT&R and PathWest RRFoC to be included in the KPI results was identified subsequent to finalising the 2017/18 Budget Paper 2, thus creating a variance between the 2017/18 KPI target and expected result. The target was recalculated to include TT&R and PathWest RRFoC as part of the 2018/19 Budget Paper 2 and this annual report target figure is based on the subsequent target calculation methodology. The original target for this KPI was $6,868.

Data sources: Hospital Morbidity Data Collection; Health Service Financial Systems.

Average Emergency Department cost per weighted activity unit

WA Government Goal	Strong communities, safe communities and supported families
WA Health Goal	Delivery of safe, quality, financially sustainable and accountable health care for all Western Australians
Outcome 1	Public hospital-based services that enable effective treatment and restorative health care for Western Australians
Service 2	Public hospital emergency services

Rationale

This indicator is a measure of the cost per weighted activity unit compared with the health service provider's Health Service Allocation Price (HSAP) set each year in the WA Activity Based Funding (ABF) Operating Model.

The measure ensures that a consistent methodology is applied to calculating and then measuring the performance of HSPs against the funding they receive through the Government Budget Statement and subsequent Service Agreements and the activity delivered by each Hospital site (reported at an aggregated entity level). With the ever-increasing demand on emergency departments and health services, it is imperative that services provided in emergency departments are continually monitored to ensure the efficient delivery of safe and high-quality care.

Target

The 2017/18 target is $7,043 per weighted activity unit. Maintained performance is demonstrated by a result below, or equal to, the target.

Results

In 2017/18 the average Emergency Department cost per weighted activity unit was below target (see Table 15). The target has been based on emergency department budgets and allocated overheads at State level. The variation between the actual cost per weighted activity at the health service level and the target comprises an actual lower average cost of emergency department weighted activity unit as well as a variation between actual overhead allocations and those considered in the target.

Table 15: Average Emergency Department cost per weighted activity unit, 2017/18

	2017/18 ($)	Target ($)	Target met
Average cost	6,095	7,043	✓

Note: This efficiency KPI target, set in 2017/18 Budget Paper 2, did not include Teaching, Training and Research (TT&R) Programs and PathWest resources received free of charge (RRFoC) (excluding direct charges to HSPs captured under the existing fee for service model). The requirement for TT&R and PathWest RRFoC to be included in the KPI results was identified subsequent to finalising the 2017/18 Budget Paper 2, thus creating a variance between the 2017/18 KPI target and expected result. The target was recalculated to include TT&R and PathWest RRFoC as part of the 2018/19 Budget Paper 2 and this annual report target figure is based on the subsequent target calculation methodology. The original target for this KPI was $6,642.

Data sources: Emergency Department Data Collection; Health Service Financial Systems.

Average non-admitted cost per weighted activity unit

WA Government Goal	Strong communities, safe communities and supported families
WA Health Goal	Delivery of safe, quality, financially sustainable and accountable health care for all Western Australians
Outcome 1	Public hospital-based services that enable effective treatment and restorative health care for Western Australians
Service 3	Public hospital non-admitted services

Rationale

This indicator is a measure of the cost per weighted activity unit compared with the health service provider's Health Service Allocation Price (HSAP) set each year in the WA Activity Based Funding (ABF) Operating Model.

The measure ensures that a consistent methodology is applied to calculating and then measuring the performance of HSPs against the funding they receive through the Government Budget Statement and subsequent Service Agreements and the activity delivered by each hospital site (reported at an aggregated entity level). It is imperative that efficiency of this Service delivery is accurately monitored and reported.

Target

The 2017/18 target is $7,160 per weighted activity unit. Maintained performance is demonstrated by a result below, or equal to, the target.

Results

In 2017/18 the average non-admitted cost per weighted activity unit was below target (see Table 16).

Table 16: Average non-admitted cost per weighted activity unit, 2017/18

	2017/18 ($)	Target ($)	Target met
Average cost	7,224	7,160	×

Note: This efficiency KPI, target set in 2017/18 Budget Paper 2, did not include Teaching, Training and Research (TT&R) Programs and PathWest Resources received free of charge (RRFoC) (excluding direct charges to HSPs captured under the existing fee for service model). The requirement for TT&R and PathWest RRFoC to be included in the KPI results was identified subsequent to finalising the 2017/18 Budget Paper 2, thus creating a variance between the 2017/18 KPI target and expected result. The target was recalculated to include TT&R and PathWest RRFoC as part of the 2018/19 Budget Paper 2 and this annual report target figure is based on the subsequent target calculation methodology. The original target for this KPI was $6,738.

Data sources: Non-admitted Data Collections; Health Service Financial Systems.

Catheter helps lung and breast cancer patients breathe easier

SCGH doctors are helping patients with advanced mesothelioma and lung and breast cancers who have a build-up of fluid on their lungs to breathe more easily and spend their last days at home instead of hospital. Patients use an implanted catheter that drains fluid so they do not need to go to hospital.

Researchers from The UWA and SCGH found that the catheter allowed people to spend more of their remaining life at home.

Their study of almost 150 patients estimated that – if used across Australia – the device would save hospitals up to 14000 bed-days and $20 million a year.

Ensuring better outcomes for babies

An early-onset sepsis calculator was introduced at KEMH during the year for newborns under 35 weeks, to help prevent over-treatment with antibiotics for sepsis, which is a potentially fatal neonatal infection.

Doing it yourself

SCGOPHCG has introduced a self-dilatation program that enables patients to manage achalasia (a swallowing disorder of the oesophagus) at home. The procedure avoids the need for an invasive surgical procedure that carries with it a long recovery time, representing a huge saving to the hospital and great outcomes for patients.

Placing collaborations centre stage

BreastScreen WA and the Centre for Genetic Origins of Health and Disease at UWA conducted a survey of 6000 BreastScreen participants to assess their knowledge and awareness of breast density seen on a mammogram, and assess the impact on the participating woman when advised that they have high breast density.

> “Dr Jennifer Stone, from the Centre for Genetic Origins of Health and Disease, said: Researchers have been investigating associations between breast density and breast cancer for many years; however, the term or concept of breast density is not well understood in the community, and there is little supporting literature.”

As the largest and most comprehensive investigation of its kind, the survey will provide relevant, consumer-focused information for WA BreastScreen and other State-run screening programs to implement breast density notification to women in the future.

Average cost per bed-day in specialised mental health inpatient units

WA Government Goal	Strong communities, safe communities and supported families
WA Health Goal	Delivery of safe, quality, financially sustainable and accountable health care for all Western Australians
Outcome 1	Public hospital-based services that enable effective treatment and restorative health care for Western Australians
Service 4	Mental health services

Rationale

Specialised mental health inpatient units provide patient care in authorised hospitals and designated mental health units located within general hospitals. In order to ensure quality care and cost-effectiveness, it is important to monitor the unit cost of admitted patient care in these units. The efficient use of hospital resources can help minimise the overall costs of providing mental health care and enable the reallocation of funds to appropriate alternative non-admitted care.

Target

The 2017/18 target is $1,417. Maintained performance is demonstrated by a result below, or equal to, the target.

Results

In 2017/18 the average cost per bed-day in specialised mental health inpatient units was above target (see Table 17).

Table 17: Average cost per bed-day in specialised mental health inpatient units, 2017/18

	2017/18 ($)	Target ($)	Target met
Average cost	1,501	1,417	×

Note: This efficiency KPI target, set in 2017/18 Budget Paper 2, did not include Teaching, Training and Research (TT&R) Programs and PathWest resources received free of charge (RRFoC) (excluding direct charges to HSPs captured under the existing fee for service model). The requirement for TT&R and PathWest RRFoC to be included in the KPI results was identified subsequent to finalising the 2017/18 Budget Paper 2, thus creating a variance between the 2017/18 KPI target and expected result. The target was recalculated to include TT&R and PathWest RRFoC as part of the 2018/19 Budget Paper 2 and this annual report target figure is based on the subsequent target calculation methodology. The original target for this KPI was $1,334.

Data sources: Bedstate, Health Service Financial Systems.

In the mood

SCGH's Mental Health Unit began a mood management therapy group during the year, designed to assist patients to access evidence-based psychotherapy while in hospital and teach cognitive skills to aid in their recovery.

Research shows improved newborn care with probiotics

Back in 2007, researchers at KEMH led by Clinical Professor Sanjay Patole found that probiotic supplementation reduced the risk of the intestinal illness, necrotising enterocolitis (NEC), in babies born under 33 weeks' gestation. Since then, KEMH researchers have discovered that with probiotic use there is a marked reduction in the risk of NEC and death, as well as the risk of late-onset sepsis. Based on these findings, probiotic supplementation has become part of routine care in Australia.

Parents take part in a Kangaroo-a-thon

As part of its Family Integrated Care initiative, the NICU participated in an annual Kangaroo-a-thon. A national event, the aptly named initiative takes the form of a two-week contest that encourages mother/baby skin-to-skin cuddling time and bonding, which has been shown to enhance baby growth and development.

From 1 to 15 May 2018, staff and parents worked together to get as many babies and their parents to perform as much 'kangaroo' care as possible, with hours being logged along the way.

The result was an impressive 1279 hours and 22 minutes of blissful mothers and baby cuddling and bonding time, which was subsequently celebrated with a morning tea shared by parents and staff.

Thanks from Community Midwifery Program patients

"Thank you for providing and running such an excellent service. – Saskia"

"I wanted to note what a wonderful experience I had from the community midwifery program."

"I was highly impressed by the amount of detail that Sara went into by taking my history. The home visits and the length of the appointments really made me feel cared for and gave ample time for discussing any concerns."

"My little girl Cíara arrived in such a hurry that we did not end up making it to meet Michelle at the birth centre. She was born just outside! But Michelle handled this unusual birth with such calm and confidence. Once she was there, she was amazing with following through with my requests for an active birth of the placenta and plenty of skin-to-skin contact. Between Michelle, Sara and Tracey, my postpartum care was exemplary."

Average cost per treatment day of non-admitted care provided by public clinical mental health services

WA Government Goal	Strong communities, safe communities and supported families
WA Health Goal	Delivery of safe, quality, financially sustainable and accountable health care for all Western Australians
Outcome 1	Public hospital-based services that enable effective treatment and restorative health care for Western Australians
Service 4	Mental health services

Rationale

Efficient functioning of public community mental health services is critical to ensure that finite funds are used effectively to deliver maximum community benefit. Services provided by public community-based mental health services include assessment, treatment and continuing care.

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

Target

The 2017/18 target is $483 per treatment day of non-admitted care provided by public mental health services. Maintained performance is demonstrated by a result below, or equal to, the target.

Results

In 2017/18 the average cost per treatment day of non-admitted care provided by public clinical mental health services was below target (see Table 18).

Table 18: Average cost per treatment day of non-admitted care provided by public clinical mental health services, 2017/18

	2017/18 ($)	Target ($)	Target met
Average cost	465	483	✓

Data sources: Mental Health Data Collections; Health Service Financial Systems.

A focus on employment opportunities

Osborne and Mirrabooka Community Mental Health services have developed a new employment placement program in partnership with MAX Employment Solutions. The initiative, which is designed to improve employment opportunities for individuals with persistent mental illness, will be officially launched on 1 July 2018.

Participation rate of women aged 50 to 69 years who participate in breast screening

WA Government Goal	Strong communities, safe communities and supported families
WA Health Goal	Delivery of safe, quality, financially sustainable and accountable health care for all Western Australians
Outcome 2	Prevention, health promotion and aged and continuing care services that help Western Australians to live healthy and safe lives

Rationale

BreastScreen Australia aims to reduce illness and death resulting from breast cancer through organised screening to detect cases of unsuspected breast cancer in women, thus enabling early intervention, which leads to increased treatment options and improved survival. It has been estimated that breast cancer detected early is considerably less expensive to treat than when the tumour is discovered at a later stage. Mass screening using mammography can improve early detection by as much as 15–35 per cent.[4]

High rates reported against this KPI will reflect the efficient use of the physical infrastructure and specialist staff resources required for the population-based breast cancer screening program. High rates will also be an indication of a sustainable health system as early detection reduces the cost to hospital services at the later stages of a patient's journey.

Target

The 2017 target is ≥ 70 per cent participation rate of women aged 50 to 69 years who participated in breast screening. Maintained performance is demonstrated by a result below, or equal to, the target.

[4] Elixhauser A, Costs of breast cancer and the cost-effectiveness of breast cancer screening, Int J Technol Assess Health Care. 1991; 7(4):604–15. Review.

Results

From 2016 to 2017, the percentage of women aged 50 to 69 years who participated in breast screening was below target (see Table 19). Nationally, AIHW has reported average participation for Australian women aged 50 to 69 years at 55 per cent. WA has performed above the national average and no state has met the target. The large rural and remote population, and areas of disadvantage impact WA health system's ability to achieve outcomes.

WA health system is implementing strategies to increase access to local communities. New communication programs and health promotion activities are targeting vulnerable groups including Aboriginal and Torres Strait Islander, CaLD, and remote and regional women.

Table 19: Participation rate of women aged 50 to 69 years who participated in breast screening, 2016/17

	2017 (%)	Target (%)	Target met
Participation rate	56.0	≥ 70	×

Note: This measure counts the women screened within a 24-month period (1 January 2016 to 31 December 2017) as it is recommended that women in the cohort attend free screening biennially.

Data sources: Mammographic Screening Register; Australian Bureau of Statistics.

Percentage of (a) adults and (b) children who have a tooth re-treated within six months of receiving initial restorative dental treatment

WA Government Goal	Strong communities, safe communities and supported families
WA Health Goal	Delivery of safe, quality, financially sustainable and accountable health care for all Western Australians
Outcome 2	Prevention, health promotion and aged and continuing care services that help Western Australians to live healthy and safe lives

Rationale

This KPI is used to assess, compare and determine the potential to improve dental care for WA clients. It represents the growing recognition that a capacity to evaluate and report on quality is a critical building block for system-wide improvement of healthcare delivery and patient outcomes.

A low unplanned re-treatment rate suggests that good clinical practice is in operation. Conversely, unplanned returns may reflect:

- less than optimal initial management
- development of unforeseen complications
- treatment outcomes that have a direct bearing on cost, use of resources, future treatment options and patient satisfaction.

By measuring and monitoring this KPI, the level of potentially avoidable unplanned returns can be assessed in order to identify key areas for improvement (i.e. cost effectiveness and efficiency, initial treatment and patient satisfaction). This is a nationally reported KPI. The inclusion of this new KPI will provide an opportunity for benchmarking across jurisdictions.

Target

Maintained performance is demonstrated by a result below, or equal to, the target. Please see the targets for adults and children in the results section (Table 20).

Results

In 2017/18 the percentage of adults and children who had a tooth re-treated within six months of receiving initial restorative dental treatment was below target (see Table 18). This result is due to training, regular monitoring and quality assurance. WA has performed better than the national peer average reported by ACHS in 2015/16.

Table 20: Percentage of adults and children who have a tooth re-treated within six months of receiving initial restorative dental treatment, 2017/18

	2017/18 (%)	Target (%)	Target met
(a) adults	6.0	≤ 7.7	✓
(b) children	2.2	≤ 2.6	✓

Data source: Dental Health Services Information Management (DenIM) database.

Dental Health Service compliment

"After my son's tooth went through his bottom lip as a result of him fainting, we visited the clinic and had a great experience. The staff not only saw him very quickly, but they were also really caring and wonderful. Everyone is to be congratulated for being awesome, thank you so much!"
– Karen Hancock

Volunteering with Kimberley Dental Team

Health Service staff member Jenni Bowman volunteered for a week with the Kimberley Dental Team, which is responsible for providing dental care for Aboriginal children and their families in the Kimberley.

Oral health promotion for aged care

The association between general and oral health is becoming important, particularly in older people with medical conditions. Here, Albany Government Dental Clinic staff are pictured training aged care workers in oral hygiene, to support better oral health care for residents in aged care homes.

Percentage of eligible school children enrolled in the School Dental Service program

WA Government Goal	Strong communities, safe communities and supported families
WA Health Goal	Delivery of safe, quality, financially sustainable and accountable health care for all Western Australians
Outcome 2	Prevention, health promotion and aged and continuing care services that help Western Australians to live healthy and safe lives

Rationale

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. By measuring the percentage of school children enrolled, the number of children proactively involved in publicly funded dental care can be determined to gauge the effectiveness of the program. This in turn can help identify areas that require more focused intervention and prevention and health promotion strategies to help ensure the improved dental health and wellbeing of Western Australian children.

Target

The 2017/18 target is ≥ 69 per cent. Maintained performance is demonstrated by a result above, or equal to, the target.

Results

In 2017/18 the percentage of eligible school children enrolled in the School Dental Program was above target (see Table 21). There is substantial variance to target as the target was based on historic enrolment data. WA's population has since increased and has resulted in a higher percentage of eligible students enrolling in the School Dental Service. Performance for this indicator is relatively consistent to the prior year. The Dental Health Service continues to actively enroll children by providing ongoing opportunities for registration into the service.

Table 21: Percentage of eligible school children enrolled in the School Dental Program, 2016/17 to 2017/18

	2016/17 (%)	2017/18 (%)	Target (%)	Target met
Eligible school children who are enrolled in the School Dental Program	80	79	≥ 69	✓

Note: Eligible school children are all school children aged 5 to 16 years, or until the end of the Year 11, whichever comes first, who attend a WA Department of Education recognised school. A parent/guardian is required to consent to dental examination and screening of their child in the School Dental Service program.

Data source: School Dental Clinics; WA Department of Education.

Percentage of eligible people who accessed Dental Health Services

WA Government Goal	Strong communities, safe communities and supported families
WA Health Goal	Delivery of safe, quality, financially sustainable and accountable health care for all Western Australians
Outcome 2	Prevention, health promotion and aged and continuing care services that help Western Australians to live healthy and safe lives

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 preventive 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 people 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.

By 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 areas that require more focused intervention and prevention and health promotion strategies to help ensure the improved dental health and wellbeing of people with the greatest need.

Target

The 2017/18 target is ≥ 15 per cent. Maintained performance is demonstrated by a result above, or equal to, the target.

Results

In 2017/18 the percentage of eligible people who accessed dental health services was equal to target (see Table 22).

Table 22: Percentage of eligible people who accessed dental health services, 2017/18

	2017/18 (%)	Target (%)	Target met
Eligible people who accessed dental health services	15	≥ 15	✓

Note: Eligible people are defined as those who hold a current Pension Concession Care (Centrelink) or Health Care Card.
Data sources: Adult Dental Clinics and participating private dental practitioners, Commonwealth Department of Human Services

Average cost per person of delivering population health programs by population health units

WA Government Goal	Strong communities, safe communities and supported families
WA Health Goal	Delivery of safe, quality, financially sustainable and accountable health care for all Western Australians
Outcome 2	Prevention, health promotion and aged and continuing care services that help Western Australians to live healthy and safe lives
Service 6	Public and community health services

Rationale

Population health units support individuals, families and communities to increase control over and improve their health.

With the aim of improving health, population health works to integrate all activities of the health sector and link them with broader social and economic services and resources by using the WA Health Promotion Strategic Framework 2017–2021. This is based on the growing understanding of the social, cultural and economic factors that contribute to a person's health status.

Target

The 2017/18 target is $19. Maintained performance is demonstrated by a result below, or equal to, the target.

Results

In 2017/18 the average cost per person of delivering population health programs by population health units was above target (see Table 23). The budget target for 2017/18 was based on a realignment of the budget parameters for hospital and non-hospital services. It excludes a significant component of costs relating to public health and community services that the health service continues to provide and therefore does not reflect sufficiently the cost of providing population health programs.

Table 23: Average cost per person of delivering population health programs by population health units, 2016/17 to 2017/18

	2016/17 ($)	2017/18 ($)	Target ($)	Target met
Average cost	63	50	19	×

Data sources: Epidemiology Branch; Health Service Financial Systems.

Dental Health Service – providing services to the community

During Homelessness Week in August 2017, volunteer dentists and dental nurses from the National Dental Foundation provided dental services in Cooloongup, Perth and Northbridge to disadvantaged people who required urgent dental care.

Limiting risk of inherited cancer

Family members at risk of inherited cancer continued to be assisted by Genetic Services of WA throughout the year.

Genetic counselling and testing provides people with, or at risk of, inherited cancers with information and coping strategies to empower them to make informed decisions. This is also good for the healthcare system generally, as it allows people at increased risk of cancer to be identified early and their risk to be appropriately managed.

Award cervical screening resource for Aboriginal women

With Aboriginal women twice as likely to be diagnosed with cervical cancer and four times more likely to die from it, a new resource was launched in March to combat the disease. The WA Cervical Cancer Prevention Program was recognised at the Health Consumers' Council Excellence Awards for creating a cervical screening flipchart resource for Aboriginal women in WA. The flipchart highlights the importance of regular cervical screening.

Women's health festival

The Women's Health Week festivities at Anderson Hall in September 2017 were a huge success, with organisers reporting the day hummed with energy, joy and magical moments.

Healthy Options WA

Following the provision of specialist advice to hospital cafeterias by NMHS health promotion staff, the percentage of healthy foods available has increased significantly, resulting in three out of four hospitals being compliant with the Healthy Options WA: Food and Nutrition Policy for WA Health Services and Facilities.

This initiative seeks to improve and maintain the health of staff, visitors and the broader community by encouraging good nutrition and healthy eating options in hospital environments.

Average cost per breast screening

WA Government Goal	Strong communities, safe communities and supported families
WA Health Goal	Delivery of safe, quality, financially sustainable and accountable health care for all Western Australians
Outcome 2	Prevention, health promotion and aged and continuing care services that help Western Australians to live healthy and safe lives
Service 6	Public and community health services

Rationale

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 to women aged 40 years and over as a preventive initiative.

Target

The 2017/18 target is $157 per breast screening. Maintained performance is demonstrated by a result below, or equal to, the target.

Results

In 2017/18 the average cost per breast screening was above target (see Table 24.)

Table 24: Average cost per breast screening, 2017/18

	2017/18 ($)	2017/18 Target ($)	Target met
Average cost	165	157	×

Data sources: BreastScreen WA; Health Service Financial Systems.

Leading the way in research

An important research project aimed at improving clinical excellence has begun as a collaboration between two services at KEMH – Genetic Services of WA and the Gynaecological Oncology Department.

TRACEBACK aims to reduce the incidence of BRCA1/2-related cancers by identifying women with a history of ovarian cancer that missed the opportunity for testing.

About 1500 women with ovarian cancer will be tested, with the project having the potential to have a major impact on women who have a family member with ovarian cancer. These women may be alerted to the fact that they face an increased risk of cancer and thus can make more informed health choices.

Average cost per patient visit of WA Health-provided dental health programs for (a) school children and (b) socioeconomically disadvantaged adults

WA Government Goal	Strong communities, safe communities and supported families
WA Health Goal	Delivery of safe, quality, financially sustainable and accountable health care for all Western Australians
Outcome 2	Prevention, health promotion and aged and continuing care services that help Western Australians to live healthy and safe lives
Service 7	Community dental health services

Rationale

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. The School Dental Service program ensures early identification of dental problems and, where appropriate, provides treatment.

Dental disease places 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.

Target

Maintained performance is demonstrated by a result below, or equal to, the target. Please see the targets for patient groups in the results section (Table 25).

Results

In 2017/18 the average cost per patient visit of WA health system-provided dental health programs was below target for school children and socioeconomically disadvantaged adults (see Table 25). Efficiency of service provision is monitored on a quarterly basis. This takes into consideration any month to month variations in consumable costs, staffing costs and number of patients seen.

Table 25: Average cost per patient visit of WA Health-provided dental health programs for (a) school children and (b) socioeconomically disadvantaged adults, 2017/18

Average cost	2017/18 ($)	Target ($)	Target met
(a) school children	198	208	✓
(b) socioeconomically disadvantaged adults	272	305	✓

Data source: Dental Information Management (DenIM); Oracle Financials.

Little Kids Dental Project

The Little Kids Dental Project is a project funded by the National Health and Medical Research Council (NHMRC) that looks at how children under six years in remote communities can receive less invasive and traumatic treatment for dental decay.

Promoting child and adolescent oral health

Dental health professionals held workshops, expos and presentations during the year to promote good oral health to children and adolescents, in addition to dental health education and information on nutritious, tooth-friendly foods.

Performance Indicators (unaudited)

Waiting times for emergency hospital care (proportion of emergency department patients seen within recommended times (by triage category)

WA Government Goal	Strong communities, safe communities and supported families
WA Health Goal	Delivery of safe, quality, financially sustainable and accountable health care for all Western Australians
Outcome 1	Public hospital-based services that enable effective treatment and restorative health care for Western Australians

Rationale

This indicator measures how effective WA emergency departments are at the starting point of the patient care journey. It captures the percentage of patients treated within the timeframes recommended by the Australasian College for Emergency Medicine. The higher the percentage, the better the performance; timely treatment in ED appropriate to triage category ensures patients receive appropriate further treatment and restorative care in WA emergency departments.

The performance of each HSP against this performance indicator will assist in monitoring and driving improvements in patient access to ED treatment within clinically recommended treatment times.

Target

The targets for ED patients seen within recommended times by triage category as per Australasian College for Emergency Medicine are as follows:

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

Maintained performance is demonstrated by a result above, or equal to, the target.

Results

In 2017/18 the percentage of ED patients seen within recommended times for Triage Category 1 was equal to target. Categories 2, 3 and 4 were below target and Category 5 was above target due to challenges associated with greater demand for services and access block (see Table 26). Strategies to address these challenges include improvements to models of care, discharge planning and staff education and training.

Table 26: Percentage of emergency department patients seen within recommended times, by triage category, 2016/17 to 2017/2018

Triage category	2016 (%)	2017 (%)	Target (%)	Target met
1	99.80	100.00	100	✓
2	76.90	79.83	≥ 80	×
3	40.20	43.14	≥ 75	×
4	57.30	59.39	≥ 70	×
5	92.90	91.61	≥ 70	✓

Data source: Emergency Department Data Collection.

World-class cancer treatment

In October 2017, SCGH's Radiation Oncology Department took possession of two $3 million Varian Truebeam linear accelerator machines, which are improving how cancer patients receive their radiotherapy and radiosurgery treatments.

Providing evidence-based care to patients with motor neurone disease

During the year, speech pathologists at SCGH were awarded a small research grant to trial expiratory muscle strength training as a rehabilitation option for patients with motor neurone disease. This groundbreaking feasibility study is a collaborative effort with the multidisciplinary team at the Perron Institute for Neurological and Translational Science.

Significant issues impacting the agency

NMHS responded to a number of significant issues and forces in 2017/18 in its continued efforts to promote and protect the health and wellbeing of our patients. Many of these influences have been in play for a number of years and we continue to hone our responses to maximise the value we can deliver.

Towards a sustainable Health Service

On 1 July 2016, WA Health (the Department of Health and five HSPs) underwent significant reform with the commencement of the *Health Services Act 2016*. This required NMHS to become a statutory authority with a new governance structure and upgraded mechanisms for improvement and accountability in the delivery of health services.

Since then, we have worked to plan, deliver and evaluate services across the healthcare spectrum to ensure our resources are allocated both effectively and efficiently to achieve maximum benefit to the community. Work started on a review of key services, both quantitative (internal and external data analysis) and qualitative (staff and stakeholder interviews). Nine focus areas were identified (emergency departments, aged-care long stay, medical workforce, nursing and midwifery workforce, corporate, outpatients, theatres, revenue and coding). Information is being used by leadership teams to introduce efficiencies and to build a more sustainable and affordable health service.

Addressing ageing infrastructure

NMHS provides health care at a number of hospitals comprising a variety of buildings with construction dates ranging from 1896 to 2016. Each building comes with its own unique set of challenges, particularly those that are heritage listed. We are no different from any other agency in respect to the age and diversity of infrastructure. In essence, every agency is struggling to tackle the same three issues: how to meet the increasing demand for new and upgraded infrastructure; how to prolong the life or renew existing infrastructure; and how to pay for it.

Over half the buildings in our Health Service are more than 30 years old and, of course, ageing infrastructure brings with it risk – in terms of potential failure and poor compliance. There is nothing new in recognising that poor infrastructure is a major problem that can have detrimental consequences to the delivery of services.

In 2017/18 we conducted a detailed asset condition audit, assessing buildings and infrastructure against established Acts, Regulations and Codes. Meanwhile, we continued to prolong the life of buildings and renewed infrastructure. Clinical areas and associated plant and equipment across SCGH, KEMH and OPH were improved. Security, access control and CCTV systems within Graylands, Selby Lodge and SCGH were upgraded. Critical items of plant and equipment across our Health Service were replaced and critical building repairs undertaken. Planning for the JHC Development Project and OPH Redevelopment continued, with business cases being developed to submit to Government next year.

Engaging staff and improving patient safety

The implementation of strategic change always poses a challenge. NMHS has seen significant change over the past 12 months including: transitioning to an independent statutory authority; establishing structures and processes to support the transition; and undergoing numerous simultaneous internal and external reviews. These in turn had both direct and indirect impacts on individuals.

NMHS staff have some of the most critical and demanding jobs in the State and it is vital that we act upon their concerns, including by committing to a culture of positive engagement. In 2017/18 we improved communication between the Board, Executive and staff through regular email newsletters, global emails, intranet sites and social media complemented by an increasing number of staff forums and departmental meetings attended by Executive and Board members. The Board's Clinical Advisory Committee also played a significant role in providing expert opinion on operational matters that are important to frontline clinicians.

A focus on motivating staff to drive change at their own places of employment provided a further mechanism for engagement. Participation of staff in the Sustainable Health Review, the Service Sustainability Plan and site-specific culture reviews increased engagement. In addition, the Board reviewed clinical engagement at WNHS in late 2017 following concerns from senior clinicians about timely involvement in decision-making and transparency. The review methodology was designed to capture staff understanding of the current culture of the organisation, to identify where system improvements could be made, to promote both system and individual accountability and to assist staff in developing and embracing a common purpose and an ethos of trust and courage.

As a result, the WNHS introduced the Speaking Up For Safety Program®, empowering staff to 'speak up' if they have safety concerns about patient management. Speaking up is one of the critical behaviours of patient safety that displays an important role for improving quality and patient safety. Management and staff receiving feedback from colleagues are encouraged to do so in a respectful manner, and to listen and act on what the person is saying.

In addition, WNHS established the Clinical Engagement Project to implement the review's 12 final recommendations. The overall aim of the project is to achieve long-term, sustainable improvement with a focus on embedding a culture of safety and quality.

Our intention is to apply this successful change model across NMHS in the years ahead.

Towards a statutory authority – PathWest

Supporting the establishment of the State's pathology service, PathWest, as a statutory entity posed a significant challenge and change of focus for NMHS. Before 1 July 2018, PathWest operated as a largely autonomous service within NMHS. Following a review in mid-2017, PathWest was established as a separate Chief Executive-governed HSP, which meant that it would be a statutory authority in its own right, have clear roles and responsibilities, and be subject to the robust governance, performance and accountability framework within the *Health Services Act 2016*.

Urgent planning for the new governance arrangements and operating model commenced in January 2018 and PathWest successfully transitioned to an independent organisation from 1 July 2018.

Developing and supporting the workforce

Our Health Service employs 10 600 people who work in multidisciplinary and support roles across a range of professions, all with a focus on providing services to patients. Supporting all of our staff (corporate, medical, allied health and support) through change is the best service that we can provide at any given time.

Attraction and retention issues continue to challenge health services across the State. As the population increases, the corresponding demand for health services will result in mounting labour and skill shortages in the health industry. In response, we have developed strategies such as improved business cases to review remuneration, revised models for delivering services, introduced more flexible training models (including training in partnership with other health services) and ensured a greater focus on management and leadership skills for the Health Service. These strategies will position NMHS to better attract and retain employees of choice.

Aligning the affordability of the workforce to our service delivery requirements is critical. Significant work was undertaken during the year to better understand the costs of delivering care and how this translates into the level of care afforded to our patients – thus maximising safe, high-quality care while reducing waste of resources. Our overall strategy requires us to:

- grow our own clinical and non-clinical staff, including nurse practitioners and other areas of workforce substitution
- develop an approach for succession planning for our leaders both at the Executive and middle management level
- embed a culture within our organisation consistent with our stated values of care, respect, excellence, equity, integrity, teamwork and leadership.

Our plans for a stronger health sector included support for several major developments during the year. These include the opening of Perth Children's Hospital, transitioning PathWest from a business entity within our Health Service to a stand-alone statutory authority, and embedding a culture of positive engagement with clinical staff at KEMH in decisions related to their service.

The next step in the growth of NMHS as an organisation will be the finalisation of our Organisational Development Strategy in 2018/19.

Insight from oversight

Independent and external oversight of agencies is an effective means of identifying risks and preventing misconduct. In this reporting year, reviews were conducted by the Public Sector Commission (PSC) and the Corruption and Crime Commission (CCC) into aspects of our work – patient confidentiality and the management of pharmaceuticals in particular.

The PSC completed a review of PathWest laboratories' management of a complaint raised by a patient in March 2016. The complaint related to the disclosure of the patient's pathology test results by a PathWest employee to a third party. The response to the allegations raised in the complaint led to a disciplinary process for the employee concerned.

The investigation identified five broad areas of opportunity to improve practices:

- management of the risk of a breach in patient confidentiality
- application of policy
- provision and receipt of advice and information to complainants
- recordkeeping
- investigation of disciplinary matters.

Since the initial misconduct, significant changes within PathWest have reduced the likelihood of similar errors occurring. This has included an increase in automation of processes and other technological advances.

PathWest became an independent statutory authority on 1 July 2018. Nevertheless, we note that the findings of the PSC review have continued relevance to the operations of the broader health service. To ensure best practice, the recommendations will be used to drive reform across the agency.

In May 2018, the CCC's *Report on Serious Misconduct Risks around Dangerous Drugs in Hospitals* was released. The report focused on the management of dangerous drugs and the issue of theft and misuse of addictive pharmaceuticals in hospitals. The CCC chose three major public hospitals to examine, one of which was SCGH.

This report was supplementary to the CCC's *Report on the Supply and Management of Schedule 8 Controlled Drugs at Certain Public Hospitals in Western Australia* (released in June 2017), which focused on the repeated theft of drugs by a senior pharmacist at Fiona Stanley Hospital. The report has significance to our Health Service as the pharmacist was previously employed at SCGH where instances of his offending were uncovered.

Measures and initiatives had already commenced at NMHS following the first report with the aim of reducing discrepancies, improving medication-handling practices, and changing the 'culture of underreporting' described in previous CCC reports. For example, NMHS had established the project Diversion of Controlled Substances to analyse the risks associated with the management of medications in our hospitals and clinics. The project pre-emptively identified many of the issues raised by the CCC in its May 2018 report. As such, reform had already commenced in key areas such as diversion prevention, evidenced-based systems and technology, and support for staff.

All four reports from the above enquiries and reviews have provided us with the opportunity to undertake a review of medication management and the framework within which discipline and staff conduct are administered.

Disclosures and legal compliance

Audit opinion

Office of the Auditor General
Serving the Public Interest

Our Ref: 7536

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Board Chair
North Metropolitan Health Service
T Block
QEII Medical Centre
NEDLANDS WA 6009

Dear Sir

FINANCIAL STATEMENTS AND KEY PERFORMANCE INDICATORS FOR THE YEAR ENDED 30 JUNE 2018

The Office has completed the annual audit of the financial statements, controls and key performance indicators for your agency. We enclose a copy of the opinion of the Auditor General, together with a set of the audited financial statements and key performance indicators. We have forwarded the audit opinion, financial statements and key performance indicators to the Minister for Health for tabling in Parliament.

Matters of Significance
Emergency Department Waiting Times
The Under Treasurer approved the removal of the following indicator as an audited key performance indicator (KPI):

- Percentage of Emergency Department patients seen within recommended times (by triage category)

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

Management Control Issues
I would like to draw your attention to the attached listing of deficiencies in internal control and other issues that were identified during the course of the audit. These matters have been discussed with your staff and their comments have been included on the attachment for your information. Issues arising from the interim audit were reported in my interim management letter dated 29 June 2018 and are included here for completeness of reporting.

Please note that the purpose of our audit was to express an opinion on the financial statements, controls and key performance indicators. The audit included consideration of internal control relevant to the preparation of the financial statements and key performance indicators in order to design audit procedures that were appropriate in the circumstances. It also included consideration of internal control for the purpose of expressing an opinion on the effectiveness of internal control in ensuring compliance with requirements prescribed by the *Financial Management Act 2006* and Treasurer's Instructions.

An audit is not designed to identify all internal control deficiencies that may require management attention. It is possible that other irregularities and deficiencies may have occurred and not been identified as a result of our audit. Further, the matters being reported are limited to those deficiencies that have been identified during the audit.

The date that agencies provided their financial statements to Audit has been recorded for purposes of reporting to Parliament. I advise that the date recorded for the receipt of your financial statements was 1 August 2018.

This letter has been provided for the purposes of the North Metropolitan Health Service and the relevant Minister and may not be suitable for other purposes.

I would like to take this opportunity to thank you, the management and the staff of your agency for their cooperation with the audit team during our audit.

Feel free to contact me on 6557 7644 if you would like to discuss these matters further.

Yours faithfully

PATRICK ARULSINGHAM
SENIOR DIRECTOR FINANCIAL AUDIT
18 September 2018

Attach

Audited key performance indicator information

Certification of key performance indicators

For the year ended 30 June 2018 signed

Government of **Western Australia**
North Metropolitan Health Service

Disclosures and Legal Compliance

Key Performance Indicators

Certification of Key Performance Indicators

For the year ended 30 June 2018

We hereby certify the key performance indicators are based on proper records, are relevant and appropriate for assisting users to assess the North Metropolitan Health Service (NMHS)'s performance, and fairly represent the performance of the NMHS for the financial year ended 30 June 2018.

Name: Professor David Forbes
North Metropolitan Health Service
A/Board Chair, NMHS Board

Date: 13 September 2018

Name: Mr Grant Robinson
North Metropolitan Health Service
Board Member and Finance Committee Chair, NMHS Board

Date: 13 September 2018

North Metropolitan Health Service I Queen Elizabeth II Medical Centre I 2 Verdun St Nedlands WA 6009

Ministerial directives

Treasurer's Instruction (TI) 902 (12) requires the disclosure of information about Ministerial directives relevant to the setting of desired outcomes or operational objectives, the achievement of desired outcomes or operational objectives, investment activities and financing activities.

As per the definition of a Ministerial Direction in Part 7, s. 60 of the *Health Services Act 2016*, NMHS has not received any ministerial directives related to this requirement. However, the Minister for Health provided a Statement of Expectation that set out the Minister's expectations for the roles and responsibilities of NMHS Board, as well as its accountabilities and priorities. NMHS Board responded with a Statement of Intent.

Click here to view these documents (external site)

Other financial disclosures

Pricing policy

The National Health Reform Agreement sets the policy framework for the charging of public hospital fees and charges. Under the Agreement, an eligible person who receives public hospital services as a public patient in a public hospital or a publicly contracted bed in a private hospital is treated 'free of charge'. This arrangement is consistent with the Medicare principles that are embedded in the *Health Services Act 2016*.

The majority of hospital fees and charges for public hospitals are set under Schedule 1 of the Health Services (Fees and Charges) Order 2016 and are reviewed annually. The following informs WA public hospital patients' fees and charges for:

Nursing home type patients

The State charges public patients who require nursing care and/or accommodation after the 35th day of their stay in hospital, providing they no longer need acute care and they are deemed to be nursing home type patients. The total daily amount charged is no greater than 87.5 per cent of the current daily rate of the single aged pension and the maximum daily rate of rental assistance.

Compensable or ineligible patients

Patients who are either 'private' or 'compensable' and Medicare ineligible (overseas residents) may be charged an amount for public hospital services as determined by the State. The setting of compensable and ineligible hospital accommodation fees is set close to, or at, full cost recovery.

Drug gives hope in skin cancer fight

A year ago, Kim Doherty was told his skin cancer was terminal. But today, SCGH doctors describe his recovery as miraculous thanks to a groundbreaking immunotherapy drug that is helping a handful of Perth patients with advanced non-melanoma skin cancer.

Patients jump on their bike

A motorised therapy bike donated by Multiple Sclerosis WA is helping people with Parkinson's disease at OPH.

The purpose-built machine allows for therapy using the forced exercise concept, where the participant maintains a higher exercise rate than their preferred voluntary rate.

Private patients (Medicare eligible Australian residents)

The Commonwealth Department of Health regulates the minimum benefit payable by health funds to privately insured patients for private shared ward and same-day accommodation. The Commonwealth also regulates the nursing home type patient 'contribution' based on March and September pension increases. To achieve consistency with the *Commonwealth Private Health Insurance Act 2007*, the State sets these fees at a level equivalent to the Commonwealth minimum benefit.

Veterans

Hospital charges to eligible war service veterans are determined under a separate Commonwealth–State agreement with the Department of Veterans' Affairs. Under this agreement, the Department of Health does not charge medical treatment to eligible war service veteran patients; instead, medical charges are fully recouped from the Department of Veterans' Affairs.

The following fees and charges also apply

The Pharmaceutical Benefits Scheme regulates and sets the price of pharmaceuticals supplied to outpatients, patients on discharge and for day-admitted chemotherapy patients. Inpatient medications are supplied free of charge.

The Dental Health Service charges to eligible patients for dental treatment are based on the Department of Veterans' Affairs fee schedule of dental services for dentists and dental specialists.

Eligible patients are charged the following co-payment rates:

- 50 per cent of the treatment fee if the patient holds a current healthcare card or pensioner concession card
- 25 per cent of the treatment fee if the patient is the current holder of one of the above cards and receives a near full pension or an allowance from Centrelink or the Department of Veterans' Affairs.

There are other categories of fees specified under Health Regulations through 'Determinations', which include the supply of surgically implanted prostheses, magnetic resource imaging services and pathology services. The pricing for these hospital services is determined according to their cost of service.

Capital works

NMHS has a substantial Asset Investment Program that facilitates remodelling and development of health infrastructure. Program initiatives include the continuation of major projects to reconfigure and invest in metropolitan general and tertiary hospitals (see Table 27 and Table 28)

Table 27: Major Asset Investment Program works completed, 2017/18

Initiative	Estimated total cost in 2017/18 $000
Capital works (including major redevelopments and equipment)	
Adult Mental Health Unit Overrun	3,352
BreastScreen WA - Digital Mammography Technology	12,581
ICT Bunbury Breastscreening Clinic	486
JHC Development - Stage 1	213,937
JHC Mental Health Unit Anti-Ligature Point Rectification	865
SCGH - Mental Health Unit	28,925
SCGH and KEMH - Upgrade of PABX Infrastructure	1,881
State Epilepsy Service relocation	1,366
QEIIMC - New Central Plant Facility	211,895
Total	475,288

Note: The information above is based upon the 2017/18 published budget papers.

Table 28: Major capital works in progress, 2017/18

Initiative	Estimated total cost 2017/18 $000	Reported in 2016/17 $000	Variation $000	Expected completion date
Graylands Hospital – Redevelopment Planning[1]	528	600	72	Completed
JHC – Telethon Paediatric Ward[1,3]	12,118	12,118	-	Completed
Joondalup Mental Health Observation Area[1,3]	7,064	7,064	-	Completed
KEMH – Holding[1]	1,380	1,380	-	N/A
KEMH Maternal Foetal Assessment[1,3]	5,379	5,500	121	Completed
OPH Reconfiguration Stage 1[1,2]	26,301	0	(26,301)	N/A
OPH Additional Parking Facility[1,3]	3,279	3,330	51	Completed
PathWest – Laboratory Equipment and Asset Replacement/Maintenance[1,2]	2,500	1,500	(1,000)	Ongoing
Reconfiguring the Western Australian Spinal Cord Injury Service[1,2]	43,252	500	(42,752)	Ongoing
Sarich Neuroscience[1,2]	34,076	-	(34,076)	Mar-2019
SCGH – Redevelopment Stage 1[1]	21,714	26,539	4,825	N/A
SCGH – Catheter Laboratory 2 Upgrade[1,3]	584	832	248	Completed
Infection Prevention and Control System[1,2]	2,387	2,387	-	Ongoing
PathWest – Replacement of Laboratory Information Systems[1,2]	22,478	24,399	1,921	Mar-2019
Fremantle Dental Clinic[1,2]	2,990	-	(2,990)	Feb-2019
Graylands Hospital – Development Stage[1,4]	92	92	-	Ongoing
KEMH – NICU[1]	1,115	-	(1,115)	Completed

Notes:

1. The information above is based upon the:
   i) 2017/18 published budget papers.
   ii) 2016/17 published budget papers.
2. Completion timeframes are based upon a combination of known dates at the time of reporting.
3. Projects listed above as 'completed' may still be in the defects period.
4. Includes new works project published in 2017/18 budget papers.

Employment profile

Government agencies are required to report a summary of the number of employees, by category. Table 29 shows the year-to-date (June 2018) number of NMHS full-time equivalent employees for 2017/18.

Table 29: NMHS total full-time equivalent employees by category, 2017/18

Category	Definition	2017/18	%
Nursing and Midwifery	All nursing and midwifery occupations, excluding agency nurses and midwives	3425	31.8
Medical Support	All allied health and scientific/ technical related occupations	2686	24.9
Administration and clerical	All clerical-based occupations including patient-facing (ward) clerical support employees (128 FTE from Department of Health Health Services Union in specific cost centres)	1760	16.3
Medical Salaried and Sessional	All medical occupations including interns, registrars and specialist medical practitioners	1387	12.9
Hotel Services	Includes catering, cleaning, stores/supply laundry and transport occupations	780	7.2
Dental Clinic Assistants	Dental clinic assistants	312	2.9
Site Services	Engineering, garden and security-based occupations	211	2.0
Agency	Includes the following occupational categories: administration and clerical, medical support, hotel services, site services, medical salaried (excludes visiting medical practitioners) and medical sessional	109	1.0
Assistants in Nursing	Support registered nurses and enrolled nurses in delivery of general patient care	64	0.6
Agency Nursing and Midwifery	Workers engaged on a 'contract for service' basis. Does not include workers employed by NurseWest	39	0.4
Other Occupations	Including, but not limited to, Aboriginal and Ethnic health employees	9	0.1
Total full-time equivalent employees		**10782**	**100**

Notes: Total FTE, excluding Department of Health is 10652.
Data Source: HR Data Warehouse via Pulse EDW, data extracted on 10 July 2018.

Industrial relations

The Industrial Relations Team provide expert advice and support to deliver strategic people outcomes, and strive to foster productive and positive interactions between NMHS and its employees, unions, and other key stakeholders.

Major activities in 2017/18 included:

- providing representation and advocacy in matters before the WA Industrial Relations Commission, Public Service Arbitrator, Public Service Appeal Board, Equal Opportunity Commission and Industrial Magistrates Court
- interpreting and applying industrial agreement/award interpretation and application
- contributing to the renegotiation of all health industrial agreements including the WA Health – HSUWA – PACTS Industrial Agreement 2016; WA Health System – United Voice – Enrolled Nurses, Assistants in Nursing, Aboriginal and Ethnic Health Workers Industrial Agreement 2016; and WA Health System – Australian Nursing Federation – Registered Nurses, Midwives, Enrolled (Mental Health) and Enrolled (Mothercraft) Nurses – Industrial Agreement 2016
- providing ongoing advice and support to implement relevant workforce changes related to the Attraction and Retention Incentives and Service Sustainability and Recovery Program
- participating in the working group review of multiple employment contracts for medical staff across HSPs
- providing advice and ongoing management of claims and disputes related to investigations, disciplinary matters, and contractual/agreement claims (e.g. pay, rosters and conditions)
- providing advice on the transition of security personnel and facilities management from Princess Margaret Hospital to the QEIIMC, the transition of service model at the Quadriplegic Centre and transition of PathWest to a HSP
- contributing to the development, review and implementation of workforce-related policies, strategies, systems and processes including new government policies such as Family and Domestic Violence, and Occupational Safety and Health (OSH) Harmonisation laws.

Employee development

NMHS is committed to developing our employees and providing learning and career development opportunities across the business, as a means to engage and equip our people to be the best they can be. We provide education and mandatory skills training for employees to support the delivery of excellence in health care for our community.

Each NMHS site delivers unique, specific role-related clinical and non-clinical training and education, either internal or external to the sites, and through online eLearning resources. Mandatory training includes Accountable and Ethical Decision-Making, Aboriginal Cultural Awareness, Emergency Procedures, Manual Tasks, Clinical Deterioration and Basic Life Support, and Management of Aggression.

In 2017/18 NMHS provided a wide range of undergraduate, graduate, employee training and leadership development programs to employees.

In addition to formal training and education programs, NMHS seeks to provide on the job learning opportunities to further build internal capability.

Congratulations to Jennifer!

Congratulations to Jennifer Pitcher who was awarded the Karrinyup Nurse/Midwife of the Year for 2018 for her role in leading OPH to achieve Baby Friendly Health Initiative (BFHI) Accreditation during July 2017.

Pathway to Excellence

In March 2018, OPH achieved four-year redesignation under the Pathway to Excellence® program, which is awarded by the American Nurses Credentialing Centre. The program recognises the hospital's commitment to creating a positive practice environment that empowers and engages nursing and midwifery staff.

Workers' compensation

NMHS has a standardised and established injury management system to assist employees who are injured in the workplace. This system has an early intervention focus within an environment where it is normal practice for employees to return to productive duties as soon as medically appropriate. This is achieved through proactive case management, line manager education and training, referral to medical practitioners with expertise in workplace injuries, access to an Employee Assistance Program, and the use of occupational health physicians to provide injury management advice.

Return to work programs are developed in consultation with the employee, manager and treating medical practitioners and are delivered in accordance with the Workers' *Compensation and Injury Management Act 1981*, and *Code of Practice (Injury Management) 2007*. Regular reviews identify and address barriers to recovery and return to work and case conferences are held with key parties to address issues that impact return to work. Vocational rehabilitation is offered to employees who are unable to return to their pre-injury employment.

In 2017/18 a total of 290 workers' compensation claims were made (see Table 30).

Table 30: Number of NMHS workers' compensation claims, 2017/18

Employee category	No.
Nursing services/dental clinic assistants	132
Administration and clerical	29
Medical (support)	41
Hotel services	62
Maintenance	21
Medical (salaried)	5
Total	**290**

Note: The Workers' Compensation total claims made and employee categories were obtained from RiskCover all claims monthly spreadsheet as at 30 June 2018 and filtered by the 2017/18 Financial Year.

Artists add personal touch to unique court

Artists from the Creative Expression Centre for Arts Therapy at Graylands Hospital have created artwork for Perth's Central Law Courts building as part of Perth's START Court Program.

Governance disclosures

Pecuniary interests

At the date of reporting, two senior officers declared the following pecuniary interests:

NMHS Board member Margaret Crowley is a Lions Eye Institute Board member, which has contracts with WA Health. The position is voluntary, with no financial benefit.

NMHS Acting Executive Director Strategy and Executive Services Sylvia Meier is a Director of Perth Children's Hospital Foundation. The position is voluntary, with no financial benefit.

Unauthorised use of credit cards

NMHS uses purchasing cards (individualised credit cards that provide a clear audit trail for management) for purchasing goods and services.

Purchasing cards are provided to employees who require one as part of their role and are not for personal use.

Twelve NMHS cardholders recorded personal purchases on their Purchasing Card. All these cardholders declared a personal expenditure and all monies were refunded at the time of reporting (see Table 31). If a cardholder makes a personal purchase, they must give written notice to the accountable authority within five working days and refund the total amount of expenditure.

Table 31: Personal use credit card expenditure by NMHS cardholders, 2017/18

Credit card personal use expenditure	Aggregate amount ($)
Reporting period	692
Settled by the due date (within 5 working days)	111
Settled after the period (after 5 working days)	581
Outstanding at balance date	0

Board and committee remuneration

The total annual remuneration for each board or committee is listed in Table 32. For details of individual board or committee members, please refer to Appendix C.

Table 32: Summary of State Government boards and committees within NMHS, 2017/18

Board/committee name	Total remuneration ($)
NMHS Board	393,787
Graylands Hospital Management Team Meeting	60
KEMH Community Advisory Committee (renamed Women and Newborn Health Service Community Advisory Council)	10,440
North Metropolitan Area Health Service Community Advisory Committee (ceased May 2017)	Nil
OPH Community Advisory Council	3,697
State Perinatal Mental Health Reference Group (ceased)	Nil

Other legal requirements

Advertising and sponsorship

In accordance with s. 175Z of the *Electoral Act 1907*, NMHS is required to report its total advertising expenditure. In 2017/18 the total expenditure was $296 982. The organisations from which advertising services were procured and the amount paid to each organisation are detailed in Table 33.

Table 33: Summary of NMHS advertising expenditure by provider, 2017/18

Category	Provider	$
Advertising agencies	Adcraft Promotional Products	3,933
	LushArt	1,663
	Picton Press	29,950
	Ronald Alan Gidgup	12,800
	Sensis Pty Ltd	1,524
	Telstra Corporation Limited	753
	White Wall Group	37,000
	Department of Local Government Sport and Cultural Industries	318
	Subtotal	**87,941**
Market research organisations	Patient Opinion	26,950
	Press Ganey Associates Pty Ltd	123,634
	SIQ Pty Ltd	13,406
	Subtotal	**163,990**
Media advertising organisations	Adcorp Australia Limited	1,271
	Optimum Media Decisions (WA) Limited	43,780
	Subtotal	**45,051**
Total		**296,982**

Disability Access and Inclusion Plan

NMHS complies with the legislative requirements of the *Western Australian Disability Services Act 1993* (as amended 2004) through a commitment to achieve the seven desired outcomes listed in Schedule 3 of the WA Disability Services Regulations 2004 (amended June 2013).

We aim to be responsible and innovative in providing support and services to people with disability, their carers and significant others. We are committed to ensuring those with disability have the same opportunities as other people to fully access the range of health services and facilities, employment, consultation and information. To achieve this, our Disability Access and Inclusion Plan (DAIP) 2017–2022 sets a clear direction and focus. Momentum is maintained through quarterly DAIP committee meetings, which monitor and review progress, and annual updates to NMHS Executive.

Access to services

NMHS regularly promotes accessibility and, for many staff, this begins at induction and is supported by newsletter updates, global emails and Disability Week events. Guidelines about access, parking and transport when planning events and/or services are available for employees on the staff intranet hub. In the case of a recent Abuse and Neglect Taskforce event, supported by the Sexual Assault Referral Centre (SARC), funding was sourced from Lotterywest to enable the event to be held at an offsite venue that met capacity and disability access requirements that were not available locally.

NMHS Mental Health brings its consumer advisory groups into event planning so they can give feedback on accessibility from a consumer and carer perspective.

This year, KEMH finalised plans for a concierge service to assist all visitors, which will be implemented in the coming year.

Access to facilities

The Geraldton Dental Clinic was remodelled to improve access by patients with wheelchairs or walking aids.

NMHS Mental Health Safety, Quality and Performance Unit assessed all its sites for disabled parking, entrances, signage and resources. Reports are being finalised and will be forwarded to respective site contacts. Further, the team tables any complaints about such issues at its regular meetings.

KEMH lowered signs on the lifts and installed a sliding door to its dining room. In planning a ward move, disabled access was also considered and addressed.

Access to information

NMHS provides consumer information in alternative formats upon request. In addition, some of its services are proactively providing relevant information to those known to have a disability, such as SARC, which has emailed its disabled clients a disability access map.

Community workshop/carer training for acquired brain injury

The State Head Injury Unit provides training and education days for carer service organisations and community volunteers who provide care support for patients, in addition to access to community carers with relevant training.

Supporting carers

The Family and Carer Group is a free, professional and confidential group available to carers of someone with a mental illness at SCGH Mental Health Unit. Due to increasing demand over the past six months, the Mental Health Unit now offers at least two individual sessions and one group onsite session per fortnight, which is almost always fully booked.

Supporting patients' wishes

Throughout the year, many partnerships were formed between various hospital departments to assist patient care.

One example involves a 64-year-old patient of SCGOPHCG who had multiple health issues and who was initially resistant to engaging with social work services. However, with perseverance and ongoing, non-judgemental communication, a positive relationship was established.

Consequently, this patient's views concerning his care needs and future medical treatments were established, and his social worker was able to advocate on his behalf with the medical team.

Quality of service

NMHS provides training about disability via employee orientation and in-service education. The WNHS has improved awareness among the special care nursery staff, and now includes a 'Recognised carer' sticker on counselling and medical files to identify clients with disability who require information conveyed to their carer.

Opportunity to provide feedback

NMHS values all feedback received by patients, carers and stakeholders.

Each hospital site or service has its own Complaints Management Policy that outlines the process for patients, carers and stakeholders to submit a complaint, compliment or feedback about the care received in our health services.

People with disability are provided with the same access to this process and can lodge a complaint via written correspondence, telephone or in person.

Participation in public consultation

Media advertising and internal notices are used to ensure people with disability, carers and members of the public are aware of public consultation opportunities and initiatives.

The SARC Manager attends and participates in the quarterly Abuse and Neglect Taskforce meetings, which are chaired by representatives from People with Disabilities (WA) Inc.

Opportunities to obtain and maintain employment

NMHS complies with WA Health Recruitment, Selection and Appointment Policy and associated procedures to ensure recruitment and selection is undertaken in a consistent, inclusive, open and transparent manner.

We demonstrate our commitment to improving opportunities for people with disability to obtain and maintain employment by training and educating employees about disability, and how we can better support staff with disability. Employees who participate on recruitment and selection panels are offered education and training to ensure they are fully aware of relevant legislation, regulations and standards, including those that relate to the consideration of people with disability.

We regularly review job descriptions to ensure they comply with relevant guidelines and templates and do not unlawfully discriminate against people with disability. We apply inclusive recruitment practices to ensure all employment opportunity advertisements include wording to encourage people with disability to apply. Advertising and recruitment processes are conducted in accordance with equal employment opportunity principles.

Regular reviews of workplace accessibility are undertaken and necessary adjustments to the work environment are undertaken as required.

We embed feedback obtained through the WA Health Employee Diversity Survey into the workforce planning strategy.

Compliance with Public Sector Standards

All NMHS employees are required to comply with the Western Australian Public Sector Standards in Human Resource Management and Commissioner's Instructions.

To assist employees to understand and comply with the principles of workplace behaviour and conduct, the following policies and guidelines are made available to all employees:

- WA Health Code of Conduct
- WA Health Recruitment Selection and Appointment Policy and Procedure
- WA Health Discipline Policy, Explanatory Notes and Template Letters
- WA Health Employee Grievance Resolution Policy
- WA Health Preventing and Responding to Workplace Bullying Policy
- NMHS Additional Employment
- NMHS Employee Record of Attendance Policy
- NMHS Redeployment and Redundancy Policy
- NMHS Staff Movement Policy
- NMHS Performance Development and Review Policy
- NMHS Expression of Interest Guidelines and Template
- NMHS Guidelines for Resolving Employee Grievances
- NMHS Redeployment Process Guide.

NMHS employees may access these information resources via NMHS intranet, which includes external links to the Public Sector Commission's website.

On-site human resource managers and Human Resource partners provide information and support to line managers in the implementation of the Public Sector Standards.

Recruitment and Selection

In 2017/18 nine (9) Breach of Standard claims were lodged regarding the recruitment, selection and appointment process, or the management process of an employee's performance. Five (5) claims were finalised internally and four (4) were sent to the Public Sector Commission for review. Of these, the breach claims all have been dismissed except for one (1), which is ongoing.

NMHS uses a central recruitment and selection process through HSS to assist with a consistent approach and capacity for monitoring the compliance of the Standards in respect to Human Resource Management. As part of the recruitment, selection and appointment process, applicants are notified of the breach claim process through a standardised letter.

Grievance Resolution

The WA Health Grievance Resolution Policy complies with the Grievance Resolution Standard, the Public Sector Code of Ethics and the WA Health Code of Conduct. All NMHS employees involved in grievances receive the WA Health Grievance Resolution policy and guidelines.

Code of Conduct

All NMHS employees are responsible for ensuring their behaviour reflects the standards of conduct embodied in the WA Health Code of Conduct. The Code defines the standards for ethical and professional conduct and outlines the behaviours expected of employees throughout the WA Health system.

NMHS informs and educates employees about their responsibilities through various online communications, eLearning and face-to-face training programs, and site-based induction programs. There is mandatory training for all staff on Accountable and Ethical Decision Making, Aboriginal Cultural eLearning, Recordkeeping Awareness, Management of aggression, and Code of Conduct and Prevention of Bullying, Harassment and Discrimination in the Workplace. These training packages are designed to communicate the expectations of workplace conduct and the process for managing breaches of conduct.

Employee compliance with the Code of Conduct is monitored through our breach of discipline internal reporting process. Under the WA Health Discipline Policy, NMHS is required to review, assess and investigate all complaints alleging non-compliance with the WA Health Code of Conduct. In 2017/18 a total of 169 matters were lodged and investigated internally.

Recordkeeping

The *State Records Act 2000* was established to mandate the standardisation of statutory recordkeeping practices for every State Government agency. Government agency practice is subject to the provision of the Act, the standards and policies. Government agencies are also subject to scrutiny by the State Records Commission.

NMHS Recordkeeping Plan was endorsed by the State Records Commission in 2015, and is due for review in 2020. An Implementation Plan for the establishment of a Recordkeeping Framework including the rollout of an electronic document and records management system (EDRMS) commenced in March 2016.

An evaluation of progress against the plan, including the rollout of the EDRMS, was completed in August 2017. The Evaluation Plan, which included recommendations for future progress, was endorsed by Executive, with a commitment to ensuring the rollout of compliant recordkeeping systems continues.

Pursuant to *State Records Act 2000* s. 16(3), records managers across WA HSPs are developing the WA Health Sector Disposal Authority to support the authorised disposal of government information. It is due to be submitted to the State Records Commission in 2018.

NMHS induction program addresses employee roles and responsibilities for compliance with NMHS Recordkeeping Plan. The Records Awareness Training eLearning package is mandatory for our employees.

NMHS has established training options for staff in the use of the EDRMS. This includes classroom training, eLearning tools and ongoing support. The focus of the implementation has been on staff creating records that are business critical and/or high risk. In addition, an intranet site for NMHS Records Management incorporates advice, policies and guidelines that staff must adhere to when undertaking recordkeeping activities. The site is updated regularly.

Current strategies used to demonstrate that staff are complying with NMHS Recordkeeping Plan include the provision of monthly statistical updates on system usage and recordkeeping activities. This information is incorporated into the Chief Executive's monthly report to the Board.

Annual estimates

NMHS annual operational budget estimates for the following financial year are reported to the Minister for Health under s. 40 of the *Financial Management Act 2006*, and TI 953.

The annual estimates for 2018/19, as approved by the Minister for Health, are provided in Table 34.

Table 34: 2018/19 Budget estimates for NMHS

Part A: Statement of comprehensive income	Note	2018/19 Estimate $000
COST OF SERVICES		
Expenses		
Employee benefits expense		1,161,027
Contracts for services		443,167
Patient support costs		316,087
Finance costs		42
Depreciation and amortisation expense		60,606
Repairs, maintenance and consumable equipment		35,599
Other supplies and services		67,599
Other expenses		64,332
Total cost of services		**2,148,460**
INCOME		
Revenue		
Patient charges		77,484
Other fees for services		61,280
Commonwealth grants and contributions		639,609
Other grants and contributions		168,450
Donation revenue		354
Other revenues		16,161
Total revenue		**963,339**
Gains		
Loss (Gain) on disposal of non-current assets	1	-
Gain on disposal of other assets	1	-
Other gains		-
Total gains		-
Total income other than income from State Government		**963,339**

Table 34: 2018/19 Budget estimates for NMHS (continued)

Part A: Statement of comprehensive income	Note	2018/19 Estimate $000
NET COST OF SERVICES		**1,185,121**
INCOME FROM STATE GOVERNMENT		
Service appropriations		1,094,889
Services received free of charge		89,843
Royalties for Regions Fund		390
Total income from State Government		**1,185,121**
SURPLUS / (DEFICIT) FOR THE PERIOD		-
OTHER COMPREHENSIVE INCOME		
Items not reclassified subsequently to profit or loss		
Changes in asset revaluation reserve		-
Total other comprehensive income		**-**
TOTAL COMPREHENSIVE (LOSS) / INCOME FOR THE PERIOD		**-**

Table 34: 2018/19 Budget estimates for NMHS (continued)

Part B: Statement of financial position	Note	2018/19 Estimate $000
ASSETS		
Current assets		
Cash and cash equivalents		17,313
Restricted cash and cash equivalents		42,480
Inventories		4,325
Receivables		56,809
Total current assets		**120,927**
Non-current assets		
Restricted cash and cash equivalents	2	9,635
Amounts receivable for services		763,934
Property, plant and equipment		1,424,514
Intangible assets		139
Other non-current assets	1	-
Total non-current assets		**2,198,221**
Total assets		**2,319,148**
LIABILITIES		
Current liabilities		
Payables		144,343
Provisions		237,690
Borrowings		777
Other current liabilities		496
Total current Liabilities		**383,306**
Non-current liabilities		
Provisions		53,922
Borrowings		38
Other non-current liabilities	1	-
Total non-current liabilities		**53,960**
Total liabilities		**437,266**
NET ASSETS		**1,881,882**
EQUITY		
Contributed equity		1,747,146
Reserves		134,736
Accumulated (deficit)/surplus		-
TOTAL EQUITY		**1,881,882**

Table 34: 2018/19 Budget estimates for NMHS (continued)

Part C: Statement of cash flows	Note	2018/19 Estimate $000
		Inflows / (Outflows)
CASH FLOWS FROM STATE GOVERNMENT		
Service appropriations		1,034,241
Capital appropriations		60,698
Royalties for Regions Fund		390
Net cash provided by State Government		**1,095,329**
CASH FLOWS FROM OPERATING ACTIVITIES		
Payments		
Employee benefits		(1,156,143)
Supplies and services		(836,942)
Receipts		
Receipts from customers		77,484
Commonwealth grants and contributions		639,609
Other grants and contributions		168,450
Donations received		354
Other receipts		77,441
Net cash used in operating activities		**(1,029,746)**
CASH FLOWS FROM INVESTING ACTIVITIES		
Payments		
Payment for purchase of non-current physical and intangible assets		(60,698)
Receipts		
Proceeds from sale of non-current physical assets	1	-
Net cash used in investing activities		**(60,698)**
CASH FLOWS FROM FINANCING ACTIVITIES		
Repayment of borrowings	1	-
Repayment of other liabilities	1	-
Net cash used in financing activities		-
Net increase in cash and cash equivalents		**4,885**
Cash and cash equivalent at the beginning of the period		69,427
Cash and cash equivalents transferred to other agencies	2	(4,885)
CASH AND CASH EQUIVALENTS AT THE END OF THE PERIOD		**69,427**

Notes:
Note 1: No balance forecasted at this point in time.
Note 2: Funds held in the special purpose account (SPA) at Treasury for the purpose of meeting the 27th pay in a financial year that typically occurs every 11th year.

Government policy

Substantive equality

NMHS is committed to identifying and eliminating all forms of discrimination as defined within the *Equal Opportunity Act 1984* (the EEO Act). Substantive equality recognises that, while some systems and processes may outwardly appear as non-discriminatory, they may not in fact be fully responsive to the needs of different people and groups and thus may be indirectly discriminatory.

NMHS considers the principles of the WA Health Substantive Equality Policy in the implementation of our strategic and operational plans, policy reviews and provision and access to services.

In 2017/18 we undertook the following initiatives:

- implemented targeted recruitment, training and employment strategies for Aboriginal people to increase their representation in our workforce
- offered Aboriginal sponsorships, scholarships and traineeships in order to provide learning opportunities to increase Aboriginal employment
- provided Mandatory Aboriginal Cultural Awareness training for all employees
- Incorporated the Aboriginal Impact Statement and Declaration process in the development of new and revised policies, programs, strategies and practices
- surveyed patients, stakeholders and employees regularly to determine experience with service delivery
- sought representatives from diversity groups to participate on committees and working groups.
- provided a Special Needs Dental Clinic in North Perth to treat eligible Disability Services Commission clients
- delivered dental services at Aboriginal Medical Services in nine regional locations so that patients did not have to attend a dental clinic
- provided a dental service in the home for those patients who are non-ambulatory
- established an Aboriginal Volunteer Program at KEMH, which is thought to the first of its kind in Australia
- designed family and domestic violence training and education programs specifically for working with CaLD and Aboriginal patients
- supported the Abuse and Neglect Taskforce (through SARC) with an application for a Lotterywest grant to hold Disability Week activities at venues with disabled access.

Graylands Festival

Held during Mental Health Week in October 2017, the Graylands Festival celebrated life, and represented a fantastic collaboration between Graylands Hospital staff, several community-managed agencies and consumers and carers.

Government building contracts

NMHS is committed to complying with the Government Building Training Policy. In 2017/18 we included appropriate clauses in our tender documentation and commenced increased monitoring of compliance of in-scope building, construction or maintenance contractors for projects with a duration of greater than three months and a value of greater than $2 million.

As at 30 June 2018, no contracts subject to the Government Building Training Policy had been awarded.

Occupational safety and health, and injury management

NMHS is committed to the provision of a safe environment for its employees, patients, visitors, agency staff, contractors and students in accordance with the *Occupational Safety and Health Act 1984*. NMHS takes a proactive approach to OSH, establishing clear goals and strategies to implement and monitor systems, responsibilities and preventive programs. The Health Service maintains an injury management system for the rehabilitation of injured employees to facilitate their return to work in a timely manner. The Executive is committed to continuous improvement towards best practice, and hazard/incident data and trends are reported to the Executive and Board.

NMHS maintains an integrated OSH management system to support the prevention of occupational injuries and illness. The system enables proactive planning based on the analysis of OSH trends and is supported by the following:

- formal consultation on OSH systems and matters
- effective incident/hazard identification, reporting, investigation and management
- proactive workplace hazard inspections
- pre-employment health assessments and clinical reviews
- in-house immunisation programs
- training programs to support employees to manage risks relevant to their work
- occupational health clinics
- manual task consultation and advice services
- safety management systems for external providers/contractors
- ergonomic expertise.

NMHS employees undertake mandatory training relevant to their profession, including an OSH induction, training in manual handling, prevention of workplace aggression and violence, and Occupational Safety and Health and Injury Management training for managers and supervisors.

OSH committees, comprising elected safety and health representatives and management representatives, meet bimonthly to review issues, data trends and discuss and resolve OSH-related matters. Issues may be referred to site management and NMHS Executive, as required. In higher risk areas, Local OSH Link Groups consult with employees to facilitate early identification, discussion and resolution of local issues.

An internal review of injury management (IM) practices was conducted in 2016/17 with the aim of providing greater consistency across all sites. Currently the revised IM program is being implemented across NMHS with a focus on early intervention and standardisation of IM practice and processes.

To prepare NMHS for the anticipated introduction of the new Work, Health and Safety (WHS) laws, a WHS project is underway to review and standardise OSH safety management systems across NMHS and identify gaps.

Frontline staff report increased occasions of aggression towards them while undertaking their role. This will be a focus area for the group for 2018/19.

Occupational safety and health assessment and performance indicators

The OSH assessment performance indicators are summarised in Table 35

Table 35: Occupational safety and health assessment and performance indicators, 2017/18

Indicator	Target	Actual	Target met
No. of fatalities	0	0	✓
Lost time injury/disease (LTI/D) incidence rate (per 100)	0 or 10% reduction (2.19)[1,3]	2.25	×
Lost time injury severity rate	0 or 10% reduction (26.7)[2,3]	32.5	×
Percentage of injured workers returned to work within 13 weeks	Greater than or equal to 80% return to work within 13 weeks	71%	×
Percentage of injured workers returned to work within 26 weeks	Greater than or equal to 80% return to work within 26 weeks	82%	✓
Percentage of managers and supervisors trained in OSH and injury management responsibilities	Greater than or equal to 80%	71%	×

Notes:

1. Target is 10% improvement on 2015/16 LTI/D.
2. Target is 10% improvement on 2015/16 severity rate as per RiskCover data for NMHS.
3. Target data have changed to two (2) years prior as per Public Sector Commission Circular but 2015/16 was prior to NMHS HSP status.

Certification of financial statements

For the year ended 30 June 2018

Government of **Western Australia**
North Metropolitan Health Service

Disclosures and Legal Compliance

Financial Statements

Certification of Financial Statements

For the reporting period ended 30 June 2018

The accompanying financial statements of the North Metropolitan Health Service have been prepared in compliance with the provisions of the Financial Management Act 2006 from proper accounts and records to present fairly the financial transactions for the reporting period ended 30 June 2018 and financial position as at 30 June 2018.

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.

Name: Jim Mitchell
North Metropolitan Health Service
Chief Finance Officer

Date: 13 September 2018

Name: Professor David Forbes
North Metropolitan Health Service
A/Board Chair, NMHS Board

Date: 13 September 2018

Name: Mr Grant Robinson
North Metropolitan Health Service
Board Member and Finance Committee Chair, NMHS Board

Date: 13 September 2018

North Metropolitan Health Service | Queen Elizabeth II Medical Centre | 2 Verdun St Nedlands WA 6009

Financial statements

Notes to the financial statements

Statement of Comprehensive Income

For the year ended 30 June 2018

	Note	2018 $000	2017 $000
COST OF SERVICES			
Expenses			
Employee benefits expense	3.1	1,388,748	1,356,459
Contracts for services	3.2	439,116	429,812
Patient support costs	3.3	316,789	325,982
Finance costs	7.2	179	596
Depreciation and amortisation expense	5.1, 5.2	78,825	61,869
Asset revaluation decrement		4,337	-
Loss on disposal of non-current assets		86	393
Repairs, maintenance and consumable equipment	3.4	44,374	49,459
Other supplies and services	3.5	78,585	78,729
Other expenses	3.6	98,173	101,949
Total cost of services		**2,449,212**	**2,405,248**
INCOME			
Revenue			
Patient charges	4.2	119,959	113,784
Other fees for services	4.3	176,207	184,813
Commonwealth grants and contributions	4.4	668,115	619,939
Other grants and contributions	4.5	174,313	179,495
Donation revenue		2,170	1,014
Interest revenue		54	587
Other revenue	4.6	21,672	21,204
Total revenue		**1,162,490**	**1,120,836**
Total income other than income from State Government		**1,162,490**	**1,120,836**
NET COST OF SERVICES		**1,286,722**	**1,284,412**
INCOME FROM STATE GOVERNMENT			
Service appropriations	4.1	1,205,059	1,271,598
Assets assumed/(transferred)	4.1	(210)	(64)
Services received free of charge	4.1	69,973	65,617
Royalties for Regions Fund	4.1	382	139
Total income from State Government		**1,275,204**	**1,337,290**
SURPLUS/(DEFICIT) FOR THE PERIOD		**(11,518)**	**52,878**
OTHER COMPREHENSIVE INCOME/(LOSS)			
Items not reclassified subsequently to profit or loss			
Changes in asset revaluation reserve	9.9	2,868	143,436
Total other comprehensive income/(loss)		**2,868**	**143,436**
TOTAL COMPREHENSIVE INCOME/(LOSS) FOR THE PERIOD		**(8,650)**	**196,314**

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

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

Statement of Financial Position

As at 30 June 2018

	Note	2018 $000	2017 $000
ASSETS			
Current Assets			
Cash and cash equivalents	7.3	46,412	33,617
Restricted cash and cash equivalents	7.3	45,542	50,398
Receivables	6.1	63,454	70,276
Inventories	6.3	5,230	6,658
Other current assets	6.4	6,957	5,919
Total Current Assets		**167,595**	**166,868**
Non-Current Assets			
Restricted cash and cash equivalents	7.3	6,376	5,300
Amounts receivable for services	6.2	774,984	695,494
Receivables	6.1	3,502	3,502
Property, plant and equipment	5.1	1,517,014	1,604,097
Intangible assets	5.2	12,238	6,222
Total Non-Current Assets		**2,314,114**	**2,314,615**
Total Assets		**2,481,709**	**2,481,483**
LIABILITIES			
Current Liabilities			
Payables	6.5	153,729	153,551
Borrowings	7.1	777	3,315
Employee benefits provisions	3.1	291,158	263,573
Other current liabilities	6.6	1,045	980
Total Current Liabilities		**446,709**	**421,419**
Non-Current Liabilities			
Borrowings	7.1	815	1,593
Employee benefits provisions	3.1	66,549	67,929
Total Non-Current Liabilities		**67,364**	**69,522**
Total Liabilities		**514,073**	**490,941**
NET ASSETS		**1,967,636**	**1,990,542**
EQUITY			
Contributed equity	9.9	1,779,972	1,794,228
Reserves	9.9	146,304	143,436
Accumulated surplus	9.9	41,360	52,878
TOTAL EQUITY		**1,967,636**	**1,990,542**

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

Statement of Changes in Equity

For the year ended 30 June 2018

	Note	2018	2017
		$000	$000
CONTRIBUTED EQUITY	9.9		
Balance at start of period		1,794,228	-
Transactions with owners in their capacity as owners:			
Capital appropriations		24,677	29,923
Other contribution by owners		14,938	1,787,465
Distributions to owners		(53,871)	(23,160)
Balance at end of period		1,779,972	1,794,228
RESERVES	9.9		
Asset Revaluation Reserve			
Balance at start of period		143,436	-
Other comprehensive income/(loss) for the period		2,868	143,436
Balance at end of period		146,304	143,436
ACCUMULATED SURPLUS (DEFICIT)	9.9		
Balance at start of period		52,878	-
Surplus/(deficit) for the period		(11,518)	52,878
Balance at end of period		41,360	52,878
TOTAL EQUITY			
Balance at start of period		1,990,542	-
Total comprehensive income/(loss) for the period		(8,650)	196,314
Transactions with owners in their capacity as owners		(14,256)	1,794,228
Balance at end of period		**1,967,636**	**1,990,542**

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

Statement of Cash Flows

For the year ended 30 June 2018

	Note	2018 $000 Inflows (Outflows)	2017 $000 Inflows (Outflows)
CASH FLOWS FROM STATE GOVERNMENT			
Service appropriations		1,125,506	1,194,242
Capital appropriations		39,234	29,213
Royalties for Regions Fund		382	139
Net cash provided by State Government		**1,165,122**	**1,223,594**
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Employee benefits		(1,359,108)	(1,340,870)
Supplies and services		(883,287)	(933,650)
Finance costs		(118)	(511)
Receipts			
Receipts from customers		115,227	109,494
Commonwealth grants and contributions		668,115	619,939
Other grants and contributions		174,313	179,495
Donations received		699	976
Interest received		116	536
Other receipts		186,117	213,356
Net cash provided by/(used in) operating activities	7.3	**(1,097,926)**	**(1,151,235)**
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments			
Payment for purchase of non-current physical and intangible assets		(55,609)	(52,761)
Receipts			
Proceeds from sale of non-current physical assets		-	162
Net cash provided by/(used in) investing activities		**(55,609)**	**(52,599)**
CASH FLOWS FROM FINANCING ACTIVITIES			
Payments			
Repayment of finance lease liabilities		(2,572)	(4,513)
Net cash provided by/(used in) financing activities		**(2,572)**	**(4,513)**
Net increase/(decrease) in cash and cash equivalents		9,015	15,247
Cash and cash equivalents at the beginning of the period		89,315	-
Cash and cash equivalents transferred from abolished agency		-	74,068
CASH AND CASH EQUIVALENTS AT END OF PERIOD	7.3	**98,330**	**89,315**

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

Notes to the financial statements

For the year ended 30 June 2018

1 Basis of preparation

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

These annual financial statements were authorised for issue by the Accountable Authority of the Health Service on 14 September 2018.

Statement of compliance

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

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

The FMA and the Instructions take precedence over AAS. Several AAS are modified by the Instructions to vary application, disclosure format and wording. Where modification is required and has had a material or significant financial effect upon the reported results, details of that modification and the resulting financial effect are disclosed in the Notes to the Financial Statements.

Basis of preparation

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

Judgements and estimates

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

Contributed equity

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

The 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.

Comparative figures

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

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

2 Health Service outputs

How the Health Service operates

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

	Notes
Health Service objectives	2.1
Schedule of Income and Expenses by Service	2.2

2.1 Health Service objectives

Mission

The Health Service's mission is to improve, promote and protect the health and wellbeing of our patients, population and community. The Health Service is predominantly funded by Parliamentary appropriations.

Services

The Health Service provides the following services:

1. Public Hospital Admitted Services
The provision of healthcare services to patients in metropolitan and major rural hospitals that meet the criteria for admission and receive treatment and/or care for a period of time, including public patients treated in private facilities under contract to the WA health system.

Admission to hospital and the treatment provided may include access to acute and/or subacute inpatient services, as well as hospital in the home services. Public Hospital Admitted Services includes teaching, training and research activities provided by the public health service to facilitate development of skills and acquisition or advancement of knowledge related to admitted services. This Service does not include any component of the Mental Health Services reported under Service Four, "Mental Health Services".

2. Public Hospital Emergency Services
The provision of services for the treatment of patients in emergency departments of metropolitan and major rural hospitals, inclusive of public patients treated in private facilities under contract to the WA health system.

The services provided to patients are specifically designed to provide emergency care, including a range of pre-admission, post-acute and other specialist medical, allied health, nursing and ancillary services. Public Hospital Emergency Services includes teaching, training and research activities provided by the public health service to facilitate development of skills and acquisition or advancement of knowledge related to emergency services. This Service does not include any component of the Mental Health Services reported under Service Four, "Mental Health Services".

3. Public Hospital Non-Admitted Services
The provision of metropolitan and major rural hospital services to patients who do not undergo a formal admission process, inclusive of public patients treated by private facilities under contract to the WA health system.

This Service includes services provided to patients in outpatient clinics, community based clinics or in the home, procedures, medical consultation, allied health or treatment provided by clinical nurse specialists. Public Hospital Non-Admitted Services includes teaching, training and research activities provided by the public health service to facilitate development of skills and acquisition or advancement of knowledge related to non-admitted services. This Service does not include any component of the Mental Health Services reported under Service Four, "Mental Health Services".

4. Mental Health Services
The provision of inpatient services where an admitted patient occupies a bed in a designated mental health facility or a designated mental health unit in a hospital setting; and the provision of non-admitted services inclusive of community and ambulatory specialised mental health programs such as prevention and promotion, community support services, community treatment services, community bed based services and forensic services.

This Service includes the provision of state-wide mental health services such as perinatal mental health and eating disorder outreach programs as well as the provision of assessment, treatment, management, care or rehabilitation of persons experiencing alcohol or other drug use problems or co-occurring health issues. Mental Health Services includes teaching, training and research activities provided by the public health service to facilitate development of skills and acquisition or advancement of knowledge related to mental health or alcohol and drug services. This service includes public patients treated in private facilities under contract to the WA health system.

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

2.1 Health Service objectives (continued)

5. Aged and Continuing Care Services

The provision of aged and continuing care services and community-based palliative care services.

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

6. Public and Community Health Services

The provision of healthcare services and programs delivered to increase optimal health and wellbeing, encourage healthy lifestyles, reduce the onset of disease and disability, reduce the risk of long-term illness as well as detect, protect and monitor the incidence of disease in the population.

Public and Community Health Services includes public health programs, Aboriginal health programs, disaster management, environmental health, the provision of grants to non-government organisations for public and community health purposes, emergency road and air ambulance services, services to assist rural-based patient travel to receive care, and state-wide pathology services provided to external WA Agencies.

7. Community Dental Health Services

Dental health services include the school dental service (providing dental health assessment and treatment for school children); the adult dental service for financially, socially and/or geographically disadvantaged people and Aboriginal people; additional and specialist dental, and oral health care 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.

8. Health System Management - Policy and Corporate Services

The provision of strategic leadership, policy and planning services, system performance management and purchasing linked to the state-wide planning, budgeting and regulation processes.

Health System Policy and Corporate Services includes corporate services, inclusive of statutory financial reporting requirements, overseeing, monitoring and promoting improvements in the safety and quality of health services and system wide infrastructure and asset management services.

9. Health Support Services

The provision of purchased health support services to WA health system entities inclusive of corporate recruitment and appointment, employee data management, payroll services, workers' compensation calculation and payments and processing of termination and severance payments.

HSS includes finance and business systems services, IT and ICT services, workforce services, project management of system wide projects and programs and the management of the supply chain and whole of health contracts.

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

2.2 Schedule of income and expenses by service

	Public Hospital Admitted Services		Public Hospital Emergency Services		Public Hospital Non-Admitted Services		Mental Health Services		Aged and Continuing Care Services	
	2018 $000	2017 $000	2018 $000	2017 $000	2018 $000	2017 $000	2018 $000	2017 $000	2018 $000	2017 $000
COST OF SERVICES										
Expenses										
Employee benefits expense	638,882	619,445	50,440	49,670	132,603	128,963	194,716	189,598	11,966	8,983
Contracts for services	298,106	291,179	84,522	82,662	22,069	21,581	21,722	21,173	5,733	5,095
Patient support costs	168,145	193,723	11,291	10,918	87,778	74,911	11,258	10,546	2,652	2,168
Finance costs	132	428	25	103	9	30	7	27	-	-
Depreciation and amortisation expense	44,515	34,912	3,985	3,234	9,727	7,418	7,651	5,085	14	13
Asset revaluation decrement	3,539	-	56	-	169	-	-	-	-	-
Loss on disposal of non-current assets	43	263	9	16	22	92	(2)	5	-	-
Repairs, maintenance and consumable equipment	17,307	19,474	1,129	1,337	6,615	6,840	4,365	4,134	286	337
Other supplies and services	34,810	35,881	2,116	2,633	8,722	9,108	12,696	11,332	329	350
Other expenses	38,102	38,315	2,175	2,455	5,994	6,740	10,910	11,628	693	290
Total cost of services	**1,243,581**	**1,233,620**	**155,748**	**153,028**	**273,708**	**255,683**	**263,323**	**253,528**	**21,673**	**17,236**
INCOME										
Revenue										
Patient charges	52,365	45,035	1,752	1,828	14,409	15,681	-	-	-	-
Other fees for services	951	1,126	76	114	58,274	72,258	397	472	-	-
Commonwealth grants and contributions	403,947	386,459	58,963	56,886	103,435	90,270	72,734	64,346	6,434	4,963
Other grants and contributions	1,215	6,616	154	109	1,748	1,240	169,848	170,676	-	-
Donation revenue	65	563	2	1	6	4	11	1	-	-
Interest revenue	24	168	4	21	7	42	8	47	-	-
Other revenue	3,735	3,445	277	239	6,274	5,680	902	351	29	1
Total income other than income from State Government	**462,302**	**443,412**	**61,228**	**59,198**	**184,153**	**185,175**	**243,900**	**235,893**	**6,463**	**4,964**
NET COST OF SERVICES	**781,279**	**790,208**	**94,520**	**93,830**	**89,555**	**70,508**	**19,423**	**17,635**	**15,210**	**12,272**
INCOME FROM STATE GOVERNMENT										
Service appropriations	726,188	799,755	91,890	96,159	81,256	66,193	7,651	6,556	19,303	12,183
Assets assumed/(transferred)	(243)	(6)	(19)	-	(26)	(1)	(29)	(4)	-	-
Services received free of charge	31,199	29,308	1,757	1,650	7,299	6,856	11,801	11,083	288	271
Royalties for Regions Fund	-	-	-	-	-	-	-	-	382	-
Total income from State Government	**757,144**	**829,057**	**93,628**	**97,809**	**88,529**	**73,048**	**19,423**	**17,635**	**19,973**	**12,454**
SURPLUS/(DEFICIT) FOR THE PERIOD	**(24,135)**	**38,849**	**(892)**	**3,979**	**(1,026)**	**2,540**	**-**	**-**	**4,763**	**182**

This year, NMHS is using OBM services for the first time in the Schedule of Income and Expenses by services. The services used in last financial year are not comparable with the current year OBM.
The Schedule of Income and Expenses by Service should be read in conjunction with the accompanying notes.

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

2.2 Schedule of income and expenses by service (continued)

	Public and Community Health Services		Community Dental Health Services		Health System Management - Policy and Corporate Services		Health Support Services **		Total	
	2018 $000	2017 $000	2018 $000	2017 $000	2018 $000	2017 $000	2018 $000	2017 $000	2018 $000	2017 $000
COST OF SERVICES										
Expenses										
Employee benefits expense	56,518	59,027	68,934	66,006	19,637	26,828	215,052	207,939	1,388,748	1,356,459
Contracts for services	5,831	5,668	959	1,079	174	1,375	-	-	439,116	429,812
Patient support costs	20,990	18,739	14,481	14,664	194	313	-	-	316,789	325,982
Finance costs	6	8	-	-	-	-	-	-	179	596
Depreciation and amortisation expense	3,604	2,997	1,698	1,725	3	-	7,628	6,485	78,825	61,869
Asset revaluation decrement	-	-	573	-	-	-	-	-	4,337	-
Loss on disposal of non-current assets	(1)	5	8	-	-	-	7	12	86	393
Repairs, maintenance and consumable equipment	2,521	3,633	2,722	2,454	105	76	9,324	11,174	44,374	49,459
Other supplies and services	4,516	5,317	3,155	2,637	2,290	2,725	9,951	8,746	78,585	78,729
Other expenses	15,162	14,039	6,814	8,547	4,206	5,027	14,117	14,908	98,173	101,949
Total cost of services	**109,147**	**109,433**	**99,344**	**97,112**	**26,609**	**36,344**	**256,079**	**249,264**	**2,449,212**	**2,405,248**
INCOME										
Revenue										
Patient charges	-	-	5,546	5,485	-	-	45,887	45,755	119,959	113,784
Other fees for services	4,817	5,154	5,241	3,545	-	-	106,451	102,144	176,207	184,813
Commonwealth grants and contributions	7,846	7,750	12,113	6,514	2,207	2,673	436	78	668,115	619,939
Other grants and contributions	-	-	689	329	-	-	659	525	174,313	179,495
Donation revenue	1,701	411	-	-	-	-	385	34	2,170	1,014
Interest revenue	11	19	-	-	-	-	-	290	54	587
Other revenue	8,211	9,001	611	910	-	1	1,633	1,576	21,672	21,204
Total income other than income from State Government	**22,586**	**22,335**	**24,200**	**16,783**	**2,207**	**2,674**	**155,451**	**150,402**	**1,162,490**	**1,120,836**
NET COST OF SERVICES	**86,561**	**87,098**	**75,144**	**80,329**	**24,402**	**33,670**	**100,628**	**98,862**	**1,286,722**	**1,284,412**
INCOME FROM STATE GOVERNMENT										
Service appropriations	85,615	85,265	71,617	78,653	24,500	32,707	97,039	94,127	1,205,059	1,271,598
Assets assumed/(transferred)	184	(47)	-	1	(6)	(7)	(71)	-	(210)	(64)
Services received free of charge	3,089	2,909	2,847	2,364	1,876	2,482	9,817	8,694	69,973	65,617
Royalties for Regions Fund	-	139	-	-	-	-	-	-	382	139
Total income from State Government	**88,888**	**88,266**	**74,464**	**81,018**	**26,370**	**35,182**	**106,785**	**102,821**	**1,275,204**	**1,337,290**
SURPLUS/(DEFICIT) FOR THE PERIOD	**2,327**	**1,168**	**(680)**	**689**	**1,968**	**1,512**	**6,157**	**3,959**	**(11,518)**	**52,878**

** Comprise pathology services provided by PathWest to organisations and patients external to NMHS.

This year, NMHS is using OBM services for the first time in the Schedule of Income and Expenses by services. The services used in last financial year are not comparable with the current year OBM.

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

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

3 Use of our funding

Expenses incurred in the delivery of services

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

	Notes	2018 $000	2017 $000
Employee benefits expense	3.1 (a)	1,388,748	1,356,459
Employee benefits provisions	3.1 (b)	357,707	331,502
Contracts for services	3.2	439,116	429,812
Patient support costs	3.3	316,789	325,982
Repairs, maintenance and consumable equipment	3.4	44,374	49,459
Other supplies and services	3.5	78,585	78,729
Other expenses	3.6	98,173	101,949

3.1 (a) Employee benefits expense

	2018 $000	2017 $000
Wages and salaries	1,272,593	1,241,650
Superannuation - defined contribution plans [(a)]	116,155	114,809
	1,388,748	**1,356,459**

(a) Defined contribution plans include West State Super (WSS), Gold State Super (GSS), Government Employees Superannuation Board (GESB) and other eligible funds.

Wages and salaries: Includes the value of fringe benefits to employees plus the fringe benefits tax component and the value of superannuation contribution component of leave entitlements.

Superannuation: The amount recognised in profit or loss of the Statement of Comprehensive Income comprises employer contributions paid to GSS (concurrent contributions), WSS, GESB, or other superannuation funds. The employer contribution paid to the Government Employees Superannuation Board (GESB) in respect of the GSS is paid back into the Consolidated Account by the GESB.

GSS (concurrent contributions) is a defined benefit scheme for the purposes of employees and whole-of-government reporting. However, it is a defined contribution plan for Health Service 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 does not recognise any defined benefit liabilities because it has no legal or constructive obligation to pay future benefits relating to its employees. 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 GESB.

The 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.

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

	2018 $000	2017 $000
3.1 (b) Employee benefits provisions		

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

Current		
Annual leave [(a)]	129,384	128,729
Time off in lieu leave [(a)]	44,535	38,090
Long service leave [(b)]	115,665	94,841
Deferred salary scheme [(c)]	1,574	1,913
	291,158	**263,573**
Non-current		
Long service leave [(b)]	66,549	67,929
Total employee benefits provisions	**357,707**	**331,502**

(a) Annual leave and time off in lieu leave liabilities: 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	118,265	116,773
More than 12 months after the end of the reporting period	55,654	50,046
	173,919	**166,819**

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

Health Support Services (HSS) has identified incorrect calculations for the Public Holiday Time off in lieu (PH TOIL) due to an inconsistent interpretation of the employee industrial awards and configuration of the payroll system. An amount of $4.5 million has been included in the Time off in lieu leave liability to accrue for the nursing cohort and other employee classes that maybe affected by the inconsistent interpretation of the PH TOIL.

(b) Long service leave liabilities: 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.

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

Within 12 months of the end of the reporting period	28,916	23,710
More than 12 months after the end of the reporting period	153,298	139,060
	182,214	**162,770**

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

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

	2018 $000	2017 $000

3.1 (b) Employee benefits provisions (continued)

(c) Deferred salary scheme liabilities: Classified as current where there is no unconditional right to defer settlement for at least 12 months after the end of the reporting period. Actual settlement of the liabilities is expected to occur as follows:

Within 12 months of the end of the reporting period	944	1,148
More than 12 months after the end of the reporting period	629	765
	1,573	**1,913**

Key sources of estimation uncertainty – long service leave

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

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

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

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

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

3.2 Contracts for services

Public patients services [(a)]	386,518	377,480
Mental Health	37,677	24,312
Other aged-care services	12,304	14,616
Other contracts	2,617	13,404
	439,116	**429,812**

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

3.3 Patient support costs

Medical supplies and services	252,412	263,497
Domestic charges	18,510	18,307
Fees for visiting medical practitioners	14,170	13,880
Fuel, light and power	12,979	11,067
Food supplies	8,611	8,405
Patient transport costs	2,433	2,637
Research, development and other grants	7,674	8,189
	316,789	**325,982**

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

3.4 Repairs, maintenance and consumable equipment

	2018 $000	2017 $000
Repairs and maintenance	33,765	37,643
Consumable equipment	10,609	11,816
	44,374	**49,459**

Repairs and maintenance costs are recognised as expenses as incurred, except where they relate to the replacement of a significant component of an asset. In that case the costs are capitalised and depreciated. Consumable equipment costing less than $5,000 is recognised as an expense (see note 5.1 Property, plant and equipment).

3.5 Other supplies and services

Sanitisation and waste removal services	2,770	2,516
Administration and management services	3,232	2,491
Interpreter services	2,092	1,977
Security services	530	749
Services provided by Health Support Services: [(a)]		
ICT services	46,686	35,872
Supply chain services	9,069	10,766
Financial services	3,845	5,733
Human resource services	10,361	13,222
Other	-	5,403
	78,585	**78,729**

Supplies and services are recognised as an expense as incurred.

(a) Services received free of charge, see note 4.1 Income from State Government.

3.6 Other expenses

Communications	4,938	4,567
Computer services	3,958	3,395
Workers' compensation insurance	14,656	20,030
Operating lease expenses	9,102	10,536
Other insurances	15,654	15,402
Consultancy fees	4,158	4,638
Other employee-related expenses	8,505	8,410
Printing and stationeries	5,057	5,453
Doubtful debts expense [(a)]	16,594	5,168
Freight and cartage	3,635	3,571
Periodical subscriptions	2,578	2,928
Write-down of assets [(b)]	-	9,478
Motor vehicle expenses	1,744	1,549
Other	7,594	6,824
	98,173	**101,949**

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

(a) Doubtful debt expense is recognised as part of the movement in the allowance for impairment of receivables (or provision for doubtful debt). See note 6.1.1 Movement of the allowance for impairment of receivables.

(b) See note 5.1 Property, plant and equipment and note 5.2 Intangible assets.

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

4 Our funding sources

How we obtain our funding

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

	Notes	2018 $000	2017 $000
Income from State Government	4.1		
Service appropriations	4.1.1	1,205,059	1,271,598
Assets transferred from/(to) other State Government agencies during the period	4.1.2	(210)	(64)
Services received free of charge from other State Government agencies during the period	4.1.3	69,973	65,617
Royalties for Regions Fund	4.1.4	382	139
Patient charges	4.2	119,959	113,784
Other fees for services	4.3	176,207	184,813
Commonwealth grants and contributions	4.4	668,115	619,939
Other grants and contributions	4.5	174,313	179,495
Donation revenue		2,169	1,014
Interest revenue		54	587
Other revenue	4.6	21,672	21,204

4.1 Income from State Government

	2018 $000	2017 $000
4.1.1 Appropriation revenue received during the period:		
Service appropriations (funding via the Department of Health)	1,205,059	1,271,598

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.

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

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

The receivable (Holding Account – note 6.2) comprises the following:

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

4.1.2 Assets assumed/(transferred) from/(to) other State government agencies during the period:		
– Transfers from/(to) the Department of Health	(21)	(7)
– Transfers from/(to) WA Country Health Service (WACHS)	-	(33)
– Transfers from/(to) South Metropolitan Health Service (SMHS)	6	-
– Transfers from/(to) East Metropolitan Health Service (EMHS)	(203)	(24)
– Transfers from/(to) Child & Adolescent Health Service (CAHS)	8	(14)
– Transfers from/(to) the Queen Elizabeth II Medical Centre Trust	-	14
	(210)	**(64)**

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

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

	2018 $000	2017 $000
4.1.3 Services received free of charge from other State government agencies during the period:		
Department of Finance - government leased accommodation	13	24
Services received from Health Support Services (HSS)		
ICT services	46,685	35,872
Supply chain services	9,069	10,766
Financial services	3,845	5,733
Human resource services	10,361	13,222
	69,973	**65,617**

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.

4.1.4 Royalties for Regions Fund

Regional Community Services Account	382	139

Represent a sub-fund within the over-arching 'Royalties for Regions Fund'. The recurrent funds are committed to projects and programs in WA regional areas and are recognised as revenue when the Health Service gains control on receipt of the funds.

4.2 Patient charges

Inpatient bed charges	50,095	45,060
Inpatient other charges	7,003	6,357
Outpatient charges	16,977	16,613
Pathology services to patients	45,884	45,754
	119,959	**113,784**

See revenue recognition under note 4.6 Other revenue.

4.3 Other fees for services

Recoveries from the Pharmaceutical Benefits Scheme	58,141	72,108
Clinical services to other health organisations	8,982	8,581
Non-clinical services to other health organisations	7,912	7,547
Pathology services to other Health Services and other government agencies [(a)]	101,172	96,337
Other	-	240
	176,207	**184,813**

See revenue recognition under note 4.6 Other revenue.

(a) Represent the pathology services billed to other Health Services (CAHS, SMHS, EMHS and WACHS) and other government agencies (WA Police and Department of the Attorney General).

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

	2018 $000	2017 $000
4.4 Commonwealth grants and contributions		
Capital Grants		
Project funded under the National Partnership Agreement	8,659	3,318
Other	129	78
Recurrent Grants		
National Health Reform Agreement (funding via Department of Health) [(a)]	529,639	506,121
National Health Reform Agreement (funding via Mental Health Commission) [(a)]	72,735	64,346
Other	56,953	46,076
	668,115	**619,939**

The grant has been recognised when the Health Service obtains control of the asset that makes the grant contribution which is usually upon cash receipt.

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

4.5 Other grants and contributions		
Mental Health Commission – service delivery agreement	168,215	168,952
Mental Health Commission – other	1,633	1,724
Disability Services Commission - community aids & equipment program	1,483	1,075
Other	2,982	7,744
	174,313	**179,495**

The grant has been recognised when the Health Service obtains control of the asset that makes the grant contribution which is usually upon cash receipt.

4.6 Other revenue		
Use of hospital facilities	5,969	6,186
Rent from commercial properties	384	1,791
Rent from residential properties	334	728
Boarders' accommodation	1,583	1,198
RiskCover insurance premium rebate	4,996	2,579
Sale of radiopharmacies	1,553	1,311
Parking	2,638	2,613
Abatements	-	471
Other	4,215	4,327
	21,672	**21,204**

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.

Notes to the Financial Statements
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5 Key assets

Assets the Health Service utilises for economic benefit or service potential

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

	Notes	2018 $000	2017 $000
Property, plant and equipment	5.1	1,517,012	1,604,097
Depreciation and amortisation expense	5.1.1	78,758	61,723
Intangible assets	5.2	12,237	6,222
Amortisation and impairment	5.2.1	67	146

5.1 Property, plant and equipment

	2018 $000	2017 $000
Land [(a) (b)]		
At fair value [(a)]	224,383	267,966
Reconciliation		
Carrying amount at start of period	267,966	-
Transfers from abolished agency	-	280,490
Transfers to other reporting entities	(38,570)	(13,200)
Revaluation increments/(decrements)	(5,013)	676
Carrying amount at end of period	224,383	267,966
Buildings		
At fair value [(a) (b)]	987,540	1,021,159
Accumulated depreciation	-	-
	987,540	1,021,159
Reconciliation		
Carrying amount at start of period	1,021,159	-
Transfers from abolished agency	-	920,090
Additions	4,576	6,234
Transfers from works in progress	9,454	39,891
Revaluation increments/(decrements)	3,544	142,760
Depreciation	(51,193)	(36,056)
Transfers between asset classes	-	(51,760)
Carrying amount at end of period	987,540	1,021,159
Site infrastructure		
At cost	136,811	136,669
Accumulated depreciation	(9,214)	(4,405)
	127,597	132,264
Reconciliation		
Carrying amount at start of period	132,264	-
Transfers from abolished agency	-	76,509
Additions	6	7,113
Transfers from works in progress	135	1,287
Depreciation	(4,808)	(4,405)
Transfers between asset classes	-	51,760
Carrying amount at end of period	127,597	132,264

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

	2018 $000	2017 $000
5.1 Property, plant and equipment (continued)		
Leasehold improvements		
At cost	2,265	2,265
Accumulated depreciation	(1,052)	(580)
	1,213	1,685
Reconciliation		
Carrying amount at start of period	1,685	-
Transfers from abolished agency	-	1,664
Additions	-	601
Depreciation	(472)	(580)
Carrying amount at end of period	1,213	1,685
Computer equipment		
At cost	957	766
Accumulated depreciation	(410)	(171)
	547	595
Reconciliation		
Carrying amount at start of period	595	-
Transfers from abolished agency	-	678
Additions	146	183
Transfer from works in progress	26	-
Disposals	-	(6)
Depreciation	(220)	(171)
Write-down of assets	-	(89)
Carrying amount at end of period	547	595
Furniture and fittings		
At cost	7,215	7,020
Accumulated depreciation	(1,331)	(665)
	5,884	6,355
Reconciliation		
Carrying amount at start of period	6,355	-
Transfers from abolished agency	-	7,680
Additions	187	358
Transfer from works in progress	20	-
Disposals	(12)	-
Depreciation	(666)	(665)
Write-down of assets	-	(1,018)
Carrying amount at end of period	5,884	6,355

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

	2018 $000	2017 $000
5.1 Property, plant and equipment (continued)		
Motor vehicles		
At cost	216	199
Accumulated depreciation	(90)	(60)
	126	139
Reconciliation		
Carrying amount at start of period	139	-
Transfers from abolished agency	-	34
Additions	-	168
Transfers from/(to) other reporting entities	11	-
Depreciation	(24)	(60)
Write-down of assets	-	(3)
Carrying amount at end of period	126	139
Medical equipment		
At cost	120,367	104,221
Accumulated depreciation	(33,026)	(15,851)
	87,341	88,370
Reconciliation		
Carrying amount at start of period	88,370	-
Transfers from abolished agency	-	86,510
Additions	16,550	23,898
Transfers from works in progress	572	512
Transfers from/(to) other reporting entities	(234)	(46)
Disposals	(66)	(549)
Depreciation	(17,489)	(15,851)
Write-down of assets	(362)	(6,104)
Carrying amount at end of period	87,341	88,370
Other plant and equipment		
At cost	75,163	74,460
Accumulated depreciation	(7,827)	(3,936)
	67,336	70,524
Reconciliation		
Carrying amount at start of period	70,524	-
Transfers from abolished agency	-	72,276
Additions	668	3,560
Transfers from works in progress	26	128
Transfers from/(to) other reporting entities	12	(178)
Disposals	(8)	-
Depreciation	(3,886)	(3,936)
Transfers between asset classes	-	221
Write-down of assets	-	(1,547)
Carrying amount at end of period	67,336	70,524

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

	2018 $000	2017 $000
Works in progress		
Buildings under construction (at cost)	14,402	14,066
Other works in progress (at cost)	313	642
	14,715	14,708
Reconciliations		
Carrying amount at start of period	14,708	-
Transfers from abolished agency	-	53,931
Additions	10,240	6,650
Transfers between asset classes	-	18
Capitalised to asset classes	(10,233)	(41,817)
Write-down of assets	-	(4,074)
Carrying amount at end of period	14,715	14,708
Artworks		
At cost	332	332
Reconciliation		
Carrying amount at start of period	332	-
Transfers from abolished agency	-	240
Additions	-	92
Carrying amount at end of period	332	332
Total Property, plant and equipment	**1,517,012**	**1,604,097**
Total reconciliation of Property, plant and equipment		
Carrying amount at start of period	1,604,097	-
Transfers from abolished agency [(c)]	-	1,500,102
Additions	32,373	48,858
Transfers between asset classes	-	239
Disposals	(86)	(555)
Transfers from/(to) other reporting entities	(38,781)	(13,424)
Revaluation increments/(decrements)	(1,469)	143,436
Depreciation	(78,758)	(61,723)
Write-down of assets [(d)]	(362)	(12,836)
Carrying amount at end of period	**1,517,014**	**1,604,097**

(a) Land and buildings were revalued as at 1 July 2017 by the Western Australian Land Information Authority (Valuation Services). The valuations were performed during the year ended 30 June 2018 and recognised at 30 June 2018. In undertaking the revaluation, fair value was determined by reference to market values for land: $3.172 million and buildings: $0.88 million. For the remaining balance, fair value of buildings was determined on the basis of current replacement cost and fair value of land was determined on the basis of comparison with market evidence for land with low level utility (high restricted use land). See also note 8.3 'Fair value measurements'.

(b) Information on fair value measurements is provided in note 8.3 'Fair value measurements'.

(c) Information on transfers from abolished Health Service is provided under note 9.9.1 'Contributed Equity'.

(d) Nil (2017: $9.478 million) write-down of assets was recognised in other expenses (Note 3.6) and $0.362 million (2017: $2.856 million) was adjustment to contributed equity (note 9.9.1).

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

5.1 Property, plant and equipment (continued)

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

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

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

The initial cost for a non-financial physical asset under a finance lease is measured at amounts equal to the fair value of the leased asset or, if lower, the present value of the minimum lease payments, each determined at the inception of the lease.

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

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

Revaluation model

(a) *Fair value where market-based evidence is available:*

The fair value of land and buildings is determined on the basis of current market values determined by reference to recent market transactions. When buildings are revalued by reference to recent market transactions, the accumulated depreciation is eliminated against the gross carrying amount of the asset and the net amount restated to the revalued amount.

(b) *Fair value in the absence of market-based evidence:*

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

Existing use buildings: Fair value is determined by reference to the cost of replacing the remaining future economic benefits embodied in the asset, i.e. the current replacement cost. Where the fair value of buildings is determined on the current replacement cost basis, the accumulated depreciation is eliminated against the gross carrying amount of the asset and the net amount restated to the revalued amount.

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

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

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

	2018 $000	2017 $000
5.1.1 Depreciation and impairment		
Depreciation expense		
Buildings	51,193	36,056
Site infrastructure	4,808	4,405
Leasehold improvements	472	579
Computer equipment	220	171
Furniture and fittings	666	665
Motor vehicles	24	60
Medical equipment	17,489	15,851
Other plant and equipment	3,886	3,936
	78,758	**61,723**

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

Please refer to note 5.2 for guidance in relation to the impairment assessment that has been performed for intangible assets.

Finite useful lives

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

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

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

Asset	Useful life
Buildings	50 years
Site infrastructure	50 years
Leasehold improvements	Term of the lease
Computer equipment	4 to 10 years
Furniture and fittings	5 to 20 years
Motor vehicles	4 to 7 years
Medical equipment	3 to 25 years
Other plant and equipment	3 to 50 years

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

Leasehold improvements are depreciated over the shorter of the lease terms and their useful lives.

Impairment

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

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

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

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

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

	2018 $000	2017 $000

5.1.1 Depreciation and impairment (continued)

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

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

5.2 Intangible assets

Computer software		
At cost	355	355
Accumulated amortisation	(212)	(145)
	143	210
Reconciliation		
Carrying amount at start of period	210	-
Transfers from abolished agency	-	526
Additions	-	53
Write-down of assets	-	(2)
Amortisation expense	(67)	(146)
Transfers between asset classes	-	(221)
Carrying amount at end of period	143	210
Works in progress		
Computer software under development (at cost)	12,095	6,012
Reconciliation		
Carrying amount at start of period	6,012	-
Additions	6,083	6,030
Transfers between asset classes	-	(18)
Carrying amount at end of period	12,095	6,012
Total intangible assets	**12,237**	**6,222**
Total reconciliation of intangible assets		
Carrying amount at start of period	6,222	-
Transfers from abolished agency [(a)]	-	526
Additions	6,083	6,083
Write-down of assets [(b)]	-	(2)
Amortisation expense	(67)	(146)
Transfers between asset classes	-	(239)
Carrying amount at end of period	**12,238**	**6,222**

(a) Information on transfers from abolished Health Service is provided under note 9.9.1 'Contributed equity'.
(b) Works in progress capitalised in prior years but expensed in the current financial year. Refer to note 3.6 'Other expenses'.

Initial recognition

Acquisitions of intangible assets costing $5,000 or more and internally generated intangible assets costing $50,000 or more that comply with the recognition criteria as per AASB 138.57 (as noted below), are capitalised.

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

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

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

	2018 $000	2017 $000

5.2 Intangible assets (continued)

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

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

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

Subsequent measurement

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

5.2.1 Amortisation and impairment

Charge for the period

Computer software	67	146

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

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.

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

The estimated useful life for the following asset is:

Computer software	5 years

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

Impairment of intangible assets

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

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

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

6 Other assets and liabilities

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

	Notes	2018 $000	2017 $000
Receivables	6.1	66,956	73,778
Amounts receivable for services	6.2	774,984	695,494
Inventories	6.3	5,230	6,658
Other current assets	6.4	6,957	5,918
Payables	6.5	153,729	153,551
Other current liabilities	6.6	1,045	980

6.1 Receivables

	2018 $000	2017 $000
Current		
Patient fee debtors	52,152	53,779
Other receivables	18,497	15,280
Less: Allowance for impairment of receivables	(37,729)	(27,511)
Accrued revenue [(a)]	23,141	21,391
GST Receivables	7,393	7,337
	63,454	**70,276**
Non-current		
Other receivables	3,502	3,502
Total receivables	**66,956**	**73,778**

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

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

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 Act 1999" whereby the Department of Health became the nominated group representative (NGR) for the GST Group. The entities in the GST group include the Department of Health, Mental Health Commission, NMHS, EMHS, SMHS, CAHS, HSS, WACHS, 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.

(a) See note 6.4(a)

6.1.1 Movement of the allowance for impairment of receivables

Reconciliation of changes in the allowance for impairment of receivables:		
Balance at start of period	27,511	-
Transfers from abolished Health Service	-	22,671
Doubtful debts expense (note 3.6)	16,594	5,168
Amounts written off during the period	(6,376)	(349)
Amount recovered during the period	-	21
Balance at end of period	**37,729**	**27,511**

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.

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

	2018 $000	2017 $000

6.2 Amounts receivable for services (Holding Account)

Non-current	774,984	695,494

The Health Service receives funding on an accrual basis. The appropriations are paid partly in cash and partly as an asset (holding account receivable). Amounts receivable for services represent the non-cash component of service appropriations. It is restricted in that it can only be used for asset replacement or payment of leave liability.

6.3 Inventories

Current		
Pharmaceutical stores – at cost	4,480	5,926
Engineering stores – at cost	750	732
	5,230	**6,658**

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.

6.4 Other current assets

Current		
Prepayments	3,304	2,793
Paid parental leave scheme	245	-
Other [(a)]	3,408	3,126
	6,957	**5,919**

Other non-financial assets include prepayments which represent payments in advance of receipt of goods or services or that part of expenditure made in one accounting period covering a term extending beyond that period.

(a) For comparative purposes, an amount of $6.312 million in 2017, which represented accrued revenue for pathology services to other Health Services (SMHS, CAHS, EMHS and WACHS), has been reclassified to Receivables (note 6.1 Receivables).

6.5 Payables

Current		
Trade creditors	18,399	22,149
Other creditors	11,370	11,170
Accrued expenses	103,674	103,357
Accrued salaries	20,282	16,869
Accrued interest	4	6
	153,729	**153,551**

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

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

6.6 Other current liabilities

Refundable deposits	1,045	955
Paid parental leave scheme	-	16
Other	-	9
	1,045	**980**

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

7 Financing

This section sets out the material balances and disclosures associated with financing and cash flows of the Health Service.

	Notes	2018 $000	2017 $000
Borrowings	7.1		
Department of Treasury loans	7.1.1	1,592	2,336
Finance Leases	7.1.2	-	2,572
Finance costs	7.2	179	596
Cash and cash equivalents	7.3		
Cash and cash equivalents	7.3.1	46,412	33,617
Restricted cash and cash equivalents	7.3.2	51,918	55,698
Reconciliation of net cost of services to net cash used in operating activities	7.3.3	(1,097,926)	(1,151,235)
Commitments	7.4		
Operating lease commitments	7.4.1	15,307	12,372
Capital commitments	7.4.2	15,939	18,904
Private sector contracts for the provision of health services	7.4.3	5,778,144	6,106,109
Other expenditure commitments	7.4.4	51,125	56,253

7.1 Borrowings

	2018 $000	2017 $000
7.1.1 Department of Treasury loans		
Current	777	743
Non-current	815	1,593
	1,592	**2,336**

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.

7.1.2 Finance Leases

Finance lease commitments		
Minimum lease payment commitments in relation to finance leases are payable as follows:		
Within 1 year	-	2,899
Less future finance charges	-	(327)
Present value of finance lease liabilities	**-**	**2,572**
The present value of finance leases payable is as follows:		
Within 1 year	-	2,572
Included in the financial statements as:		
Current		
Finance lease liabilities – Joondalup Health Campus	-	2,572

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 that has been 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 Health Service has the option to purchase leased assets at their agreed fair value on expiry of the lease. These leasing arrangements do not have escalation clauses, other than in the event of payment default. There are no restrictions imposed by these leasing arrangements on other financing transactions. Certain finance leases have a contingent rental obligation; however, these are not material when compared to the total lease payments made.

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.

7.2 Finance costs

	2018 $000	2017 $000
Finance lease charges	118	511
Interest expense	61	85
	179	**596**

'Finance cost' includes Finance lease charges and interest components of finance lease repayments.

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

	2018 $000	2017 $000
7.3 Cash and cash equivalents		
7.3.1 Cash and cash equivalents		
Cash and cash equivalents	46,412	33,617
7.3.2 Restricted cash and cash equivalents		
Current		
Other capital grants from the Commonwealth Government	4,137	3,554
Restricted cash assets held for other specific purposes [(a)]	41,281	46,720
Mental Health Commission funding [(b)]	124	124
	45,542	**50,398**
Non-current		
Accrued salaries suspense account [(c)]	6,376	5,300
	51,918	**55,698**

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

(a) These include medical research grants, donations for the benefits of patients, medical education, medical equipment, scholarships, recurrent grants from the Commonwealth Government, employee contributions and employee benevolent funds.

(b) See note 9.7 Special purpose accounts.

(c) Funds held in the suspense account at the Department of Treasury will be used only for the purpose of meeting the 27th pay in a financial year that occurs every 11 years.

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

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

Net cost of services (Statement of Comprehensive Income)	(1,286,722)	(1,284,412)
Non-cash items		
Doubtful debts expense (note 3.6)	16,594	5,168
Depreciation and amortisation expense (note 5.1.1 and 5.2.1)	78,825	61,869
Net (gain)/loss from disposal of non-current assets	86	393
Interest paid by Department of Health	63	89
Net donation of non-current assets	(1,470)	(39)
Asset revaluation decrement	4,336	-
Services received free of charge (note 4.1.3)	69,973	65,617
Write-down of assets (note 3.6)	-	9,478
(Increase)/decrease in assets		
GST receivable	(56)	(615)
Other current receivables [(a)]	(9,715)	(3,086)
Inventories	1,428	185
Prepayments and other current assets [(a)]	(1,038)	4,897
Increase/(decrease)in liabilities		
Payables	3,501	(23,351)
Current employee related provisions	27,585	8,465
Non-current employee related provisions	(1,380)	4,287
Other current liabilities	64	(180)
Net cash used in operating activities (Statement of Cash Flows)	**(1,097,926)**	**(1,151,235)**

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

(a) See note 6.4(a)

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

	2018 $000	2017 $000

7.4 Commitments

The commitments below are inclusive of GST where relevant.

7.4.1 Operating lease commitments

Commitments in relation to non-cancellable leases contracted at the end of the reporting period but not recognised as liabilities are payable as follows:

Within 1 year	5,089	4,313
Later than 1 year and not later than 5 years	9,389	6,953
Later than 5 years	829	1,106
	15,307	**12,372**

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

Operating lease commitments predominantly consist of contractual agreements for office accommodation and residential accommodation. The basis on which contingent operating leases payments are determined is the value for each lease agreement under the contract terms and conditions at current values.

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

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

7.4.2 Capital commitments

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

Within 1 year	15,939	18,904

7.4.3 Private sector contracts for the provision of health services

Expenditure commitments for private sector organisations contracted at the end of the reporting period but not recognised as liabilities, are payable as follows:

Within 1 year	523,306	492,173
Later than 1 year and not later than 5 years	2,192,513	2,073,142
Later than 5 years and not later than 10 years	3,062,325	2,918,447
Later than 10 years	-	622,347
	5,778,144	**6,106,109**

7.4.4 Other expenditure commitments

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

Within 1 year	34,328	33,722
Later than 1 year and not later than 5 years	16,762	22,531
Later than 5 years	35	-
	51,125	**56,253**

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

8 Risks and Contingencies

8.1 Financial risk management

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

(a) Summary of risks and risk management

Credit risk

Credit risk arises when there is the possibility of 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 asset is the gross carrying amount of those assets inclusive of any allowance for impairment as shown in the table at Note 8.1(c) 'Ageing analysis of financial assets' and Note 6.1 'Receivables'.

Credit risk associated with the Health Service's financial assets is minimal because the main receivable are amounts receivable for services (Holding Account). For receivables other than Government, 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 minimal. At the end of the reporting period, there were no significant concentrations of credit risk.

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 trading in the normal course of business.

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

Market risk

Market risk is the risk that changes in market prices such as foreign exchange rates and interest rates will affect 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 (for example, equity securities or commodity prices changes). The Health Service's exposure to market risk for changes in interest rates relate primarily to the long-term debt obligations.

(b) Categories of financial instruments

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

	2018 $000	2017 $000
Financial assets		
Cash and cash equivalents	46,412	33,617
Restricted cash and cash equivalents	51,918	55,698
Loans and receivables [(a)(b)]	834,547	761,935
Total financial assets	**932,877**	**851,250**
Financial liabilities		
Financial liabilities measured at amortised cost	155,320	158,458
Total financial liability	**155,320**	**158,458**

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

(b) See note 6.4(a)

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

8.1 Financial risk management (continued)

(c) Ageing analysis of financial assets

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 for the financial assets it holds.

			Past due but not impaired				
	Carrying amount $000	Not past due and not impaired $000	1–3 months $000	3 months to 1 year $000	1–5 years $000	More than 5 years $000	Impaired financial assets $000
2018							
Cash and cash equivalents	46,412	46,412	-	-	-	-	-
Restricted cash and cash equivalents	51,918	51,918	-	-	-	-	-
Receivables [(a)]	59,563	45,617	7,590	412	5,944	-	-
Amounts receivable for services	774,984	774,984	-	-	-	-	-
	932,877	**918,931**	**7,590**	**412**	**5,944**	**-**	**-**
2017							
Cash and cash equivalents	33,617	33,617	-	-	-	-	-
Restricted cash and cash equivalents	55,698	55,698	-	-	-	-	-
Receivables [(a)(b)]	66,441	36,972	13,822	8,716	6,931	-	-
Amounts receivable for services	695,494	695,494	-	-	-	-	-
	851,250	**821,781**	**13,822**	**8,716**	**6,931**	**-**	**-**

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

(b) See note 6.4(a)

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

8.1 Financial risk management (continued)

(d) 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 $000	Fixed interest rate $000	Variable interest rate $000	Non-interest bearing $000	Nominal Amount $000	Up to 3 months $000	3 months to 1 year $000	1–5 years $000	More than 5 years $000
2018										
Financial assets										
Cash and cash equivalents	-	46,412	-	-	46,412	46,412	46,412	-	-	-
Restricted cash and cash equivalents	-	51,918	-	-	51,918	51,918	45,542	-	-	6,376
Receivables – non interest bearing [(a)]	-	56,061	-	-	56,061	56,061	56,061	-	-	-
Receivables – interest bearing	1.50	3,502	-	3,502	-	3,574	-	-	3,574	-
Amounts receivable for services	-	774,984	-	-	774,984	774,984	-	-	-	774,984
		932,877	**-**	**3,502**	**929,375**	**932,948**	**148,015**	**-**	**3,574**	**781,360**
Financial liabilities										
Payables	-	153,728	-	-	153,729	153,729	153,729	-	-	-
Department of Treasury loans	3.06	1,592	-	1,592	-	1,661	206	615	840	-
		155,320	**-**	**1,592**	**153,729**	**155,390**	**153,935**	**615**	**840**	**-**

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

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

8.1 Financial risk management (continued)

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

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

		Interest rate exposure				Maturity dates			
	Weighted average effective interest rate %	Carrying amount $000	Fixed interest rate $000	Variable interest rate $000	Non-interest bearing $000	Nominal Amount $000	Up to 3 months $000	3 months to 1 year $000	1–5 years $000	More than 5 years $000
2017										
Financial assets										
Cash and cash equivalents	1.98	33,617	-	6,190	27,427	33,617	33,617	-	-	-
Restricted cash and cash equivalents	-	55,698	-	-	55,698	55,698	50,398	-	-	5,300
Receivables – non-interest bearing [(a)(b)]	-	62,939	-	-	62,939	62,939	62,939	-	-	-
Receivables – interest bearing	1.50	3,502	-	3,502	-	3,626	-	-	3,626	-
Amounts receivable for services	-	695,494	-	-	695,494	695,494	-	-	-	695,494
		851,250	**-**	**9,692**	**841,558**	**851,374**	**146,954**	**-**	**3,626**	**700,794**
Financial liabilities										
Payables	-	153,551	-	-	153,551	153,551	153,551	-	-	-
Department of Treasury loans	3.18	2,335	-	2,335	-	2,416	198	595	1,623	-
Finance lease liabilities – Joondalup Health campus	8.54	2,572	2,572	-	-	2,691	-	2,691	-	-
		158,458	**2,572**	**2,335**	**153,551**	**158,658**	**153,749**	**3,286**	**1,623**	**-**

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

(b) See note 6.4(a)

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

8.1 Financial risk management (continued)

(e) Interest rate sensitivity analysis

The following table is 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.

		-100 basis points		+100 basis points	
	Amount Exposed to Interest Rate Risk $000	Surplus $000	Equity $000	Surplus $000	Equity $000
2018					
Financial assets					
Receivables	3,502	(35)	(35)	35	35
Financial liabilities					
Department of Treasury loans	1,592	16	16	(16)	(16)
Total Increase/(Decrease)		**(19)**	**(19)**	**19**	**19**
2017					
Financial assets					
Cash and cash equivalents	6,190	(62)	(62)	62	62
Restricted cash and cash equivalents	3,502	(35)	(35)	35	35
Financial liabilities					
Department of Treasury loans	2,335	23	23	(23)	(23)
Total Increase/(Decrease)		**(74)**	**(74)**	**74**	**74**

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

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

	2018 $000	2017 $000

8.2 Contingent assets and liabilities

Contingent assets and contingent liabilities are not recognised in the Statement of Financial Position but are disclosed and, if quantifiable, measured at nominal value.

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

8.2.1 Contingent assets

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

Litigation in progress		
Pending litigation that may be recoverable on settlement of claims from former employee	640	-
Number of claims	1	-

8.2.2 Contingent liabilities

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

Litigation in progress		
Pending litigation that is not recoverable from RiskCover insurance and may affect the financial position of the Health Service.	-	340
Number of claims	-	1

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

Sites with external flammable cladding
The Department of Health is coordinating a review across the built environment for all Health Service Providers. The purpose of the review is to establish if any building contains aluminium composite cladding that may present a fire risk under the amended National Construction Code 2016 and Australian Standard AS5113:2016 Fire propagation testing and classification of external walls of buildings.

On this basis, the Department of Health has engaged the Department of Finance, Building Management and Works (BMW) to undertake the review and assessment of North Metropolitan Health Service buildings. This review process is underway and as such, at time of reporting, the NMHS is unable to determine whether any liability may arise as a result of aluminium cladding that may present a fire risk.

8.3 Fair value measurements

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).

Assets measured at fair value: 2018	**Level 1 $000**	**Level 2 $000**	**Level 3 $000**	**Fair value at end of period $000**
Land				
Vacant land	-	-	-	-
Residential	-	21	-	21
Specialised	-	3,150	221,212	224,362
Buildings				
Residential and commercial car park	-	130	9,456	9,586
Specialised	-	750	977,203	977,953
	-	**4,051**	**1,207,871**	**1,211,922**

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

8.3 Fair value measurements (continued)

Assets measured at fair value: 2017	Level 1 $000	Level 2 $000	Level 3 $000	Fair value at end of period $000
Land				
Vacant land	-	-	-	-
Residential	-	64	-	64
Specialised	-	18,270	249,632	267,902
Buildings				
Residential and commercial car park	-	59	9,818	9,877
Specialised	-	760	1,010,522	1,011,282
	-	**19,153**	**1,269,972**	**1,289,125**

Valuation techniques used to derive Level 2 fair values

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 provide the basis for fair value measurement.

Valuation techniques used to derive Level 3 fair values

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.

Land
For current use land assets, fair value is measured first 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.

Buildings and infrastructure
The Health Service's hospitals and medical centres are specialised buildings valued under the cost approach. Employee accommodation on hospital grounds is also considered as specialised buildings for valuation purpose. This approach uses the current replacement cost method that is the cost to a market participant buyer to acquire or construct a substitute asset of comparable utility, adjusted for obsolescence. Obsolescence encompasses physical deterioration, functional (technological) obsolescence and economic (external) obsolescence.

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

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

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

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

8.3 Fair value measurements (continued)

Fair value measurements using significant unobservable inputs (Level 3)

2018	Land $000	Buildings $000
Fair value at start of period	249,632	1,020,340
Additions and transfers from work in progress	-	14,028
Revaluation increments/(decrements)	(4,920)	3,467
Transfers to other reporting entity	(23,500)	-
Depreciation	-	(51,176)
Fair value at end of period	**221,212**	**986,659**

2017	Land $000	Buildings $000
Fair value at start of period	-	-
Fair value of balance transferred from abolished Health Service	249,632	919,170
Additions and transfers from work in progress	-	46,126
Revaluation increments/(decrements)	-	142,842
Transfers from/(to) other asset class	-	(51,760)
Depreciation	-	(36,038)
Fair value at end of period	**249,632**	**1,020,340**

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

Transfers in and out of a fair value level are recognised on the date of the event or change in circumstances that caused the transfer. Transfers are generally limited to assets newly classified as non-current assets held for sale, as Treasurer's instructions require valuations of land, buildings and infrastructure to be categorised within Level 3 where the valuations will utilise significant Level 3 inputs on a recurring basis.

Amendments to AASB 136
Mandatory application of AASB 2016-4 *Amendments to Australian Accounting Standards – Recoverable Amount of Non-Cash-Generating Specialised Assets of Not-for-Profit Entities* has no financial impact as the Health Service is classified as not-for-profit and regularly revalues land and buildings. Therefore, the recoverable amount of such assets is expected to be materially the same as fair value.

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

9 Other disclosures

9.1 Events occurring after the end of the reporting period

Western Australia's state-wide pathology service, PathWest Laboratory Medicine WA (PathWest), has become a separate Health Service Provider from 1 July 2018. Therefore, from July 2018 onwards, PathWest will no longer be part of NMHS.

9.2 Future impact of Australian Standards issued not yet operative

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

Title		Operative for reporting periods beginning on/after
AASB 9	*Financial Instruments* This Standard supersedes AASB 139 *Financial Instruments: Recognition and Measurement*, introducing a number of changes to accounting treatments. The mandatory application date of this Standard is currently 1 January 2018 after being amended by AASB 2012-6, AASB 2013-9 and AASB 2014-1 *Amendments to Australian Accounting Standards*. The Health Service has not yet determined the application or the potential impact of the Standard.	1 Jan 2018
AASB 15	*Revenue from Contracts with Customers* This Standard establishes the principles that the Health Service shall apply to report useful information to users of financial statements about the nature, amount, timing and uncertainty of revenue and cash flows arising from a contract with a customer. The mandatory application date of this Standard is currently 1 January 2019 after being amended by AASB 2016-7. The Health Services income is principally derived from appropriations that will be measured under AASB 1058 *Income of Not-for-Profit Entities* and will be unaffected by this change. For other type of income such as grants and contribution revenues, the Health Service has not yet determined the potential impact of the Standard. In broad terms, it is anticipated that the terms and conditions attached to these revenues will defer revenue recognition until the Health Service has discharged its performance obligations.	1 Jan 2019
AASB 16	*Leases* This Standard introduces a single lessee accounting model and requires a lessee to recognise assets and liabilities for all leases with a term of more than 12 months, unless the underlying asset is of low value. While the impact of AASB 16 has not yet been quantified, the entity currently has commitments for $15.307 million worth of non-cancellable operating leases that will mostly be brought onto the Statement of Financial Position. Interest and amortisation expense will increase and rental expense will decrease.	1 Jan 2019

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

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

AASB 1058	*Income for Not-for-Profit-Entities* This Standard clarifies and simplifies the income recognition requirements that apply to not-for-profit (NFP) entities, more closely reflecting the economic reality of NFP entity transactions that are not contracts with customers. Timing of income recognition is dependent on whether such a transaction gives rise to a liability, a performance obligation (a promise to transfer a good or service), or a contribution by owners, related to an asset (such as cash or another asset) received by a Health Service. The Health Service has not yet determined the application or the potential impact of the Standard.	1 Jan 2019
AASB 1059	*Service Concession Arrangements: Grantors* This Standard addresses the accounting for a service concession arrangement (a type of public private partnership) by a grantor that is a public sector agency by prescribing the accounting for the arrangement from the grantor's perspective. Timing and measurement for the recognition of a specific asset class occurs on commencement of the arrangement and the accounting for associated liabilities is determined by whether the grantee is paid by the grantor or users of the public service provided. The Health Service has not identified the impact of the standard.	1 Jan 2019
AASB 2010-7	*Amendments to Australian Accounting Standards arising from AASB 9 (December 2010) [AASB 1, 3, 4, 5, 7, 101, 102, 108, 112, 118, 120, 121, 127, 128, 131, 132, 136, 137, 139, 1023 & 1038 and Int 2, 5, 10, 12, 19 & 127]* This Standard makes consequential amendments to other Australian Accounting Standards and Interpretations as a result of issuing AASB 9 in December 2010. The mandatory application date of this Standard has been amended by AASB 2012-6 and AASB 2014-1 to 1 January 2018. The Health Service has not yet determined the application or the potential impact of the Standard.	1 Jan 2018
AASB 2014-1	*Amendments to Australian Accounting Standards* Part E of this standard makes amendments to AASB 9 and consequential amendments to other Standards. The Health Service has not yet determined the application or the potential impact of the Standard.	1 Jan 2018
AASB 2014-5	*Amendments to Australian Accounting Standards arising from AASB 15* This Standard gives effect to the consequential amendments to Australian Accounting Standards (including Interpretations) arising from the issuance of AASB 15. The mandatory application date of this Standard has been amended by AASB 2015-8 to 1 January 2018. The Health Service has not yet determined the application or the potential impact of the Standard.	1 Jan 2018
AASB 2014-7	*Amendments to Australian Accounting Standards arising from AASB 9 (December 2014)* This Standard gives effect to the consequential amendments to AAS (including Interpretations) arising from the issuance of AASB 9 (December 2014). The Health Service has not yet determined the application or the potential impact of the Standard.	1 Jan 2018
AASB 2015-8	*Amendments to Australian Accounting Standards – Effective Date of AASB 15* This Standard amends the mandatory application date of AASB 15 to 1 January 2018 (instead of 1 January 2017). It also defers the consequential amendments that were originally set out in AASB 2014-5. The Health Service has not yet determined the application or the potential impact of AASB 15.	1 Jan 2018
AASB 2016-3	*Amendments to Australian Accounting Standards – Clarifications to AASB 15* This Standard clarifies identifying performance obligations, principal versus agent considerations, timing of recognising revenue from granting a licence, and, provides further transitional provisions to AASB 15. The Health Service has not yet determined the application or the potential impact.	1 Jan 2018
AASB 2016-7	*Amendments to Australian Accounting Standards – Deferral of AASB 15 for Not-for-Profit Entities* This Standard defers, for not-for-profit entities, the mandatory application date of AASB 15 to 1 January 2019, and the consequential amendments that were originally set out in AASB 2014-5. There is no financial impact arising from this standard.	1 Jan 2018
AASB 2016-8	*Amendments to Australian Accounting Standards – Australian Implementation Guidance for Not-for-Profit Entities* This Standard inserts Australian requirements and authoritative implementation guidance for not-for-profit entities into AASB 9 and AASB 15. This guidance assists NFP entities in applying those Standards to particular transactions and other events. There is no financial impact.	1 Jan 2019

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

	2018	2017

9.3 Key management personnel

The Health Service has determined that key management personnel includes Ministers, Board members (accountable authority) and senior officers of the Health Service. However, the Health Service is not obligated to compensate Ministers and therefore disclosures in relation to Ministers' compensation may be found in the *Annual Report on State Finances*.

The total fees, salaries and superannuation for members of the accountable authority of the Health Service for the reporting period are presented within the following bands:

Compensation band of members of the accountable authority

$0	1	2
$30,001 – $40,000	2	-
$40,001 – $50,000	6	7
$70,001 – $80,000	1	1
	10	10

	$000	$000
Short-term employee benefits [a]	360	342
Post-employment benefits [b]	34	33
Total compensation of members of the accountable authority	**394**	**375**

Compensation band of senior officers

A senior officer is any officer who has responsibility and accountability for the functioning of a section or division that is significant in the operation of the reporting entity or who has equivalent responsibility. For the purposes of this report, senior officers comprise CEO and the head of services reporting to CEO.

The total fees, salaries, superannuation, non-monetary benefits and other benefits for senior officers of the Health Service for the reporting period are presented within the following bands:

$50,001 – $60,000	-	1
$60,001 – $70,000	1	-
$110,001 – $120,000	1	-
$140,001 – $150,000	1	-
$170,001 – $180,000	1	-
$180,001 – $190,000	3	-
$190,001 – $200,000	-	1
$200,001 – $210,000	-	1
$210,001 – $220,000	1	-
$220,001 – $230,000	1	2
$230,001 – $240,000	1	2
$240,001 – $250,000	1	-
$260,001 – $270,000	1	1
$280,001 – $290,000	-	1
$310,001 – $320,000	1	1
$320,001 – $330,000	1	-
$380,001 – $390,000	-	1
$420,001 – $430,000	1	1
$490,001 – $500,000	1	-
$530,001 – $540,000	-	2
$580,001 – $590,000	-	1
Total:	**16**	**15**

	$000	$000
Short-term employee benefits [a]	2,890	3,580
Post employment benefits [b]	313	424
Other long-term benefits [c]	348	339
Termination benefits [d]	241	361
Total compensation of senior officers	**3,792**	**4,704**

The 2017 figures have been restated for comparative purpose. The restatement is required due to a different interpretation of the accounting standard.

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9.3 Key management personnel (continued)

(a) The short-term employee benefits include salary, motor vehicle benefits, district and travel allowances incurred by the Health Service in respect of senior officers.
(b) The post-employment benefits represent the employer superannuation contributions.
(c) The other long-term benefits comprise annual and long service leave accrued during the current financial year.
(d) Termination benefits include severance payments, annual and long service leaves paid on terminations.

9.4 Related party transactions

The Health Service is a wholly owned and controlled entity of the State of Western Australia. In conducting its activities, the Health Service is required to pay various taxes and levies (such as transfer duty and licensing duty) to the State and entities related to State. The payment of these taxes and levies is based on the standard terms and conditions that apply to all tax and levy payers.

Related parties of the Health Service include:

• all senior officers and their close family members, and their controlled or jointly controlled entities;
• all cabinet ministers and their close family members, and their controlled or jointly controlled entities;
• other departments and public sector entities, including related bodies included in the whole-of-government consolidated financial statements;
• associates and joint ventures, that are included in the whole-of-government consolidated financial statements; and
• GESB.

All related party transactions have been entered into on an arm's length basis.

Significant Transactions with Government-related entities

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

• service & capital appropriations
The Health Service receives appropriation funding from Treasury via the Department of Health to cover the net cost of service and project delivery.

• services received free of charge
The Health Service receives ICT, financial, human resources and supply chain services provided free of charge from HSS. The Health Service also leases accommodation free of charge from the Department of Finance.

• pathology services
The Health Service provides pathology services to other Health Service Providers, WA Police and the Department of the Attorney General.

The Health Service makes payments to:
• The Insurance Commission and RiskCover for the provision of insurance;
• State Fleet for the provision of motor vehicle fleet management;
• The Auditor General as remuneration for the provision of audit service.

Material transactions with related parties

Outside of normal citizen type transactions with the Health Service, there were no related party transactions that involved key management personnel and their close family members. No provision for doubtful debts has been required, any commitments disclosed, nor any expense incurred.

Significant transactions with other related parties

The Health Service makes superannuation payments to GESB as nominated by employees.

9.5 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.

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

	2018 $000	2017 $000

9.6 Affiliated bodies

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

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

9.7 Special purpose accounts

Mental Health Commission Fund Account

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

Balance at the start of period	124	-
Add Receipts		
Transfers from abolished Health Service	-	685
Service delivery agreement		
Commonwealth contributions	72,734	64,346
State contributions	168,215	168,952
Other	1,633	1,724
	242,582	235,022
Less Payments	(242,582)	(235,583)
Balance at the end of period	**124**	**124**

The special purpose accounts are established under section 16(1)(d) of FMA.

9.8 Remuneration of auditors

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	288	165

9.9 Equity

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 9.9.2 Asset revaluation reserve).

9.9.1 Contributed equity

Balance at start of period	1,794,228	-
Contributions by owners [c]		
Capital appropriation [b]	24,677	29,923
Transfers of net assets from abolished Health Service [a] [c]	-	1,789,941
Write-down of net assets transferred from abolished Health Service [f]	(361)	(3,356)
Transfer of land and building from Health Ministerial Body (HMB)[g]	15,300	-
Transfers of other assets from other agencies	(1)	880
Total contributions by owners	**1,833,843**	**1,817,388**
Distributions to owners [c] [d]		
Transfer of Amount Receivables for Services to EMHS [e]	-	(8,920)
Transfer of land for the Midland Public Hospital to EMHS	-	(13,200)
Transfer of lands and buildings to Health Ministerial Body (HMB):		
Selby Reserve in Shenton Park [g]	(38,800)	-
Perth Chest Clinic [h]	(4,071)	-
Middle Swan land [i]	(11,000)	-
Transfers of other assets to other agencies	-	(1,040)
Total distributions to owners	**(53,871)**	**(23,160)**
Balance at end of period	**1,779,972**	**1,794,228**

Notes to the Financial Statements
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	2018 $000	2017 $000

9.9.1 Contributed equity (continued)

(a) The *Health Services Act 2016* has been enacted to replace the *Hospitals and Health Services Act 1927* as from 1 July 2016. The old Metropolitan Health Service as a statutory authority was abolished and its assets and liabilities transferred to five health service providers (CAHS, EMHS, NMHS, SMHS and HSS), which are separate statutory authorities.

(b) 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'*.

(c) 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 Health Service accounts for a non-discretionary and non-reciprocal transfer of net assets as a contribution by owners, the transferor Health Service accounts for the transfer as a distribution to owners.

(d) 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.

(e) The St John of God Midland Public Hospital (SJOG MPH) assets were transferred to EMHS from the abolished Metropolitan Health Service at the establishment of EMHS as a new statutory reporting entity at 1 July 2016. The Amount Receivables for Services (ARS), also known as Holding Accounts, for depreciation associated with SJOG MPH assets were however transferred to NMHS at the opening balance 1 July 2016. In May 2017, the ARS balance of $8.92 million associated with SJOG MPH assets was transferred from NMHS to EMHS. The transfers were accounted for under equity as it relates to the original restructure (abolishment of Metropolitan Health Service and creation of new statutory reporting entities).

(f) Some work in progress amounts included in the property, plant and equipment transferred from the abolished Health Service as explained under note 9.9.1 Contributed equity (a) above were subsequently written down as new information became available after the initial transfers. The write-down was accounted for under equity as it relates to the original transfers.

(g) A single block of land held by NMHS (Selby Reserve) was transferred to the Health Ministerial Body (HMB) as non-discretionary transfer. HMB split the block into three smaller parcels of lands. Of these three new blocks, one was then transferred to NMHS and one was transferred to the Department of Education (both transfers were accounted for as discretionary transfers), leaving one block retained by HMB.

(h) The land and buildings relating to the Perth Chest Clinic have been transferred to the Health Ministerial Body for disposal.

(i) The Middle Swan land is registered as surplus asset. HMB has organised with LandCorp to undertake the rezoning for the purpose of selling the land. Therefore, the land was transferred to HMB and retained by HMB until sold.

9.9.2 Asset revaluation reserve [(a)]

Balance at start of period	143,436	-
Net revaluation increments/(decrements):		
Land	(676)	676
Buildings	3,544	142,760
	146,304	**143,436**

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

Asset revaluation decrement recognised as an expense:		
Land	4,337	-

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

	2018 $000	2017 $000
9.9.3 Accumulated surplus (deficit)		
Balance at start of period	52,878	-
Result for the period	(11,518)	52,878
	41,360	**52,878**

9.10 Supplementary financial information

(a) Revenue, public and other property written off

Revenue and debts written off under the authority of the Accountable Authority	6,376	349
Public and other property written off under the authority of the Accountable Authority	-	-
Revenue and debts written off under the authority of the Minister	-	-
	6,376	**349**

(b) Losses of public monies and other property

Losses of public monies, and public or other property through theft or default	40	150
Less amount recovered	(14)	(68)
	26	**82**

(c) Services provided free of charge

During the reporting 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	1,788	1,413
Disability Services Commission – dental treatment	1,805	1,925
Aboriginal Community Controlled Health Services – dental treatment	1,075	785
East Metropolitan Health Service – pathology services [(a)]	14,433	22,056
South Metropolitan Health Service – pathology services [(a)]	22,514	30,175
WA Country Health Services – pathology services [(a)]	23,482	29,491
Child and Adolescent Health Service – pathology services [(a)]	4,878	6,005
	69,975	**91,850**

(a) Represent the cost of providing pathology services above the amounts billed to other Health Services.

9.11 Other statement of receipts and payments

Commonwealth Grant - Christmas and Cocos Island

Balance at the start of period	-	-
Receipts		
Commonwealth grant	72	24
Payments		
Purchase of health services	(72)	(24)
Balance at the end of period	**-**	**-**

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

9.12 Explanatory statement

For the year ended 30 June 2018

All variances between estimates (original budget) and actual results for 2018 are shown below. Narratives are provided for major variances, which are defined as generally greater than 5% and $25 million.

Statement of Comprehensive Income

	Note	2018 Estimate $000	2018 Actual $000	2017 Actual $000	Variance between estimate and actual $000	Variance between actual 2017 and 2018 $000
COST OF SERVICES						
Expenses						
Employee benefits expense	1	1,289,481	1,388,748	1,356,459	99,267	32,289
Contracts for services	2	396,939	439,116	429,812	42,177	9,304
Patient support costs		296,184	316,789	325,982	20,605	(9,193)
Finance costs		184	179	596	(5)	(417)
Depreciation and amortisation expense		64,773	78,825	61,869	14,052	16,956
Asset revaluation decrement		-	4,337	-	4,337	4,337
Loss on disposal of non-current assets		-	86	393	86	(307)
Repairs, maintenance and consumable equipment		63,546	44,374	49,459	(19,172)	(5,085)
Other supplies and services		72,244	78,585	78,729	6,341	(144)
Other expenses		74,284	98,173	101,949	23,889	(3,776)
Total cost of services		**2,257,635**	**2,449,212**	**2,405,248**	**191,577**	**43,964**
INCOME						
Revenue						
Patient charges		107,789	119,959	113,784	12,170	6,175
Other fees for services	3	59,477	176,207	184,813	116,730	(8,606)
Commonwealth grants and contributions	4, a	554,032	668,115	619,939	114,083	48,176
Other grants and contributions	5	244,291	174,313	179,495	(69,978)	(5,182)
Donation revenue		640	2,170	1,014	1,530	1,156
Interest revenue		-	54	587	54	(533)
Other revenue	6	72,210	21,672	21,204	(50,538)	468
Total Revenue		**1,038,439**	**1,162,490**	**1,120,836**	**124,051**	**41,654**
Total income other than income from State Government		**1,038,439**	**1,162,490**	**1,120,836**	**124,051**	**41,654**
NET COST OF SERVICES		**1,219,196**	**1,286,722**	**1,284,412**	**67,525**	**2,310**
INCOME FROM STATE GOVERNMENT						
Service appropriations	b	1,155,632	1,205,059	1,271,598	49,427	(66,539)
Assets assumed/(transferred)		-	(210)	(64)	(210)	(146)
Services received free of charge		63,564	69,973	65,617	6,409	4,356
Royalties for Regions Fund		-	382	139	382	243
Total income from State Government		**1,219,196**	**1,275,204**	**1,337,290**	**56,008**	**(62,086)**
SURPLUS/(DEFICIT) FOR THE PERIOD		**-**	**(11,518)**	**52,878**	**(11,518)**	**(64,396)**
OTHER COMPREHENSIVE INCOME/(LOSS)						
Items not reclassified subsequently to profit or loss						
Changes in asset revaluation reserve		-	2,868	143,436	2,868	(140,568)
Total other comprehensive income/(loss)		**-**	**2,868**	**143,436**	**2,868**	**(140,568)**
TOTAL COMPREHENSIVE INCOME/(LOSS) FOR PERIOD		**-**	**(8,650)**	**196,314**	**(8,650)**	**(204,964)**

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

9.12 Explanatory statement (continued)

Statement of Financial Position		2018 Estimate $000	2018 Actual $000	2017 Actual $000	Variance between estimate and actual $000	Variance between actual 2017 and 2018 $000
ASSETS						
Current Assets						
Cash and cash equivalents		28,317	46,412	33,617	18,095	12,795
Restricted cash and cash equivalents		50,398	45,542	50,399	(4,856)	(4,857)
Receivables		76,449	63,454	70,276	(12,995)	(6,822)
Inventories		6,658	5,230	6,658	(1,428)	(1,428)
Other current assets		12,231	6,957	5,919	(5,274)	1,038
Total Current Assets		**174,053**	**167,595**	**166,869**	**(6,458)**	**726**
Non-Current Assets						
Restricted cash and cash equivalents		10,600	6,376	5,300	(4,224)	1,076
Amounts receivable for services	c	760,267	774,984	695,494	14,717	79,490
Receivables		3,502	3,502	3,502	-	-
Property, plant and equipment	d	1,586,417	1,517,014	1,604,097	(69,403)	(87,083)
Intangible assets		4,184	12,238	6,222	8,054	6,016
Total Non-Current Assets		**2,364,970**	**2,314,114**	**2,314,615**	**(50,856)**	**(501)**
Total Assets		**2,539,023**	**2,481,709**	**2,481,484**	**(57,314)**	**225**
LIABILITIES						
Current Liabilities						
Payables		163,112	153,729	153,551	(9,383)	178
Borrowings		678	777	3,315	99	(2,538)
Employee benefits provisions	7, e	263,573	291,158	263,573	27,585	27,585
Other current liabilities		910	1,045	980	135	65
Total Current Liabilities		**428,273**	**446,709**	**421,419**	**18,436**	**25,290**
Non-Current Liabilities						
Borrowings		914	815	1,593	(99)	(777)
Employee benefits provisions	7, e	67,929	66,549	67,929	(1,380)	(1,380)
Total Non-Current Liabilities		**68,843**	**67,364**	**69,522**	**(1,479)**	**(2,158)**
Total Liabilities		**497,116**	**514,073**	**490,941**	**16,957**	**23,132**
NET ASSETS		**2,041,907**	**1,967,636**	**1,990,543**	**(74,271)**	**(22,907)**
EQUITY						
Contributed equity		1,898,471	1,779,972	1,794,228	(118,499)	(14,256)
Reserves		143,436	146,304	143,436	2,868	2,868
Accumulated surplus /(deficit)		-	41,360	52,878	41,360	(11,518)
TOTAL EQUITY		**2,041,907**	**1,967,636**	**1,990,542**	**(74,271)**	**(22,906)**

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

9.12 Explanatory statement (continued)

Statement of Cash Flows

		2018 Estimate $000	2018 Actual $000	2017 Actual $000	Variance between estimate and actual $000	Variance between actual 2017 and 2018 $000
			Inflows (Outflows)	Inflows (Outflows)		
CASH FLOWS FROM STATE GOVERNMENT						
Service appropriations	b	1,090,793	1,125,506	1,194,242	34,713	(68,736)
Capital appropriations		51,644	39,234	29,213	(12,410)	10,021
Royalties for Regions Fund		-	382	139	382	243
Net cash provided by State Government		**1,142,437**	**1,165,122**	**1,223,594**	**22,684**	**(58,473)**
Utilised as follows:						
CASH FLOWS FROM OPERATING ACTIVITIES						
Payments						
Employee benefits	1	(1,284,181)	(1,359,108)	(1,340,870)	(74,927)	(18,238)
Supplies and services	9, g	(839,633)	(883,287)	(933,650)	(43,654)	50,363
Finance costs		(118)	(118)	(511)	-	393
Receipts						
Receipts from customers		107,789	115,227	109,494	7,438	5,733
Commonwealth grants and contributions	4, a	554,032	668,115	619,939	114,083	48,176
Other grants and contributions	5	244,291	174,313	179,495	(69,978)	(5,182)
Donations received		640	699	976	59	(277)
Interest received		-	116	536	116	(420)
Other receipts	8, f	131,687	186,117	213,356	54,430	(27,239)
Net cash used in operating activities		**(1,085,493)**	**(1,097,926)**	**(1,151,235)**	**(12,433)**	**53,309**
CASH FLOWS FROM INVESTING ACTIVITIES						
Payments						
Payment for purchase of non-current physical and intangible assets		(49,072)	(55,609)	(52,761)	(6,537)	(2,848)
Receipts						
Proceeds from sale of non-current physical assets		-	-	162	-	(162)
Net cash used in investing activities		**(49,072)**	**(55,609)**	**(52,599)**	**(6,537)**	**(3,010)**
CASH FLOWS FROM FINANCING ACTIVITIES						
Payments						
Repayment of finance lease liabilities		(2,572)	(2,572)	(4,513)	-	1,941
Net cash used in financing activities		**(2,572)**	**(2,572)**	**(4,513)**	**-**	**1,941**
Net increase / (decrease) in cash and cash equivalents		5,300	9,015	15,247	3,715	(6,233)
Cash and cash equivalents at the beginning of the period		89,315	89,315			
Cash and cash equivalents transferred from abolished agency			-	74,068	-	(74,068)
Cash and cash equivalents transferred to other agencies		(5,300)	-	-	5,300	-
CASH AND CASH EQUIVALENTS AT END OF PERIOD		**89,315**	**98,330**	**89,315**	**9,015**	**(80,301)**

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

9.12 Explanatory statement (continued)

Significant variances between estimate and actual for 2018

1 **Employee benefits expense**
The higher actual employee benefits expense compared with the estimate is attributed to (i) actuarial adjustment to the leave provision (liability) at the end of the financial year ($14.5 million) (ii) voluntary severance scheme payment ($6.3 million) (iii) transfer of Commonwealth programs to be performed by NMHS during the year that were not included in the estimate ($3.6 million). The balance of the variance is the result of the estimate being offset by Pathwest revenue, whereas the actual has no revenue offset. The actual Pathwest revenue is included in 'Other fees for services' ($81 million).

2 **Contracts for services**
Estimate includes only contract payments for in-hospital services. Actuals include contract payments for purchase of non-hospital related services.

3 **Other fees for services**
In the estimate, a portion of the estimated income for pathology services provided by Pathwest to organisations and patients external to NMHS were reported under 'Other revenue' ($20 million) with the remainder offset as recoveries against employee benefits expense ($81 million). The actual income for these services have been reported under 'Other fees for services' revenue ($101 million). Similarly in the Statement of Cash Flows, a portion of the estimated receipt for the pathology service were reported under "Other receipts" ($20 million) with the remainder offset against "Employee benefits" ($81 million). The actual receipt for the pathology services were recorded as "Other receipts" ($101 million)

4 **Commonwealth grants and contributions**
See explanation under 5 'Other grants and contributions' below for the $66.3 million variance. Dental Health Service received $7 million in revenue from the Commonwealth under the National Partnership Agreement (NPA) subsequent to the estimate. In addition, there were various adjustments to Commonwealth programs during the financial year that were not included in the estimate ($6.7 million). These adjustments include the organ tissue donation program and expansion of the Breastscreen Australia program.

5 **Other grants and contributions**
Mental Health Commission (MHC) funding sourced from the State is recorded as revenue under 'Other grants and contributions', whereas MHC funding sourced from the Commonwealth is reported under 'Commonwealth grants and contributions'. When the estimate was prepared, it was not known whether the $66.3 million MHC funding was to be sourced from the State or the Commonwealth. In the estimate, the source of the funding was considered State and thus reported under 'Other grants and contributions'; however, in the actual, the source of funding was Commonwealth and thus is reported under 'Commonwealth grants and contributions'.

6 **Other revenue**
See explanation under 3. 'Other fees for services'.

7 **Employee benefits provisions**
The actual was higher than estimate due to an upward adjustment of $14.5 million from the actuarial valuation at the end of financial year (30 June 2018), which was not foreseeable when the estimate was prepared. In addition, leave provision (liability) transferred to NMHS for employees associated with Commonwealth programs also contributed to the increase (see explanation under 1. 'Employee benefits expense').

8 **Other receipts**
See explanation under 3. 'Other fees for services'.

9 **Supplies and services**
The variance in payment for supplies and services is driven by lower drug supplies ($15.5 million) and various timing differences of payments.

Significant variances between actual 2017 and actual 2018

a **Commonwealth grants and contributions**
The increase in Commonwealth grants and contributions is due to the change in the funding structure against the State appropriations (state funding). The increase is reflected by a decrease in service appropriations (state funding).

b **Service appropriations**
See explanation under a) 'Commonwealth grants and contributions' above.

c **Amounts receivable for services**
The increase is due to non-cash appropriation for asset replacement.

d **Property, plant and equipment**
The reduction in Property, plant and equipment balance is mainly due to $78.8 million in depreciation and amortisation expense and transfer of $38.7 million to other reporting entities. However, the Property, plant and equipment was also offset by additions of $32.4 million.

e **Employee benefits provisions**
See explanation under 7. 'Employee benefits provisions'.

f **Other receipts**
See explanation under 3. 'Other fees for services'.

g **Supplies and services**
See explanation under 9. 'Supplies and services'.

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

10 Administered disclosures

	Notes
Disclosure of administered income and expenses by service	10.1

10.1 Disclosure of administered income and expenses by service

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 monies.

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

	2018 $000	2017 $000
Balance at the start of period	176	156
Add Receipts	1,127	1,093
Less Payments	(1,146)	(1,073)
Balance at the end of period	**157**	**176**

b) Other trust accounts not controlled by the Health Service:

RF Shaw Foundation	1,226	1,201
King Edward Memorial Clinical Staff Association	53	48
	1,279	**1,249**

Balance at the start of period	1,249	1,221
Add Receipts	29	28
Less Payments	-	-
Balance at the end of period	**1,278**	**1,249**

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.

Appendices

A Abbreviations and acronyms

ABF	Activity Based Funding
ACHS	Australian Council on Healthcare Standards
ABI	Acquired Brain Injury
AHLO	Aboriginal Health Liaison Officer
AIHW	Australian Institute of Health and Welfare
CAC	Community Advisory Council
CAHS	Child and Adolescent Health Service
CaLD	Culturally and Linguistically Diverse
CCC	Corruption and Crime Commission
DAIP	Disability Access and Inclusion Plan
DAMA	Discharged Against Medical Advice
DSC	Disabilities Service Commission
DHS	Dental Health Service
ECU	Edith Cowan University
EEO	Equal Employment Opportunity
EDRMS	Electronic Document and Records Management System
ED	Emergency Department
EMHS	East Metropolitan Health Service
FiCare	Family Integrated Care
FMA	*Financial Management Act 2006*
GESB	Government Employees Superannuation Board
GSS	Gold State Superannuation Scheme
HA-SABSI	Healthcare-associated *Staphylococcus aureus* bloodstream infections
HSP	health service provider
HSS	Health Support Services
ICT	Information, Communications and Technology
IM	Injury Management
IOMRI	Intraoperative Magnetic Resonance Imaging
JHC	Joondalup Health Campus
KEMH	King Edward Memorial Hospital
KPI	key performance indicator
MHOA	Mental Health Observation Area
NEC	necrotising enterocolitis
NHMRC	National Health and Medical Research Council
NICU	Neonatal Intensive Care Unit
NMHS	North Metropolitan Health Service
NSMHS	National Standards for Mental Health Services
NSQHS	National Safety and Quality Health Service
NSU	Neurosciences Unit
NMHS	North Metropolitan Health Service
OAG	Office of the Auditor General
OBM	outcome-based management
OPH	Osborne Park Hospital
OSH	occupational health and safety
PHAC	Public Health and Ambulatory Care
PPP	public–private partnership
PSC	Public Sector Commission
QEIIMC	Queen Elizabeth II Medical Centre
SAC	Severity Assessment Code
SARC	Sexual Assault Referral Centre
SCGH	Sir Charles Gairdner Hospital
SCGOPHCG	Sir Charles Gairdner Osborne Park Health Care Group
SJGHC	St John of God Health Care
TI	Treasurer's Instruction
UWA	The University of Western Australia
WA	Western Australia/n
WACHS	WA Country Health Service
WSS	West State Superannuation Scheme
WNHS	Women and Newborn Health Service
YHiTH	Youth Hospital in The Home

B Contact information

NMHS

Street address: Queen Elizabeth II Medical Centre, 2 Verdun Street, NEDLANDS WA 6009
Postal address: Locked Bag 2012, NEDLANDS WA 6009
Telephone: (08) 6457 3496
Web: www.nmhs.health.wa.gov.au

Sir Charles Gairdner Hospital

Street address: Queen Elizabeth II Medical Centre, 2 Verdun Street, NEDLANDS WA 6009
Postal address: Locked Bag 2012, NEDLANDS WA 6009
Telephone: (08) 6457 3333
Fax: (08) 6457 3759
Web: www.scgh.health.wa.gov.au

NMHS Public Health and Ambulatory Care

Address: 54 Salvado Road, WEMBLEY WA 6014
Telephone: (08) 9380 7700
Fax: (08) 9380 7719
Email: NMHS.PHACSQ@health.wa.gov.au
Web: www.scgh.health.wa.gov.au

NMHS Mental Health

Street address: 83 Fairfield Street, MT HAWTHORN WA 6016
Postal address: Private Bag 1, CLAREMONT WA 6910
Telephone: (08) 9242 9642
Fax: (08) 9242 9644
Web: www.nmahsmh.health.wa.gov.au
Email: NMHS.MHExecOffice@health.wa.gov.au

Osborne Park Hospital

Street address: 36 Osborne Park Place, STIRLING WA 6021
Postal address: Private Bag 1, CLAREMONT WA 6910
Telephone: (08) 9346 8000
Fax: 9346 8008
Web: www.oph.health.wa.gov.au

Women and Newborn Health Service

Street address: 374 Bagot Road, SUBIACO WA 6008
Postal address: PO Box 134, SUBIACO WA 6904
Telephone: (08) 6458 2222
Email: kemhcsu@health.wa.gov.au
Web: www.kemh.health.wa.gov.au

PathWest

Street address: J Block, Queen Elizabeth II Medical Centre, 2 Verdun Street, NEDLANDS WA 6009
Postal address: Locked Bag 2009, NEDLANDS WA 6909
Telephone: (08) 9346 3000
Fax: (08) 9381 7594
Email: pathwest@health.wa.gov.au
Web: pathwest.health.wa.gov.au

Dental Health Service

Street address: 43 Mount Henry Road, COMO WA 6152
Postal address: Locked Bag 15, BENTLEY DELIVERY CENTRE WA 6983
Telephone: (08) 9313 0555
Fax: (08) 9313 1302
Email: enquiries@dental.health.wa.gov.au
Web: www.dental.wa.gov.au

BreastScreen WA

Address: 9th Floor, Eastpoint Plaza, 233 Adelaide Terrace, PERTH WA 6000
Telephone: (08) 9323 6700
Fax: (08) 9323 6799
Email: breastscreenwa@health.wa.gov.au
Web: www.breastscreen.health.wa.gov.au

Joondalup Health Campus (Public)*

Address: Shenton Avenue, JOONDALUP WA 6027
Telephone: (08) 9400 9400

*Operated on behalf of the State Government by Joondalup Hospital Pty Ltd, a subsidiary of Ramsay Health Care

Graylands Hospital Campus

Street address: Brockway Road, Mount Claremont WA 6010
Postal address: PO Private Bag No. 1, Claremont WA 6910
Telephone: (08) 9347 6600
Fax: (08) 9385 2701
Email: Feedback.NMHSMH@health.wa.gov.au

C Board and committee remuneration, 2017/18

NMHS Board

Position	Name	Type of remuneration	Period of membership (months)	Gross/actual remuneration, $
Chair	Professor Bryant Stokes AM	Per annum	12	72,356
Deputy Chair	Dr Rosanna Capolingua	Per annum	12	43,414
Member	Dr Margaret Crowley	Per annum	12	43,414
Member	Dr Felicity Jefferies	Per annum	8	30,056
Member	Michele Kosky AM	Per annum	12	43,414
Member	Dr Rhonda Marriott	Per annum	7	30,891
Member	Geoff Mather	Per annum	12	43,414
Member	Graham McHarrie	Per annum	12	43,414
Member	Maria Saraceni	Per annum	12	43,414
Member	Professor Grant Waterer	Per annum	12	0
			Total	**393,787**

Graylands Hospital Management Team Meeting

Position	Name	Type of remuneration	Period of membership (months)	Gross/actual remuneration, $
Chair	Dr Samir Heble	Per hour	12	Nil
Deputy Chair	Michael Sitas	Per hour	5	Nil
Member	Hazel McLean	Per hour	8	Nil
Member	Dannielle Orifici	Per hour	12	Nil
Member	Azlee Sultan	Per hour	10	Nil
Member	Ann Brown	Per hour	12	Nil
Member	Tony Jonikis	Per hour	12	Nil
Member	Naomi Oliver	Per hour	3	Nil
Member	Sue Bascombe	Per hour	12	Nil
Member	Patricia Fonceca	Per hour	12	Nil
Member	Kevin Lau	Per hour	12	Nil
Member	Serene Teh	Per hour	12	Nil
Member	Lisa Valentine	Per hour	6	Nil
Member	Janie Ingram	Per hour	4	Nil
Member	Robyn Vogel	Per hour	11	Nil
Member	Patricia Tran	Per hour	8	Nil
Member	Ron Deng	Per hour	8	Nil
Member	Rachel Megan Dixon	Per hour	1	60
			Total	**60**

KEMH Community Advisory Committee

(name changed to Women and Newborn Health Service Community Advisory Council)

Position	Name	Type of remuneration	Period of membership (months)	Gross/actual remuneration, $
Chair	Jody Blake	Per meeting	12	1,380
Vice Chair	Sonja Whimp	Per meeting	12	1,290
Member	Amanda Hocking	Per meeting	12	750
Member	Ann McRae	Per meeting	12	840
Member	Briony McKenzie	Per meeting	2	60
Member	Gail Yarran	Per meeting	12	660
Member	Gemma Cadby	Per meeting	12	780
Member	Jamie Yallup Farrant	Per meeting	5	420
Member	Jane Jones	Per meeting	12	600
Member	Maureen Helen	Per meeting	12	1,050
Member	Nicole Woods	Per meeting	12	720
Member	Sarah Sibson	Per meeting	11	330
Member	Wendy Hunt	Per meeting	6	330
Member	Maryam Aghamohammadi	Per meeting	12	420
Member	Joanne Beedie	Per meeting	5	300
Member	Caitlin Kameron	Per meeting	5	300
Member	Alison Vaughan	Per meeting	5	210
			Total	**10,440**

OPH Community Advisory Council

Position	Name	Type of remuneration	Period of membership (months)	Gross/actual remuneration, $
Chair	Joan Varian	Per meeting	12	390
Deputy Chair	Joey Cookman	Per meeting	12	240
Member	Peter Merralls	Per meeting	4	195
Member	Pam Van Ome	Per meeting	12	397
Member	Tom Benson	Per meeting	12	330
Member	Ramah Raymond	Per meeting	1	60
Member	Dianne Glenister	Per meeting	12	540
Member	Sue Haydon	Per meeting	12	525
Member	Beverley Port-Louis	Per meeting	12	330
Member	Diane Yappo	Per meeting	12	330
Member	Merriane Soloways	Per meeting	7	360
			Total	**3,697**

D NMHS Board member meetings, 2017/18

The number of Board and Board committee meetings, and the number of meetings attended by each Board member during the 12 months ending 30 June 2018, are shown in the table below.

	Board		Audit & Risk		Safety & Quality		Finance		Engagement	
Number of meetings held	**12**		**6**		**10**		**11**		**8**	
	Attended	**Eligible to attend**	**Attended**	**Eligible to attend**	**Attended**	**Eligible to attend**	**Attended**	**Eligible to attend**	**Attended**	**Eligible to attend**
Professor Bryant Stokes AM (Chair)	11	12								
Dr Rosanna Capolingua (Deputy Chair)	11	12	1	6	9	10				
Dr Margaret Crowley	12	12	3	6	5	5			7	8
Dr Felicity Jefferies	6	7					6	7	3	5
Michele Kosky AM	12	12	6	6	10	10			5	8
Dr Rhonda Marriott	5	7								
Geoff Mather	11	12					9	11	7	8
Graham McHarrie	12	12	4	6			11	11		
Maria Saraceni	10	12	6	6						
Professor Grant Waterer	10	12			6	10	9	11		

E NMHS staff awards and recognition, 2017/18

Date	Title of achievement	Recipient name, department	Service
Jul-17	Sole St John Ambulance Volunteer representative for 2017 Emergency Services Conference in Copenhagen	Maria Godwell, Dental Therapy	DHS
Jul-17	Telethon Children's Ward, winner Bankwest WA Master Builders Excellence in Construction Awards	Jim Lynton, Facilities Management	JHC
Jul-17	Mental Health Employee Excellence Award for Outstanding Contribution to mental health in Western Australia by an individual employed in the sector, WA Association for Mental Health	Andrew Miller, Graylands Hospital	NMHS MH
Jul-17	Clinical Champion for Cognitive Commitment to Care Campaign	Meegan Truarn, Occupational Therapy	OPH
Jul-17	Rotary Nurse of the Year Excellence in Graduate Nursing	Denise Lynch, Nursing	SCGH
Jul-17	Rotary Nurse of the Year Excellence in Clinical Nursing	Lucy Stopher, Nursing	SCGH
Jul-17	Rotary Nurse of the Year Excellence in Leadership	Mary King, Nursing	SCGH
Aug-17	Finalist, WA Innovator of the Year, Research Innovation and Enterprise	Professor Tim Inglis, Clinical Microbiology	PathWest
Aug-17	Inaugural IQ Award for Research Innovation and Enterprise, UWA	Professor Tim Inglis, Clinical Microbiology	PathWest
Aug-17	Best Clinical Paper Award, Australian Cardiovascular Health and Rehabilitation Associations Annual Scientific Meeting	Hazel Mountford, Physiotherapy	SCGH
Sept-17	Finalist for WA Apprentice of the Year 2017	Lauren Bruce-Smith, Dental Health Service	DHS
Sep-17	Shimadzu Award: Inaugural winner, for research into the advancement of radiopharmaceutical science, Australian and New Zealand Society of Nuclear Medicine Annual Scientific Meeting	Dr Joe Ioppolo, Medical Technology and Physics	SCGH
Sep-17	Australasian Simulation Conference 2017 Best Paper Award	Di Dennis, Physiotherapy	SCGH
Sep-17	Fellowship of the Australasian College of Health Service Management	Dr David Joske, Medical Specialties Division	SCGH
Sep-17	Fellowship of the Australasian College of Health Service Management	Jan Honter, Executive Services	SCGH
Sep-17	National Stroke Foundation 2017 Stroke Care Champion Award, Stroke Society Australasia Conference	Erin Godecke, Speech Pathology	SCGH
Sep-17	Certificate of Commendation, Rotary Allied Health Team Excellence Awards	Pharmacy Team	WNHS
Oct-17	Paul Ramsay Foundation $13 million donation to ORIGINS project, a collaborative research project being run by JHC and the Telethon Kids Institute. Funding has been matched by the federal government dollar-for-dollar	Professor Desiree Silva, Paediatrics	JHC

Date	Title of achievement	Recipient name, department	Service
Oct-17	WA Nursing & Midwifery Excellence Graduate of the Year Award 2017	Ashleigh Joy, Midwifery	OPH
Oct-17	WA Nursing & Midwifery Excellence Consumer Appreciation Award 2017	Elena Adams, Nursing	OPH
Oct-17	2017 Churchill Fellowship, Exploring aphasia therapies that optimise communication from hospital to home (post-stroke)	Deborah West and Angela Cream, Speech Pathology	OPH
Oct-17	Elected National President, Institute of Healthcare Engineering, Australia	Peter Easson, Facilities Management	NMHS
Oct-17	WA Health Service Union Clinical Excellence Award	Belinda Morrell, Speech Pathology	SCGH
Oct-17	Department of Health's Future Health WA Merit Awards funding – 'Best evidence: helping enhance aphasia rehabilitation using local data (BE HEARD)'	Erin Godecke, Speech Pathology	SCGH
Oct-17	SCGH Support Staff Recognition	Lesley Harland, Social Work	SCGH
Oct-17	Paywise Rookie of the Year	Sian Fitzgerald, Occupational Therapy	SCGH
Oct-17	Paywise Outstanding Contribution	Tracy Hebden-Todd, Physiotherapy	SCGH
Oct-17	Carers WA Commitment to Improving Carer Engagement Award	Ward C16	SCGH
Oct-17	Carer's WA Outstanding Support of Carers Award	Ward C17	SCGH
Oct-17	Carers WA Continued Support of Carers Award	Ward G72	SCGH
Oct-17	Curtin Graduate Diploma in Midwifery Clinical Midwifery Prize	Lea Hulbert, Midwifery	WNHS
Oct-17	Society of Hospital Pharmacists in Australia (WA) Awards, Early Career Pharmacist	Monica Sajogom, Pharmacy	WNHS
Oct-17	Society of Hospital Pharmacists in Australia (WA) Awards, Intern of the Year	Carla Payne, Pharmacy	WNHS
Oct-17	Jon Rampono Award for Significant Contribution to Perinatal Mental Health, Australasian Marcé Society for Perinatal Mental Health	Megan Galbally, Women's Health, Genetics and Mental Health	WNHS
Oct-17	Innovative Practice Category in the Rotary Allied Health Excellence Awards 2017	Andrew Miller, Barbara Murray, Isobel Wallace, Jess Darmody, Jo Varne, Alan, Stone Jessica Dennis, Patricia Tran, Ruth Hill, Rob Miller Doreen Sanyika, Petra Elias	Graylands Hospital NMHS MH
Nov-17	Dementia Champion, Alzheimer's WA	Christine Robinson, Social Work	OPH
Nov-17	Rotary Club of Osborne Park Recognition, Hospital Equipment for Cambodia Project 2018	Diane Evans, Occupational Therapy	OPH
Nov-17	2017 Nursing New Investigator Award, Research Week	Debbie Fortnum, Dialysis	SCGH, JHC
Nov-17	Australian & New Zealand Hip Fracture Registry Annual Report	Orthopaedic Surgery, SCGH	SCGH
Nov-17	WA Health Excellence Award – workforce initiatives to improve service delivery (theatre efficiency)	Surgical Division, SCGH	SCGH

Date	Title of achievement	Recipient name, department	Service
Nov-17	WA Health Excellence Awards Preventing illness and injury and keeping the community healthy 'Life Now Life Now exercise program'	WA Youth Cancer Services	SCGH
Nov-17	2017 Allied Health New Investigator	Alex Hunting, Speech Pathology	SCGOPHCG
Nov-17	WA Health Excellence Awards Overcoming Inequities, Medicine Information in Pregnancy and Lactation	Karen Rickman, Library and Pharmacy Team	WNHS
Nov-17	Preceptorship in Nursing Excellence Award	Pushpamma Mathew, Nursing	WNHS
Nov-17	Preceptorship in Midwifery Excellence Award	Christine O'Connor, Midwifery	WNHS
Nov-17	Andrea Sabitay Memorial Midwifery Education Award	Liz Ashton, Midwifery	WNHS
Nov-17	Churchill Fellowship	Angela O'Connor, Obstetrics and Gynaecology	WNHS
Nov-17	WA Health Excellence Awards, Finalist	WA Obstetric Medicine Information Service and Pharmacy Teams	WNHS
Dec-17	Diploma of Leadership and Management	Carl Dohse, Dental Health Services	DHS
Dec-17	Diploma of Leadership and Management	Jo Stephenson, Dental Health Services	DHS
Dec-17	Diploma of Leadership and Management	Manoj Krishnan, Dental Health Services	DHS
Dec-17	Diploma of Leadership and Management	Simon Martin, Human Resources	DHS
Dec-17	'HESTA Preceptor of the Month' for outstanding leadership and mentoring skills	Louise Graham, Nursing	JHC
Dec-17	Diploma of Leadership and Management	Sue Byrne, Nursing	SCGH
Dec-17	Diploma of Leadership and Management, Outstanding student 2018 Award	Sara Tilley, Nursing	SCGH
Dec-17	Most Valuable Team Award	Parkinson's Clinic, Occupational Therapy	OPH
Dec-17	Community Services Health & Education Training Council WA Award for Excellence Certificate IV in Mental Health	Samuel Garlett, Aboriginal Mental Health YouthReach	NMHS Youth Mental Health
Dec-17	SCGH and Carers WA Award for continued outstanding support of carers in 2017	Alison Maclean, Social Work	SCGH
Dec-17	2017 Charlies Excellence in Service Award	Joanne Willox, Social Work	SCGH
Dec-17	Staff Excellence Award, Team	Physical Resources, KEMH	WNHS
2018	Twentieth anniversary as ISO9001 Accredited Organisation	Medical Technology & Physics Department	SCGH
2018	Western Australia Police Force Certificates of Appreciation	Cathy Disspain, Nursing Alex Wright, Social Work Tyson O'Hara, Nursing	Mental Health Service
Jan-18	Outstanding Teaching Award, Royal College of Pathologists of Australasia	Dr Michael O'Sullivan, Clinical Microbiology	PathWest
Jan-18	Outstanding Teaching Award, Royal College of Pathologists of Australasia	Patricia Green, Microbiology	PathWest

Date	Title of achievement	Recipient name, department	Service
Jan-18	Raine Medical Research Foundation Clinician Research Fellowship Program	Dr Nathan Harvey, Pathology	PathWest
Jan-18	Appointed Co-Director of Genetic and Rare Diseases Research, Telethon Kids Institute	Gareth Baynam, Genetics	WNHS
Feb-18	Prize for the student demonstrating the best performance in the clinical practice, dental public health and community dentistry streams of the Oral Health Therapy	Monique Olds, Dental Therapy	DHS
Feb-18	2018 Raine Medical Research Foundation Cockell Research Collaboration Award, 'Lessons learned following an episode of intensive care unit crisis: what experienced intensivists can teach their peers'	Di Dennis, Physiotherapy	SCGH
Feb-18	2018 Rare Disease Day Inaugural Award Genetic and Rare Disease Network in recognition of the extraordinary difference made through research into genetic and rare diseases in WA	Dr John De Roach, Medical Technology and Physics	SCGH
Feb-18	Elected to the Governance Council of the International Cerebral Palsy Genomics Consortium	Gareth Baynam, Genetics	WNHS
Mar-18	Integrated partnership between JHC and the Community Alcohol and Drug Service and Joondalup Community Mental Health, Mental Health Commission winner partnerships category	Joondalup Community Mental Health and North Metropolitan Community Alcohol and Drug Service	JHC
Mar-18	Alcohol and Other Drugs (AOD) Excellence Awards the 'Partnerships – Partnerships for Improved AOD Outcomes' category	Joondalup Community Mental Health Team & North Metropolitan Community, Alcohol and Drug Service (NMCADS)	NMHS
Mar-18	Diploma of Leadership and Management	Jill Jones, Records	NMHS
Mar-18	Diploma of Leadership and Management	Owen Ward, Facilities Management	NMHS MH
Mar-18	Diploma of Leadership and Management	Andrew Barnett, Facilities Management	NMHS MH
Mar-18	DS Nelson prize winner for trainee oral presentation, The Royal College of Pathologists of Australasia	Dr Michael Page, Biochemistry	PathWest
Mar-18	Roche Scientific Poster Display prize winner, The Royal College of Pathologists of Australasia	Dr Mireille Hardie, Anatomical Pathology	PathWest
Mar-18	Roche Scientific Poster Prize for Genetic Pathology, The Royal College of Pathologists of Australasia	Dr Sarah Nickerson, Genetic Pathology	PathWest
Mar-18	Scientist Teacher of the Year	Patricia Green, Microbiology	PathWest
Mar-18	ECU Master of Midwifery Practice Clinical Midwifery Prize	Samara Swarts, Midwifery	WNHS
Mar-18	Elected Director, Academy of Child and Adolescent Health	Gareth Baynam, Genetics	WNHS
Apr-18	Australian Psychological Society Student Prize for Clinical Psychology	Shenooka Nanthakumar, Clinical Psychology, YouthReach	NMHS Youth Mental Health

Date	Title of achievement	Recipient name, department	Service
Apr-18	Best abstract award (lung infection), Thoracic Society of Australia and New Zealand Annual Scientific meeting	Natalia Popowicz, Pharmacy	SCGH
Apr-18	National Association of Testing Authorities (NATA) accreditation based upon Royal Australian and New Zealand College of Radiologists guidelines	Department of Radiology	SCGH
Apr-18	Australian College of Midwives Annual Awards 2018, nomination for 'Excellence in Bereavement'	Sonya Criddle and Belinda Jennings-Perinatal Loss Service	WNHS
Apr-18	Health Consumers' Council Consumer Excellence Awards, 'Health Organisation Award'	WA Cervical Cancer Prevention Program	WNHS
May-18	WA Nursing and Midwifery Excellence Award, Excellence in Midwifery	Amber Murphy, Nursing	JHC
May-18	Rotary Club of Karrinyup Osborne Park Hospital Nurse/ Midwife of the Year 2018	Jennifer Pitcher, Midwifery	OPH
May-18	WA Nursing/Midwifery Excellence Awards finalist 2018	Jennifer Pitcher, Midwifery	OPH
May-18	Charlies Excellence in Service Awards – Team	Aseptic Services Team, Pharmacy	SCGH
May-18	Cancer Council WA Early Career Cancer Researcher of the Year 2018	Dr Chan Cheah, Haematology	SCGH
May-18	Finalist, Health Consumer Council Excellence Awards in response to feedback from patients and families regarding their positive experiences around eating disorders treatment at SCGH	Dr Lisa Millar, Psychiatry	SCGH
May-18	WA Nursing and Midwifery Excellence Award finalist 2018	Linda Campbell, Nursing	SCGH
May-18	Lorraine Johnson Preceptor Award	Jeremy Goh, Nursing	SCGH
May-18	Rotary Nurse of the Year Excellence in Graduate Nursing	Jessica Highlands, Nursing	SCGH
May-18	Rotary Nurse of the Year Excellence in Leadership Award 2018	Marian Knox, Nursing	SCGH
May-18	Australasian Leukaemia and Lymphoma Group, Janey Stone Perpetual Award 2018 for clinical trial data managers	Ms Amie Connor, Haematology	SCGH
May-18	Australian Association of Practice Management Meritorious Award for excellence and outstanding contributions in the healthcare industry 2017	Shayne Murray, Haematology	SCGH
May-18	WA Nursing and Midwifery Excellence Award, Excellence in Midwifery	Alison Jennings, Midwifery	WNHS
May-18	WA Nursing and Midwifery Excellence Award, Graduate Nurse/Midwife	Christian Wright, Midwifery	WNHS
May-18	Finalist, WA Nursing and Midwifery Excellence Awards, Education & Research	Lucy Lewis, Midwifery	WNHS
May-18	Johnson & Johnson, WA Midwife of the Year	Teagan Boyne, Midwifery Group Practice	WNHS
Jun-18	Smart Strokes Scholarship 2018	Jessica Nolan, Physiotherapy	OPH
Jun-18	Smart Strokes Scholarship 2018	Toni Heinemann, Occupational Therapy	OPH

Date	Title of achievement	Recipient name, department	Service
Jun-18	Member of the Order of Australia (AM) for significant service to medicine, particularly in the field of pathology, as a clinician, and to medical education as a researcher and author	Dr Dominic Spagnolo, Anatomical Pathology	PathWest
Jun-18	Member of the Order of Australia (AM) for significant service to medicine in the field of pain management as a clinician, academic and mentor, and to professional societies	Dr Roger Goucke, Pain Management	SCGH
Jun-18	Member of the Order of Australia (AM) for significant service to medicine as an anaesthesiologist and physician, to medical research into sleep disorders, and to professional organisations	Prof David Hillman, Anaesthesia, Respiratory and Sleep Medicine	SCGH
Jun-18	Rotary Award for Excellence in Clinical Nursing	Jacky Woods, Nursing	SCGH
Jun-18	Olive Anstey Nurse of the Year	Jacky Woods, Nursing	SCGH
Jun-18	Best Poster, Physiotherapy, European Cystic Fibrosis Conference, Serbia	Jamie Wood, Physiotherapy	SCGH
Jun-18	Research Advisory Committee 2018/19 Annual RAC Grant Funding – POW WOW: Improving Junior Doctor Wellbeing through Clinical Debriefing at SCGOPHCG	Dr Jasmin Korbl, Dr Nick Martin and Dr Hadley Markus, Post-graduation Medical Education	SCGOPHCG

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