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

ANNUAL REPORT 2019

NMHS.health.wa.gov.au

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Statement of compliance

For year ended 30 June 2019

Hon. 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 2019.

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

Jim McGinty
Board Chair
North Metropolitan Health Service
13 September 2019

Robyn Lawrence
Chief Executive
North Metropolitan Health Service
13 September 2019

Contents

Foreword

Looking back on 2018/19, the hard work undertaken by NMHS staff in pursuit of our overall mission to care for the health and wellbeing of our patients, population and community was outstanding. Through the dedication and skills of our people, we continued to provide high-quality, patient-centred care where it was most needed.

Through a challenging but in many ways rewarding year, we have remained focused on our seven core values – care, respect, excellence, equity, integrity, teamwork and leadership. These values have guided our day-to-day activities and shaped the way we plan and deliver our health services.

The NMHS offers highly specialised multidisciplinary services from several hospital and outpatient/ambulatory care settings statewide, as well as services specifically aimed at the north metropolitan catchment area. The geographical area of our catchment covers almost 1000 square kilometres. We provide care to more than 36 per cent of Western Australia's total population, a community that is projected to grow to more than 1.1 million by 2020.

The year saw some significant changes to the NMHS. A new Board commenced on 1 July 2018 and several new senior leaders were appointed throughout the year. Together, we have refreshed the focus and direction for the NMHS.

While supporting the NMHS to maintain high standards of service delivery, the Board and Executive have identified a number of key priority areas and opportunities to improve our operations including:

- engaging our workforce
- revitalising our values
- improving our financial performance
- stabilising the Executive leadership.

Consolidating our service and delivery in these areas will ensure the NMHS continues to be a high performing health service and continues to make significant contributions to the broader Western Australian health system.

While an investigation by the Corruption and Crime Commission that became public in August 2018 was an excellent piece of investigative work, it raised questions about our integrity, processes and controls.

The report, which served as a serious warning for all public sector agencies and private sector contractors, prompted our own internal reviews and improved controls. We are open to hearing about improvements we could make. However, we are confident our monitoring systems, procedures, controls and safeguards under the new Board and management will reflect our strong new culture of integrity and also give the community every reason to trust the people and processes of the NMHS.

Looking ahead

Many of our commitments have targets that are meaningful to our clients and challenge us to deliver the best possible service. Operational challenges this past year included strengthening our governance – both to promote integrity and to meet the standards expected of a high performing government organisation – and achieving financial sustainability for our purposes. Only institutions that know the full costs of their activities and projects can judge if they are able to operate on a financially sustainable basis. Financial sustainability comprises all aspects of our mission and we plan to address all relevant aspects of this issue individually in further projects and activities – specifically, by providing care closer to home and increasing primary health interventions and community care to reduce demand for expensive hospital services.

The year ahead will see a renewed focus on innovation in two criteria – to help embed a healthy organisational culture across the NMHS and to focus on 'person-centred' health care. This is a way of thinking and doing things that sees the people using our health services as equal partners in planning, developing and monitoring care to make sure it meets their needs. This means putting people and their families at the centre of decisions and seeing them as experts, working alongside professionals to get the best outcome.

We will invest in a new program of work aligned to the modernising strategies and recommendations of the government's 2019 *Sustainable Health Review* to make a real and enduring difference to the health of Western Australians.

We are extremely proud of all the NMHS has achieved and we look forward to the year ahead.

Jim McGinty
Board Chair

Robyn Lawrence
Chief Executive

Encouraging diversity

Our agency reflects the cultural diversity of Western Australia in its many facets. We recognise that understanding people and their backgrounds is crucial. It allows us to strengthen engagement, build relationships and provide the best possible health care and services to the community. Our approach is based on the belief that we celebrate our differences as well as our common interests and understand each other's perspectives in order to broaden our own.

Our programs have been designed to eliminate discrimination and promote equality of opportunity. By fostering mutual respect in the workplace, we bring about better decision making, problem solving, policy development and service delivery, for our patients and their families and for our organisation.

By means of a reputation for good ethics and fair employment practices, we will be able to attract a broader range of applicants from diverse community groups and so be better resourced to provide quality health care for our community.

Getting treatment and support quickly can make a significant difference to the recovery of young people with eating disorders.

Our Centre for Clinical Interventions worked with the Sydney Children's Hospital Network Eating Disorders Service to develop an urgent treatment pathway for adolescents with anorexia nervosa and their families.

Emphasising the crucial involvement of family in such situations, the new pathway provides immediate support to adolescents with anorexia nervosa and their families, and access to specialist treatment thereafter.

It also helps to address a gap in services for young people aged 16 to 18 years, who previously fell between child and adult mental health services.

This initiative by the Centre for Clinical Interventions, which is the only public service providing tertiary care for people over 16 years with eating disorders in Western Australia, has significantly reduced waiting times and also helps to reduce dropout.

Aboriginal health and employment matters to our health services

Aboriginal health is everyone's business. Our new Aboriginal[1] Health and Wellbeing Action Plan was an important step towards ensuring we continued to address the systemic barriers that prevent the achievement of health equity for Aboriginal people in our health region.

Key strategies of the action plan include:

- addressing prevention and early intervention
- promoting good health over the life course
- building a culturally respectful and non-discriminatory health system
- caring for individual, family and community wellbeing
- providing equitable and timely access to the best quality and safe care
- creating a strong, skilled and growing Aboriginal health workforce.

In 2018/19, we increased training opportunities for Aboriginal people, including the continuation of our Aboriginal Dental Clinic Assistant sponsorship initiative. Three Aboriginal people were sponsored through completion of the Certificate IV in 'Dental Assisting' with an offer of permanent employment on graduation.

To increase Aboriginal representation in our workforce, we implemented section 51 of the *Equal Opportunity Act 1984* to advertise employment opportunities. This section allowed us to introduce recruitment measures specifically targeted at increasing Aboriginal employee numbers across the health service.

We established employee support mechanisms with the aim of retaining existing Aboriginal staff. For example, we hosted an Aboriginal professional development 'Our Time' workshop in April 2019 to nurture a support network, establish peer mentoring and provide information, training and professional development to staff. Our Aboriginal Employee Network also provided an ongoing supportive environment for Aboriginal staff.

Along with these initiatives, we continued to work on ways to improve health outcomes, to attract, appoint and retain Aboriginal people in our workforce, and to strive for cultural security for all.

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

NMHS map

993 square kilometres

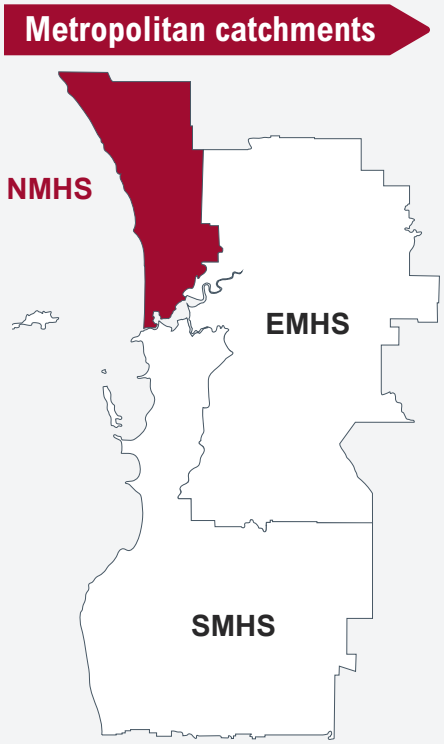
716 679 population

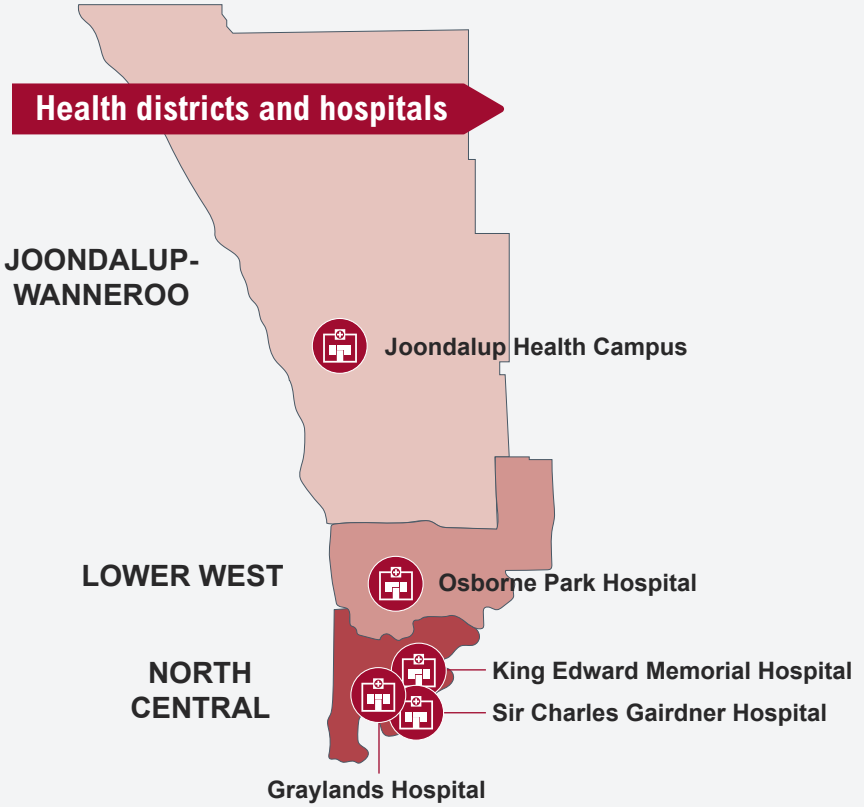
5 hospitals

10.5* local government areas

43.7% born overseas

9073 employees





*(Cambridge, Claremont, Cottesloe, Joondalup, Mosman Park, Nedlands, Peppermint Grove, Subiaco, Wanneroo, Stirling (94%), and Vincent (52%). Also Swan (15%), Perth (9.8%) and Bayswater (9%).

Overview

Who we are

The NMHS provides timely access to high quality health care, embracing acknowledged best practice to deliver improved clinical outcomes in the face of rising challenges for all healthcare providers.

Our north metropolitan catchment area covers almost 1000 square kilometres, with a population of almost 717,000. Approximately 1.2 per cent of the population is Aboriginal, 43.7 per cent were born overseas and 18 per cent are from culturally and linguistically diverse (CaLD) backgrounds.

Our population represents more than 36 per cent of Western Australia's total, and is projected to grow to more than 1.1 million by 2020.

NMHS healthcare providers are fully accredited and offer a range of statewide, highly specialised, multidisciplinary services from several hospital and outpatient/ambulatory care settings, as well as services specifically aimed at the north metropolitan catchment.

Our hospital network comprises tertiary, specialist and general hospitals including:

Sir Charles Gairdner Hospital (SCGH) – 609-bed tertiary and teaching hospital

Osborne Park Hospital (OPH) – 205-bed general hospital

King Edward Memorial Hospital (KEMH) – 252-bed women's and neonatal tertiary and teaching hospital

SCGH Mental Health Services – 54 beds across a range of services

Graylands Health Campus – 174-bed tertiary psychiatric and teaching hospital

Joondalup Health Campus (JHC) – 514 public-bed and 146 private-bed 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 employs 5500 staff who treat over 600 000 patients every year. Located at the Queen Elizabeth II (QEII) Medical Centre, it is also home to Western Australia's largest Comprehensive Cancer Centre and is Western Australia's principal hospital for neurosurgery and liver transplant services. SCGH also plays a critical role in the research hub at the QEII Medical Centre 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.

NMHS provides a comprehensive range of mental health services that are delivered by hospitals on the Graylands Health Campus and QEII Medical Centre site, and in partnership with community health centres.

Graylands Health Campus accommodates Graylands Hospital, the state's largest and only public standalone 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 high secure forensic inpatient facility.

SCGH Mental Health Services comprise a Mental Health Unit, Hospital in the Home and Neuroscience Services, and a Mental Health Observation Area. 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 Western Australia Tuberculosis Control Program, Humanitarian Entrant Health Service and Dental Health Services.

Dental Health Services is the largest public dental service in Western Australia, 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 (WNHS) incorporates King Edward Memorial Hospital (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 Western Australia. 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 of WA, Newborn Emergency Transport Service, the Western Australia 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.

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

Our vision, mission and core strategies

VISION

Excellence in health care for our community

MISSION

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

STRATEGIES

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

How we made a difference, 2018/19

176 713
people presented to emergency department

9939 births

80 870
patients underwent elective surgery

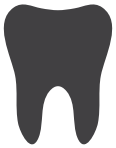
715 704
outpatient appointments provided

74
transplant patients (56 kidney and 18 liver)

38 786
Poisons Information Centre callers

20 884
cancer patients received treatment

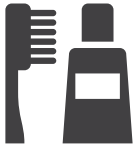
15 796
mental health patients cared for



169 948
School Dental Service patients

&

294 548
occasions of service (visits and screenings to individuals)



188 731
patients admitted to our wards

Performance highlights

This section of the report outlines our achievements and how we go about delivering our services to the community. To do this, we follow the five core strategies adopted in our Strategic Plan 2017–2021, which supports our aspirations to deliver safe, high quality and timely health services to the people we serve. This includes:

- providing the right care and support at the right time and in the right place
- taking a whole-of-system approach – working together to do the right thing for the patient, population and community
- developing seamless pathways between our hospitals and community services to improve care
- strengthening partnerships to better provide services and reach the best outcomes for patients, population and community
- aspiring and committing to creating a learning organisation through teaching, training and research.

Examples follow in this section and throughout the report, demonstrating how we put people first and how we place our patients at the centre of what we do.

"People with cystic fibrosis are living with a life-long condition meaning it is essential they attend regular appointments with their specialist team to maintain their health.

"We found patients were so tired of traveling they simply didn't attend the regular clinics required, which in turn affected their clinical outcomes.

"With telehealth we are able to provide patient-centred care in a way that meets the clinical and the social needs of our patients, by taking services directly to them."

Senior Physiotherapist Jamie Wood

Core strategy 1

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

In partnership with Medical Oncology and Pharmacy, Sir Charles Gairdner Hospital Home Link service ran a pilot study to deliver **immunotherapy infusion at home**. The service was well received and tolerated, with patients appreciating the convenience and the ability to resume usual activities sooner. Plans are underway to expand the service to include more cancer therapies as the service also proved to be cost effective.

Post-anaesthetic care units, with specially trained staff, have been established to provide post-operative care for patients who undergo certain surgical procedures. The specialist care and proximity of the units has resulted in reduced symptoms and recovery times for patients. Further, additional capacity has been created in theatre enabling more patients to undergo surgery.

The efficiency of patient transfer practices at SCGH was improved. The **Getting on track in managing operating theatre** (Go Time OT) project helped transfer patients needing urgent general surgery from the emergency department to the operating theatre within the recommended time. This shortened waiting times, reduced pressure within the emergency department and improved clinical outcomes.

Consistent with our ongoing commitment to continuous quality improvement, we adopted an electronic tool that measures compliance against National Safety and Quality Health Service Standards. The **Consumer Engaged National Standard Audits** (CENSAs) allows information about patient outcomes, including falls, pressure injuries and blood management, to be collected in real time at the patient's bedside. This allows us to identify areas for improvement promptly.

With one in eight women developing breast cancer in their lifetime, early detection is vital both for reducing illness and improving survival. With increased participation, BreastScreen WA's **Mobile in the Suburbs** pilot project, which offers free breast screening to women at their workplaces and in their communities, will be continued. BreastScreen WA received a Department of Health Award for Best Practice in Health and Wellbeing at the Institute of Public Administration Australia (WA) 2019 Achievement Awards.

Dr Matthew Anstey has been the chair of the Advisory Group for Choosing Wisely Australia for the past two years. Choosing Wisely is a national program that is endeavouring to eliminate unnecessary and sometimes harmful tests and procedures. “More (blood tests, radiology, medications, procedures) is not always better” encapsulates the concept behind Choosing Wisely. The advisory group provides guidance on strategic development, implementation and evaluation of Choosing Wisely Australia projects including appropriate and responsible use of antibiotics or optimising end of life care. There has been significant success in establishing ‘Champion Health Services’ across Australia that have committed to implementing Choosing Wisely projects. Sir Charles Gairdner Hospital has been a Champion Health Service since the beginning, and now all health service providers in Western Australia are involved. The recent Sustainable Health Review has recognised the benefits of clinician-led resource stewardship programs and the WA High Value Healthcare Collaborative has been established to align work on Choosing Wisely items across WA. The NMHS is represented by Dr Anstey.

Core strategy 2

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

Through the **NMHS Discretionary Travel Grant Scheme**, 21 junior clinical researchers from a range of clinical areas received funding to attend conferences, take part in international collaborations or take up positions in other laboratories. The experience provided researchers with opportunities to broaden their career prospects and benefit from exchanging ideas with colleagues, ideas that will inform treatment options and advance health care, patient outcomes and the performance of our health service.

A local research grant provided seed money that led to a high profile multinational randomised clinical trial – the **AMPLE (Australasian Malignant PLeural Effusion) trial**. Following a successful proof of concept study, Professor Gary Lee secured national funding to examine the use of an indwelling catheter that enables patients with lung cancer to reduce the time they spend in hospital and the frequency of drainage procedures. In practice, the catheter improves the patient's quality of life, lowers healthcare costs and reduces the number of inpatient stays required.

The SCGH Green Team was recognised for their innovative work in **reducing anaesthetic waste** in the 2018 Infinity Awards, which acknowledge efforts to change practices that divert waste from landfill. SCGH operating theatres have implemented measures to recycle a variety of products that are used during the hundreds of surgical procedures performed each month, significantly reducing the amount of clinical waste and costs associated with disposal.

A new **Leading Teams Program** was developed in response to significant demand from managers and supervisors across the NMHS. The course focuses on contemporary challenges facing health leaders in understanding, communicating, developing and leading a successful team. Over 60 managers and supervisors have participated so far.

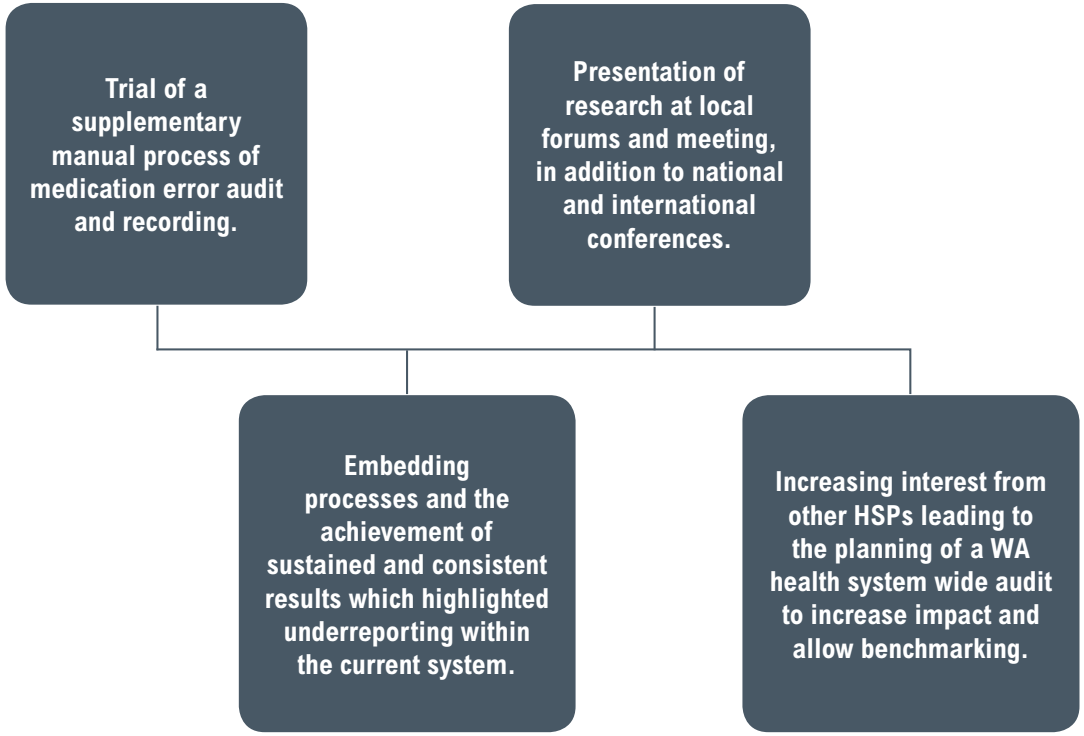
The NMHS chose the Research Electronic Data Capture (REDCap) Consortium, a free web-based application, to manage data. In a secure online environment, researchers and staff are able to **design clinical trials** as well as **create and administer surveys** that focus on improving patient care and outcomes, and inform clinical practice. Already hosting over 150 operational and research projects, we plan to expand this initiative to offer opportunities to collaborate nationally and internationally.

Developing and scaling safety and quality research to improve care systems

Although we know that medical care can sometimes result in patient harm, the services we provide are complex and it is often difficult to determine where there is harm, and what has caused it.

A project led by NMHS Safety, Quality, Governance and Consumer Engagement with the SCGH Pharmacy Department has resulted in a better understanding of the organisation's medicines-related risks.

The development of a supplementary system for recording medicines incidents found many such incidents were not being reported. This shone light on where the issues were and what was causing them. Other health service providers have begun similar audits, benefiting more patients.



Collaboration in research, teaching and training

NMHS researchers collaborate with many high-profile local and international organisations. We continue to collaborate with all Western Australian universities as well as maintaining our strong links with health service providers across WA Health.

Over 157

national and international collaborations in our research projects

Harvard University
Stanford University
The Alfred Hospital
The Mayo Clinic
Australian National University
Cambridge University
The Cleveland Clinic
Peter MacCallum Cancer Centre

Our location at the QEII Medical Centre also situates us well for collaboration in research, teaching and training. There are over 25 other hospitals, university centres and private research institutes that we connect with to deliver the best learning experiences for our students and clinicians and conduct world class research. Some of these include the Harry Perkins Institute of Medical Research, Parkinson's Western Australia, Rocky Bay, Lions Eye Institute and the Perron Institute.

Redefining research support systems to improve research practice has and continues to be a focus of the NMHS Board and Executive. This focus stems from our commitment to excellence in research, acknowledging that conducting and translating quality, clinician-led research drives improvements in patient outcomes. In the past year, the development of a white paper examining current research structures and practices provided the required insight for the development of an organisational strategy for improvement.

The NMHS is committed to improving:

- organisational-wide coordination of initiatives such as the rollout of REDCap and implementation of REDCap staff education and training
- education in research conduct, the development of new quality research, and the application of learning across the organisation's services and staff, including for those conducting research and the staff supporting research operations
- efficiencies gained through coordination of infrastructure, administration and investment in research development, in addition to review of current processes for opportunities for improvement
- consistent and reliable processes and practices across the organisation to ensure a uniform high quality minimum standard in research conduct and practice.

How far and wide are our published research findings read?

467 Research publications by our staff have been cited by other national and international researchers

2250 Total number of citations for our research in 2018/19

How much research do we approve and conduct?

844 Current research projects actively being conducted within SCGOPHCG

203 Current research projects actively being conducted within KEMH

69 Current research projects actively being conducted within Graylands Hospital and North Metropolitan Mental Health Services (NMMHS)

How much research do we publish and where do we publish?

Over 900

published peer-reviewed journal articles, books or book chapters by our staff

- Journal of the American Medical Association
- British Medical Journal
- New England Journal of Medicine
- Journal of Allergy and Clinical Immunology
- The Lancet
- Medical Journal of Australia
- Anaesthesia
- Chest
- Nature Genetics
- BMC Cancer

SCGOPHCG 717

NMMHS 100

WNHS 196

The NMHS is proudly home to three Human Research Ethics Committees. These committees service research offices based at SCGH, KEMH and Graylands Hospital and collectively review, approve and monitor research conducted throughout the NMHS. In 2018, the committees and research offices approved and oversaw 99 research projects and granted a further 135 approvals to conduct research at our sites and services.

Consumer engagement in research

Clinical trials are studies that explore the impact of new or existing approaches to health care. Given the valuable insights that they offer, they are an important component of a 'self-improving healthcare system'.

The Australian Commission on Safety and Quality in Health Care is developing the National Clinical Trials Governance Framework as a first step towards nationally consistent accreditation of health services undertaking clinical trials in Australia.

In response, we reviewed our internal governance of research, assessing whether our governance processes and practices adhered to requirements. The key components of the new requirements are the involvement of patients in the planning of research and a greater focus on individual patient safety for those participating in clinical trials.

To achieve these goals, we worked with the Consumer and Community Health Research Network, a partner of the Western Australian Health Translation Network, to facilitate our review and support consumer engagement in our research.

Researcher spotlight

Dr Chan Cheah, clinical haematologist and lymphoma team leader at SCGH, is the driving force behind the WA Lymphoma Centre of Research Excellence.

"The number of clinical trials West Australians can access is low; if you run out of treatment options in Perth, there are no options left," Dr Cheah said.

Increasing access to potentially life-saving treatments by fostering research is part of the reason Dr Cheah was named the 2018 Cancer Council WA Early Career Cancer Researcher of the Year. Research that is beginning to be conducted by the NMHS will benefit the 600 patients diagnosed with lymphoma in WA each year.

Core strategy 3

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

Supported by Traditional Elders, heart health information was translated into four major languages of the Goldfields region – Ngaanyatjarra, Pitjantjatjarra, Wangkatja and Tjupan. This was part of the **Heart Foundation and the Australian Healthcare and Hospitals Association Lighthouse Project**. The resources were developed to educate Aboriginal patients from the region and improve their patient experience.

A new statewide model of care for eating disorder services (**WA Eating Disorder Specialist Service**) was developed in consultation with consumers and carers as well as public and private providers. If the preferred option receives approval, it will result in a person-centred service that offers linked services and structures to provide better access to care and an increased focus on individual recovery.

The **People Engagement and Culture Advisory Council**, supported by 30 **cultural ambassadors**, was established to hear from staff across the organisation and provide insights to foster a positive, healthy and engaged workforce.

A new in-house training and education package was developed to build understanding about Aboriginal cultural groups. The **Cross-cultural communication: working with Aboriginal people** session explored cultural values and views to identify the needs of Aboriginal people and positively influence treatment outcomes.

The Dementia Care Unit, in partnership with university researchers, introduced **evidence-based interventions** to support and include family carers in the provision of care of patients with delirium. As a result, family carers felt more informed, included and capable of caring for their suffering relative. In recognition of the program's success, the team received a WA Health Excellence Award.

Renal Medicine and Homelink, working closely with an external provider, established a home nursing service to provide **assisted automated peritoneal dialysis**. This model of care supports patients in their own home, reducing the number times they need to be admitted to hospital. As well as improving the patient's quality of life, hospital performance was also enhanced by increasing our capacity to deliver additional healthcare and cost-effective therapy. In recognition of their achievement, the team received a WA Health Excellence Award for developing sustainable solutions for out-of-hospital health care.

In 2018/19, we took a fresh look at mechanisms for engagement with patients to enhance the relationships that exist and build upon them. Many of the strategies form the 'Your Experience Matters to Us' Patient Experience Framework that was endorsed in late 2018.

We have sought to further raise the profile of the patient experience with an ongoing focus on compliments and complaints received via formal channels and through the Patient Opinion web platform. Year round, stories from consumers feature on the Executive Group agenda to keep patients and their needs front of mind for other discussions and business decisions. High achievers in patient experience are highlighted with focus stories on our websites, intranets and social media and, for the first time this year, on YouTube. As part of Patient Experience Week, we ran a campaign promoting staff who had been complimented by patients. With more than 4554 formal compliments received this year by our services, the staff profiled through the campaign offer merely a glimpse into what our staff are doing well that makes for a great experience. Highlighting them is our way of ensuring staff receive the commendation they deserve and inspiring others to contribute to a culture where we are all working together for the best patient experience.

We continue to use our official social media accounts to supplement traditional communication methods, to better engage with the community. Given more and more people now access information online via social media, we have shared features, events and updates steadily throughout the year to build awareness of, and access to, our services, via Facebook, Instagram and Twitter.

Patient Opinion continues to grow as a feedback avenue. It is particularly attractive to those who wish to maintain their anonymity on the online platform. We've received more than 120 stories in 2018/19. We are continually promoting the platform and hope to see further growth in the coming years.

Community Advisory Councils (CAC) have long supported us in the design and delivery of our services. We are extremely grateful to CAC members from diverse backgrounds who have contributed throughout the year providing invaluable advice from the patient, carer or consumer perspective. We have used strong networks with CaLD groups to recruit additional members to two of our CACs who bring highly valuable cultural knowledge about some critical health issues.

Our CACs are longstanding across the organisation. We partner with consumers and carers through the councils to gather feedback and generate ideas to improve our services. This year, our Safety, Quality, Governance and Consumer Engagement Unit has held a series of joint-CAC workshops aiming to build relationships between the CACs, harness the great experience the members collectively share, and identify how the organisation can better support the CACs and improve the extent to which they are involved, are representative, have influence, and are heard.

A range of strategies was identified at the workshops with a more standardised governance structure prioritised. This will better support the CACs, and enhance linkages between them, the Board and the Executive.

During 2018/19, the WNHS Community Advisory Council joined those lobbying the Minister for Health for a solution to the degrading infrastructure at KEMH and welcomed the funding for the planning of its relocation to the QEII Medical Centre. It looks forward to representing carers and consumers as the planning process progresses.

The WNHS CAC also lobbied for a crosswalk outside the hospital. With the support of the hospital, discussions were held with Subiaco Council and the crosswalk is proceeding. These are two examples of the consumer voice being heard.

During the year, the SCGOPHCG welcomed the CAC Chair to its Executive meetings for the first time as a voting member.

The North Metropolitan Mental Health Service (NMMHS) CAC participated in the opening address as part of the Australian Commission on Safety and Quality in Health Care's Accreditation Survey and joined our Executive at their Leadership strategic planning day.

We have continued our ongoing commitment to engage by supporting more staff to undergo formal engagement training underpinned by the C4 Engagement Framework. Building capacity in our staff is essential to ensuring that engagement becomes a standard part of the work we do. Participants came from a broad range of fields and skill sets – from Executive, clinicians, administration personnel, planners, communications staff and CAC members. We hope to see this knowledge being applied to projects in the future.

Core strategy 4

Enable, **empower and engage our workforce**

An innovative approach to **postgraduate training in cancer nursing** in the clinical environment received national recognition and prompted interest from other state nursing organisations. The training, developed by Stacey Fuller from the Centre for Nursing Education, was launched in 2019. Currently five nurses are enrolled, supported by professional mentors in public and private sector settings.

The NMHS undertook a **Safety Climate Survey** of safety and quality improvement across the organisation during the year. More than 1000 staff members participated, with responses showing an overall positive workplace safety climate in NMHS of 76.8 per cent. Results will be used to engage and support staff through a variety of initiatives to deliver excellence in health care.

After noticing the high incidence of symptoms of depression and burnout among junior medical colleagues, Dr Jasmin Korbl developed **Project Pow Wow** to help junior doctors cope with on-the-job stress. The program has run successfully at SCGH and is being expanded to other hospitals in Western Australia in 2019. Jasmin was recently presented with the prestigious Confederation of Postgraduate Medical Education Councils Australia and New Zealand Junior Doctor of the Year Award in recognition of her commitment and dedication to improving junior doctor training and wellbeing.

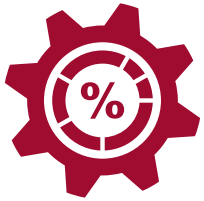
Following a significant rise in occupational violence and aggression in hospitals, we introduced a range of objectives and initiatives to **optimise the emotional and physical safety** of staff who provide care. These measures focus on prevention and early intervention through awareness raising and building skills and knowledge within the workforce.

As part of our commitment to nurturing a high-performing workforce and improving patient care, we secured funding from the Institute for Health Leadership that enabled 250 clinical staff to complete the **Basic Certificate in Patient Safety** through the Institute of Health Improvement.

2019 Australia Day and Queen's Birthday honours

- Professor David Forbes for significant service to medicine in the field of paediatric gastroenterology. Professor Forbes is Deputy Board Chair NMHS, Clinical Professor University of Western Australia and the former A/Chief Medical Officer for the Department of Health.
- Dr William Carroll for significant service to neurological medicine, and to people with multiple sclerosis.
- Dr Lindy Roberts for significant service to medicine.

Core strategy 5



Enhance our clinical services through **professional and efficient corporate support**

In response to employee and manager feedback, two new training programs, '**Managing Your Data**' and '**Presenting Your Data**', were introduced to help translate data into action. The training helps uncover trends and patterns in data that will inform decision making to improve clinical care outcomes.

We implemented a range of activities that clarified policies and processes in relation to gifts and conflicts of interest, as well as procurement and contract management. These activities were undertaken as part of the WA health system's integrated program for **integrity fraud and corruption management**.

A **single source of truth** dataset, supported by clear metrics and definitions, was established to enable the organisation to monitor and understand current performance as well as forecast future performance with greater confidence.

The WA Tuberculosis Control Program team developed a new **Guideline for the Health Management of Leprosy** in response to updates in World Health Organisation recommendations for leprosy management, research findings and an increase in the number of leprosy notifications. The policy emphasises early access to leprosy diagnosis and treatment, as well as prevention. The team was recognised for their significant achievement, receiving a WA Health Excellence Award in 2018.

The **Clinical Variability Tool**, developed by the Business Information and Performance Department working closely with clinicians, reduced unwarranted clinical variation and continuously improved the quality of health care delivered to patients. The data-driven tool identified and validated opportunities to change clinical practice and workflow. This team-based, patient-focused approach improved the patient experience and lowered the cost of care in several specialties.

Learning from clinical incidents and promoting safety and quality

Health care is an undeniably complex environment with many interdependent parts. Despite the very best efforts of our staff, failure of just one of these parts may have serious consequences for those in our care.

We encourage staff to report clinical incidents – defined as any unplanned event that causes, or has the potential to cause, harm to a patient.
By reporting clinical incidents, we are able to investigate and identify what ultimately caused its occurrence. By putting processes in place, we hope to prevent further incidents and harm to patients.

In 2018/2019, a total of 129 serious clinical incidents were reported by the NMHS and 39 by Joondalup Health Campus (JHC) for publicly funded patients (Table 1). At 30 June 2019, there were 14 serious clinical incidents still under investigation by the NMHS, and four by JHC. Where health care was found not to have been a factor in the event, the incident may be 'declassified' after receiving approval from the Department of Health. NMHS had 37 incidents that met these criteria, and JHC had five such incidents for the year.

Health care was identified as a contributing factor in 126 serious clinical incidents (NMHS 92; JHC 34, including those still under investigation). Death of a patient was the outcome in 23 incidents (NMHS 17; JHC 6) and serious harm was the outcome in 66 incidents (NMHS 48; JHC 18). The NMHS will continue to strive towards improving the safety of our services, with clinical incident reporting an essential way of achieving this goal. The ultimate aim is always to keep our patients, and our staff, safe, and to provide high quality care.

Table 1: NMHS SAC1 (Severity Assessment Code) clinical incidents reported, 2018/19

SAC1 clinical incident	**NMHS**	**JHC** (publicly-funded activity)
Total reported	**129**	**39**
Declassified*	**37 (29%)**	**5 (13%)**
Investigation completed	78	30
Investigation in progress	14	4
Completed + SAC1 investigations in progress	**92 (71%)**	**34 (87%)**
Outcome of completed + SAC1 in progress		
Death	17 (19%)	6 (18%)
Serious harm	48 (52%)	18 (53%)
Moderate harm	9 (10%)	8 (23%)
Minor harm	4 (4%)	2 (6%)
No harm	14 (15%)	0 (%)

* Declassification of a reported serious 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 serious 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. An example of an investigated serious clinical incident is provided below.

Learning from a serious clinical incident

Situation:

The incident involved a frail, elderly man with multiple medical conditions who was admitted to hospital with a fractured femur. While in theatre, the patient was given a number of medications and was noted to have low blood pressure. After surgery, while in hospital, he developed acute renal failure and died.

Investigation:

A panel of experts was convened and conducted a thorough investigation of the incident and concluded that while the patient had numerous risk factors the decision to operate was appropriate. The panel agreed that while the patient's death was probably unavoidable there was an opportunity to implement positive changes in the care for this high-risk group. This included highlighting the large proportion of elderly patients who develop low blood pressure after this type of surgery.

Contributory factors:

The panel agreed that the patient's low blood pressure was likely to have contributed to his renal failure and subsequent death. On this point the panel discussed the benefits of a medicine called Midodrine, available under a special access scheme, and discussed how it could be more readily accessed for use in the future for patients with similar low blood pressure. The panel also agreed that one of the pain-relieving medicines that was given to the patient, a nonsteroidal anti-inflammatory drug (NSAID), should be carefully considered in the future for elderly patient populations.

Recommendations:

- Present the findings of the investigation at the hospital's Anaesthetic Department Morbidity and Mortality meeting to raise awareness of the risks of nonsteroidal anti inflammatory drug use in elderly people and the alternative medicines available to help with low blood pressure such as Midodrine.
- Review and revise the hospital guideline for the use of Midodrine.
- Provide education to the Anaesthetic Department on a newly implemented hospital process to make it easier for staff to access medicines like Midodrine for their patients.

Lessons Learned:

- Real renal function of elderly patients may be difficult to determine and may require close examination.
- Midodrine is safe and effective in patients with low blood pressure.
- NSAIDs should be carefully considered and avoided where possible for patients with renal risk factors.

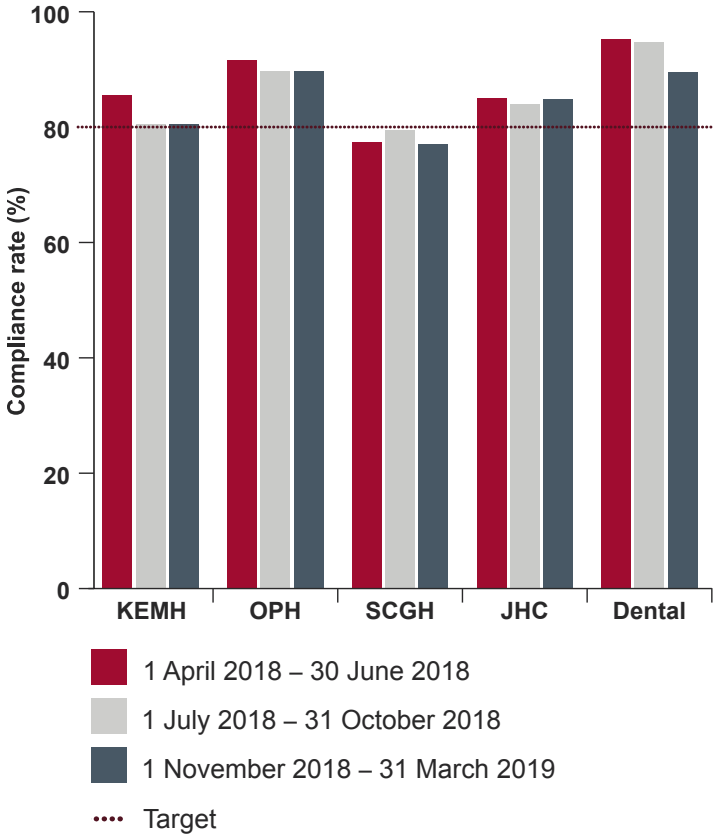
Hand hygiene

Good hand hygiene (washing or decontaminating hands with soap and water or an alcohol-based hand rub) is an important part of quality patient care and a way to reduce infections associated with health care.

The estimated hand hygiene rate for a health service 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. The national benchmark for hospitals is 80 per cent.

Figure 1 shows the hand hygiene compliance rate for the NMHS and JHC over three audits conducted between April 2018 and March 2019. Where we did not meet the hand hygiene compliance target, action plans were put in place and monitored by our Board's Safety and Quality Committee.

Figure 1: Hand hygiene compliance rates, April 2018 to March 2019, by hospital



Governance

Enabling legislation

The NMHS was established as a health service provider on 1 July 2016 under section 32 of the *Health Services Act 2016 (WA)*.

Accountable authority

The NMHS is a board governed health service provider pursuant to section 70 of the *Health Services Act 2016*. The NMHS Board is the accountable authority for NMHS and The Hon. Jim McGinty AM is the Board Chair.

Responsible Minister

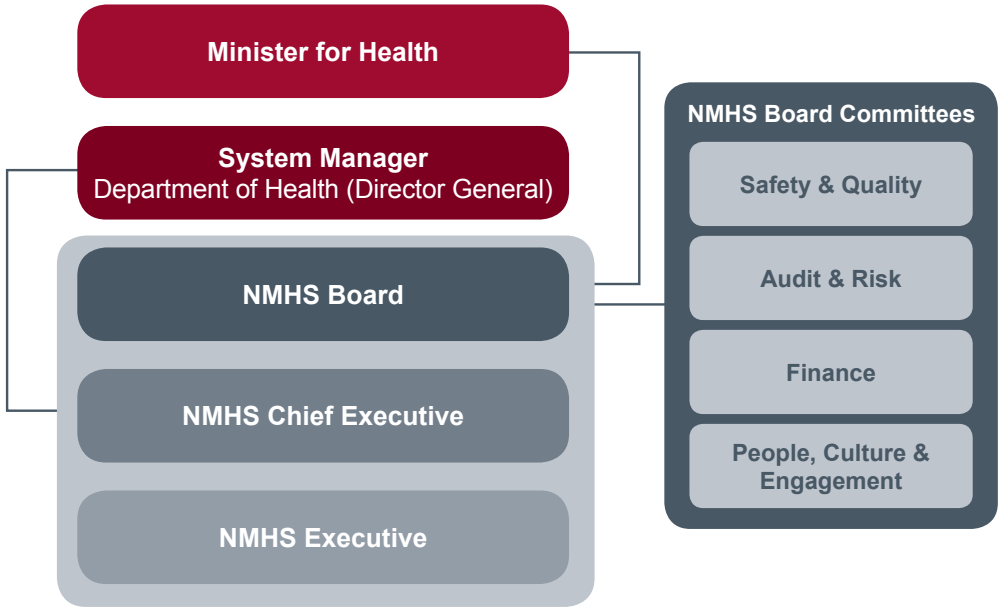
The NMHS is responsible to The Hon. Roger Cook MLA – Deputy Premier; Minister for Health; Mental Health.

Board of authority

Under section 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 three years 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 our activities.

Our governance structure



Board profiles

Hon. Jim McGinty AM

Board Chair

Jim was the Member for Fremantle in the State Parliament from 1990 to 2009. During that time, he held the positions of Minister for Health, Attorney General and Leader of the Opposition. Post political life, he has served on the boards of several not for profit organisations including Telethon Kids Institute, Brightwater Care Group, Communicare, Access Housing Australia and Health Workforce Australia. Jim is a volunteer with Fremantle Sea Rescue.

Professor David Forbes

Deputy Board Chair
Chair, NMHS Board Safety and Quality Committee
Member, NMHS Board Finance Committee

David has had a career in academic paediatrics, working primarily as a paediatric gastroenterologist, but has also worked in paediatric emergency medicine, general and rural paediatrics and child and adolescent mental health. He led undergraduate teaching in paediatrics vocational training at the Princess Margaret Hospital for Children at different points in his career. David was a member and then Chair of the Royal Australasian College of Physicians Paediatric Physician Training Committee, and the Division of Paediatrics and Child Health Policy and Advocacy Committee. He has also held roles in health service management as the Chair of Paediatric medicine at Princess Margaret Hospital for Children, and as a Clinical Advisor and Acting Chief Medical Officer in the Department of Health.

Professor Selma Alliex

Member, NMHS Board Safety and Quality Committee
Member, NMHS Board People, Culture and Engagement Committee

Selma is currently the Pro-Vice Chancellor, Head of Fremantle Campus University of Notre Dame. Prior to undertaking this role, Selma was the Dean of the School of Nursing and Midwifery at the university, responsible for nursing programs in Fremantle and Broome. Selma has been on the Board of several nursing and non-nursing organisations including research committees. She is the immediate past Chair of the Human Research Ethics Committee at the University of Notre Dame Australia and has worked at the university for 16 years in roles ranging from lecturing and research supervision to administration. Selma currently oversees the university's Department of Rural Health based in the Kimberley.

Ms Angela Edwards

Member, NMHS Board Audit and Risk Committee
Member, NMHS Board People, Culture and Engagement Committee

Angela has an extensive background in human resources, industrial relations, change management, organisational development and stakeholder management. She is currently Human Resources Director Asia Pacific, CHC Helicopter Australia. She formerly held the position of General Manager – Human Resources, Crown Perth. Angela is also a board member of the not-for-profit cancer support group, Blue Dot Army.

Assoc. Professor Christopher Etherton-Beer

Member, NMHS Board Audit and Risk Committee
Member, NMHS Board Safety and Quality Committee

Christopher is a Clinical Academic in Geriatric Medicine at The University of Western Australia and Medical Co-director at Royal Perth Hospital. He is Chair of the Western Australian Therapeutics Advisory Group and is a member of the Pharmaceutical Benefits Advisory Committee.

Dr Hilary Fine

Chair, NMHS Board People, Culture and Engagement Committee
Member, NMHS Board Safety and Quality Committee

Hilary has been a GP in urban and rural general practice for over 30 years. She is currently Principal GP and Medical Director at East Fremantle Medical Centre and Adjunct Associate Professor at Notre Dame University. Hilary has held director and chair positions on the boards of local, state and national not-for-profit primary care organisations together with the Royal Australian College of General Practitioners and External Advisory Board, Notre Dame.

Ms Carol Innes

Member, NMHS Board People, Culture and Engagement Committee

Carol is the Manager, Aboriginal Cultural Heritage and Arts at the Metropolitan Redevelopment Authority. She is currently the Aboriginal Co-Chair of Reconciliation WA and is a former director of the Leadership Unit at the South West Aboriginal Land and Sea Council. She worked in the Aboriginal and Torres Strait Islander arts sector for 11 years with experience in the government sector at both state and national levels.

Mr Grant Robinson

Chair, NMHS Board Finance Committee
Member, NMHS Board Audit and Risk Committee

Grant is a former partner of KPMG in the Audit, Assurance and Risk Consulting division, an FCA and has many years' experience as a board/committee member of various not-for-profit organisations. His professional experience extends across a variety of sectors including financial services, mining, mining services, health care, property and construction, education and government. He is a board member of the following organisations: Bethesda Health Care, Juniper, Botanic Gardens and Parks Authority and the Perth Festival. He is also the president of Netball WA.

Ms Rebecca Strom

Chair, NMHS Board Audit and Risk Committee
Member, NMHS Board Finance Committee

Rebecca is a principal at LSV Borrello Lawyers and has extensive experience as a commercial property lawyer across Australia. She was previously a partner at Corrs Chambers Westgarth and is currently a non-executive director of Access Housing Australia and Chair of the Governance Committee. Rebecca is also a member of the Executive Finance and Property Committee of the Western Australian Planning Commission.

Mr Steve Toutountzis

Member, NMHS Board Finance Committee
Member, NMHS Board Audit and Risk Committee

Steve is a certified practising accountant and has an extensive background in finance, procurement, public sector service delivery and policy at an executive and strategic level. In his former role as Director, Performance and Evaluation – Group 1, Department of Treasury, his responsibilities included analysis and strategic advice to the WA Government on budgetary and financial management issues impacting a range of portfolios including Health. He is currently a member of the Board of Commissioners, Legal Aid Western Australia.

Our organisational structure

Robyn Lawrence
Chief Executive

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

Responsible for

- Aboriginal Health Strategy
- Area Mental Health Services
- Dental Health Services
- DonateLife Western Australia
- Public Health
- State Head Injury Unit

Jodi Graham
Acting Executive Director
Women and Newborn Health Service

Responsible for

- BreastScreen WA
- Community Midwifery Program
- Genetic Services and Familial Cancer programs
- King Edward Memorial Hospital
- Newborn Emergency Transport Service Western Australia
- 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

Janet Zagari
Acting Executive Director
Sir Charles Gairdner Osborne Park Health Care Group

Responsible for

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

Donald Coid
Acting Area Executive Director
Clinical Services

Responsible for

- Medical education and research
- Medical governance
- Medical workforce

Tony Dolan
Area Executive Director
Nursing and Midwifery Services

Responsible for

- Nursing and Midwifery Medical Equipment Replacement Program
- Nursing education and research
- Nursing governance
- Patient Support Services

Tanya Adair
Acting Executive Director
Procurement, Infrastructure and Contract Management

Responsible for

- Facilities management
- Fleet management
- Mail
- Metropolitan parking
- Public Private Partnership JHC
- Procurement, contract management and leasing
- Security
- Strategic asset planning and delivery
- Telecommunications

Jordan Kelly
Acting Executive Director
Business and Performance

Responsible for

- Audit and Risk Management
- Business information and performance
- Clinical planning (and Telehealth Service)
- Data stewardship and governance
- Finance
- Integrity and ethics
- Records management
- Workforce

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

Responsible for

- Clinical governance
- Community and stakeholder engagement
- Corporate governance
- Intellectual property
- Medico-legal services
- Safety and quality

Performance management framework

Outcome-based management framework

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

The OBM framework describes how outcomes, services and key performance indicators (KPIs) are used to measure the performance of the WA health system 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 framework measure the effectiveness and efficiency of the services delivered against agreed State Government priorities and desired outcomes.

The NMHS, as a health service provider, 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 5	Aged and continuing care services
Service 6	Public and community health services
Service 7	Community dental health services
Service 8	Small rural hospital services

Notes:
The NMHS provides some aged and continuing care services (Service 5); however, most are provided by the Department of Health on our behalf.

The Find Cancer Early program is an election commitment-funded program (Service 8). It aims to educate people throughout regional Western Australia about the signs and symptoms of cancer, which will lead them to seek help from a doctor. The program is being administered by the NMHS via the Cancer Council Western Australia and the messages are being delivered through partnerships with community organisations, local media, radio and newspaper advertisements, presentations and campaign resources across seven regions (Goldfields, Wheatbelt, Great Southern, Pilbara, Kimberley, Midwest and Southwest). Resources are also focused on hard-to-reach audiences, specifically remote and Aboriginal and Torres Strait Islander people.

No performance measures are reportable for services 5 and 8 as per the OBM framework.

Performance against these activities and outcomes is summarised in Table 4 and subsequently described in detail in the section 'Detailed information in support of KPIs'.

Shared responsibilities with other agencies

NMHS works closely with the Department of Health, as the System Manager, and partners with others, both government and non-government, in delivering health services to achieve the stated desired outcomes of the OBM framework.

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

Effectiveness KPIs

- Unplanned hospital readmissions for patients within 28 days for selected surgical procedures
- Percentage of elective waitlist patients waiting over boundary for reportable procedures
- Healthcare-associated *Staphylococcus aureus* bloodstream infections (HA-SABSI) per 10 000 occupied bed-days
- Survival rates for sentinel conditions
- Percentage of admitted patients who discharged against medical advice
- Percentage of liveborn term infants with an Apgar score of less than 7 at five minutes post-delivery
- Readmissions to acute specialised mental health inpatient services within 28 days of discharge
- Percentage of post-discharge community care within seven days following discharge from acute specialised mental health inpatient services

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

Outcome 2

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

Effectiveness KPIs

- Rate of women aged 50–69 years who participate in breast screening
- Percentage of adults and children who have a tooth re-treated within six 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 school children and socio-economically disadvantaged adults.

To support staff, patients and visitors to be smoke free while on and in NMHS sites, the NMHS Health Promotion Team developed a range of smoke free resources as part of their smoke free campaign.

The campaign – focused on protecting others from harmful exposure to tobacco smoke as opposed to stopping people from smoking – forms part of our commitment to making all NMHS sites and services smoke free.

For staff this included a wealth of resources designed to equip them with the tools needed to start the conversation with patients and visitors about creating a healthier smoke free environment. This included how to access free nicotine replacement therapy and training on smoking cessation (online and face-to-face), as well as wider resources for use by patients, visitors and staff, including smoking cessation strategies, smoke free tools and brochures, and case studies on smoke free health sites to demonstrate the benefits experienced to date.

We are committed to protecting and improving the health of staff, patients, visitors, contractors and volunteers, and providing a smoke free environment is one way of doing so.

Agency performance

Report on operations

Our annual budget is contained within the approved Minister for Health *Financial Management Act 2006* section 40 Annual Financial Estimates, which were developed based on the initial (2019) Service Agreement.

This agreement outlines the health services to be provided by the health service provider during the term of the agreement that are within the overall expense limit set by the Department CEO, as System Manager, in accordance with the State Government's purchasing intentions.

In 2018/19 the total cost of providing state services and health services to the NMHS community was $2.2 billion. Results for 2018/19 against agreed financial targets (based on the Budget Statements) are presented in Table 2.

Full details of the health service's financial performance during 2018/19 are provided in the financial statements.

Our Mental Health team joined forces with East Metropolitan Health Service clinicians and WA Police to help coordinate an effective response to mental health incidents.

The Mental Health Co-Response (MHCR) trial was introduced in response to steadily increasing demand on police to attend to and manage incidents that involved a mental health element.

WA Police, the Mental Health Commission and WA Health conducted the trial, which focused on reducing demand on emergency services, sharing risk-related information between agencies, and increasing police capabilities in dealing with people who appear to have a mental illness.

The trial, which started in 2016, operated six days a week from Monday to Saturday and from 2 pm to 10 pm. Mental health clinicians were embedded at the Police Operations Centre, the Perth Watch House and with two mobile police teams to advise at each stage of the police response to crisis situations.

Over 20 000 'welfare calls' were reviewed and advice was provided on risk. (A welfare call is when the police check on individuals where there is a reasonable belief that their health or wellbeing is at risk.) About 2900 people were immediately assessed in the community and mobile co-response teams transported the person to hospital only 25 per cent of the time.

The project was recognised as a finalist in the Mental Health Commissioner's Award category in the 2018 WA Health Excellence Awards.

Table 2: Actual results versus budget targets

Financial targets	2019 Target[1] $000	2019 Actual $000	Variation[2] $000	Explanation of variance Key factors
Total cost of services (expense limit) (sourced from Statement of comprehensive income)	2,148,460	2,212,397	63,937	▶ Expenditure on continuing and additional services for which funding had not been included in the initial target, but was the subject of budget adjustments throughout the year and at Mid-year Review. ▶ Higher dispensing of drugs under the Pharmaceutical Benefits Scheme, which is offset by recovery of this expenditure.
Net cost of services (sourced from Statement of comprehensive income)	1,185,121	1,222,806	37,685	▶ Commonwealth and Other Grants received for services that were not included in the initial target, but were the subject of budget adjustments throughout the year and at Mid-year Review. ▶ The $4.3 million reversal of the asset valuation decrement recorded in 2017/18 being reflected within the 2018/19 revenue position.
Total equity (sourced from Statement of financial position)	1,881,882	1,860,006	(21,876)	▶ $29.1 million increment in revaluation reserve, arising largely from Landgate's valuation of NMHS's land and buildings as at 30 June 2019. ▶ $2.7 million increase in accumulated surplus. ▶ $6.4 million increase in the Pathwest demerger value. ▶ Negative variation in contributed equity of $49 million relating to lower capital appropriation.
Net increase / (decrease) in cash held (sourced from Statement of cash flows)	4,885	33,701	28,816	▶ $40.9 million more Service Appropriation received, offset by a $9.9 million increase in operating expenditure. The majority of the additional appropriation was received in lieu of reduced National Health Reform Agreement funding ($20.5 million), $8.6 million relating to price increase for Activity Based Funded services, and allocation of $3.3 million funding for additional activity to address waitlist pressures.
Approved salary expense level	1,161,028	1,183,905	22,877	▶ Expenditure on services funded through budget adjustments received during the year, which were not included in the initial target.

Data sources: Budget strategy and reporting:

[1] As per 2018/19 section 40 Annual Financial Estimates.

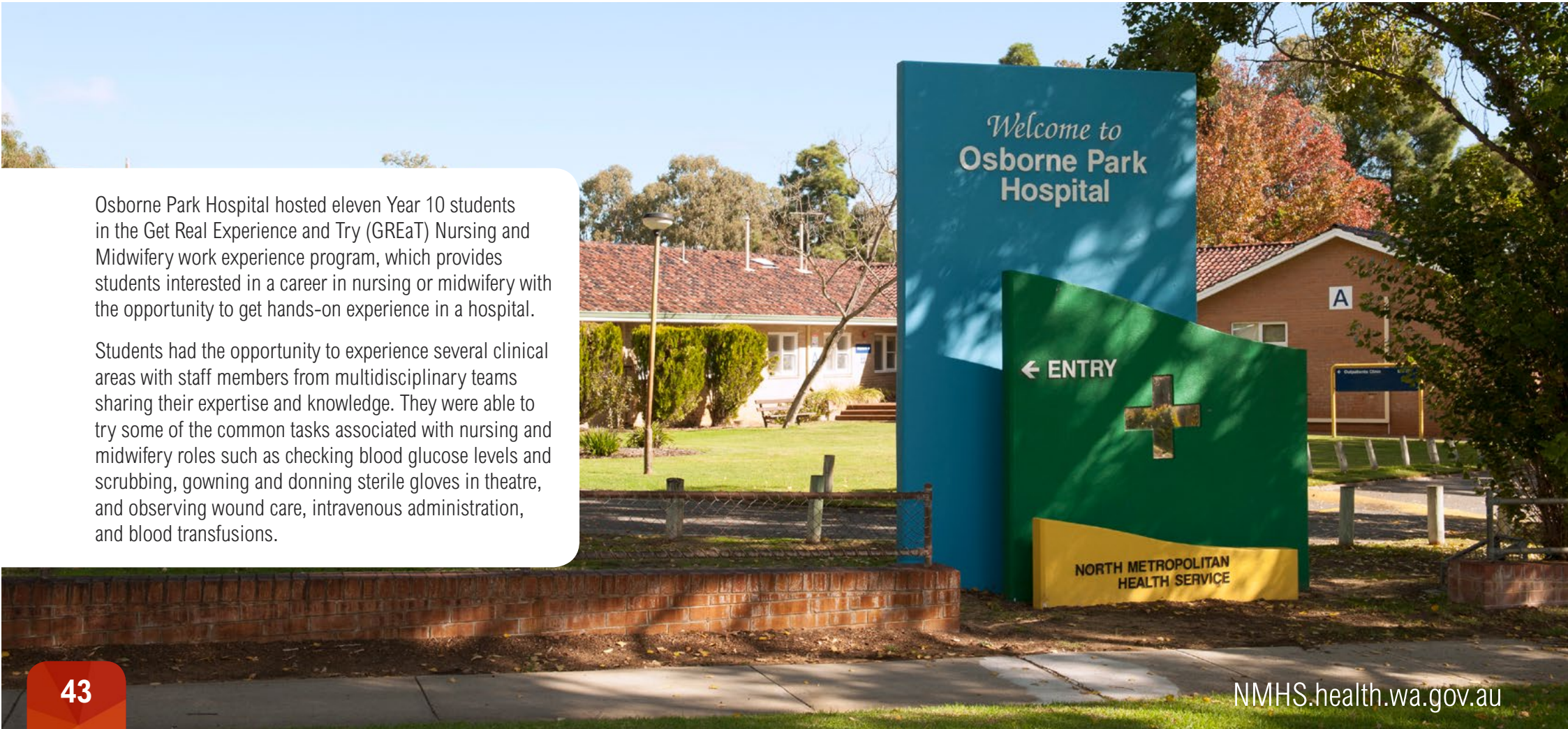
[2] Further explanations of variances are contained in Note 9.13 'Explanatory statement' to the Financial statements.

Table 3: Working cash targets

Financial targets	2019 Agreed limit $000	2019 Target/Actual $000	Variation $000
Agreed working cash limit (at budget)	101,176	101,176	0
Agreed working cash limit (at actuals)	102,493	112,176[(a)]	9,683

Data source: Funding plan from the NMHS Service Agreement 2018/19.

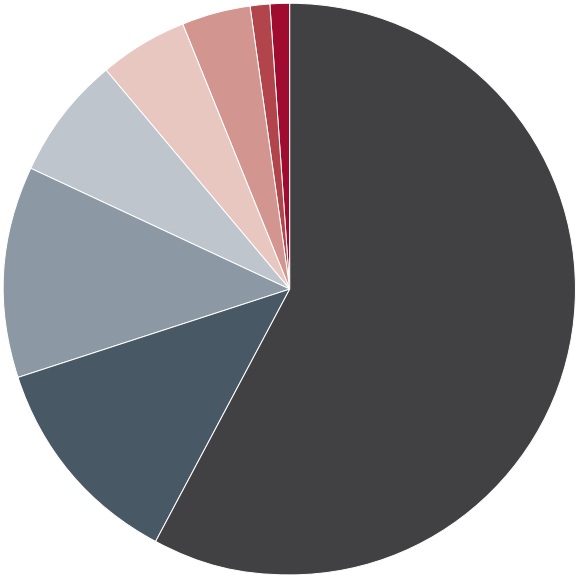
[(a)] The actual working cash held totals $112,175,775 which includes an amount of $2,999,207 held for Asset Investment Program milestone payments and $42,116,715 held for restricted or contractual obligations. The NMHS therefore has $67,059,853 discretionary cash of which $10,111,182 is quarantined primarily for research.



Osborne Park Hospital hosted eleven Year 10 students in the Get Real Experience and Try (GREaT) Nursing and Midwifery work experience program, which provides students interested in a career in nursing or midwifery with the opportunity to get hands-on experience in a hospital.

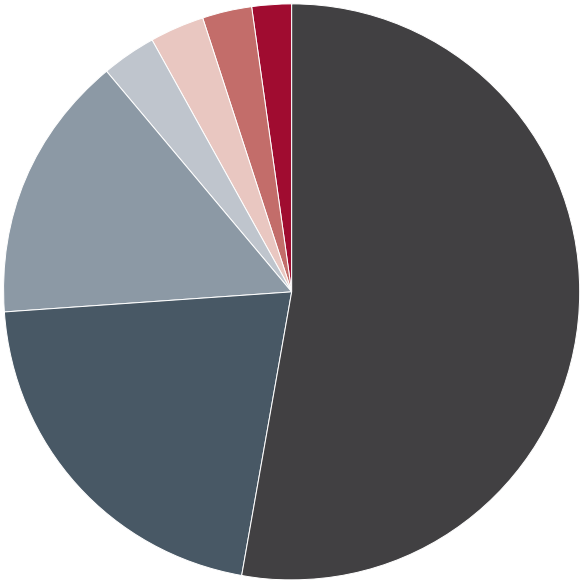
Students had the opportunity to experience several clinical areas with staff members from multidisciplinary teams sharing their expertise and knowledge. They were able to try some of the common tasks associated with nursing and midwifery roles such as checking blood glucose levels and scrubbing, gowning and donning sterile gloves in theatre, and observing wound care, intravenous administration, and blood transfusions.

Expenses by services



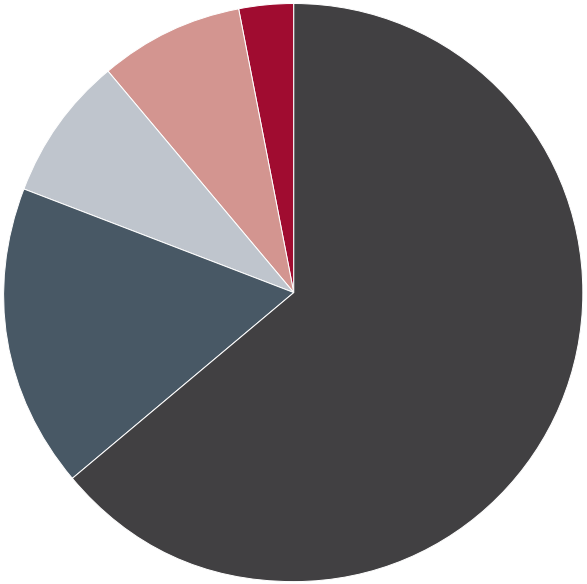
Public hospital admitted services	58%
Public hospital non-admitted services	12%
Mental health services	12%
Public hospital emergency services	7%
Public and community health services	5%
Community dental health services	4%
Aged and continuing care services	1%
Health system management – policy and corporate services	1%

Operating expenses



Employee benefits expense	53%
Contracts for services	21%
Patient support costs	15%
Other expenses	3%
Other supplies and services	3%
Depreciation and amortisation expenses	3%
Repairs, maintenance and consumable equipment	2%

Income other than income from State Government



Commonwealth grants and contributions	64%
Other grants and contributions	17%
Other fees for services	8%
Patient charges	8%
Other revenue	3%

Summary of key performance indicators

KPIs help us to assess and monitor the extent to which government outcomes are being achieved.

Effectiveness indicators provide information that help assess 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 we are performing.

Table 4 provides a summary of our KPIs and variation from the 2018/19 targets.

Table 4: Actual results versus KPI targets
Outcome 1: Public hospital-based services that enable effective treatment and restorative health care for Western Australians

	Calendar year			
Effectiveness KPI	**2018 Target**	**2018 Actual**	**Variation**	**Target met**
Unplanned hospital readmissions for patients within 28 days for selected surgical procedures				
Knee replacement	≤ 26.2	27.0	0.8	x
Hip replacement	≤ 17.2	14.4	2.8	✓
Tonsillectomy and adenoidectomy	≤ 61.0	102.7	41.7	x
Hysterectomy	≤ 41.3	51.9	10.6	x
Prostatectomy	≤ 38.8	48.9	10.1	x
Cataract surgery	≤ 1.1	1.1	0.0	✓
Appendicectomy	≤ 32.8	33.5	0.7	x
Healthcare-associated *Staphylococcus aureus* bloodstream infections (HA-SABSI) per 10 000 occupied bed-days	≤ 1.0	1.0	0.0	✓
Survival rates for sentinel conditions				
Stroke				
0 to 49 years	94.4%	92.8%	1.6%	x
50 to 59 years	93.3%	92.2%	1.1%	x
60 to 69 years	92.9%	93.1%	0.2%	✓
70 to 79 years	90.0%	88.7%	1.3%	x
80+ years	82.2%	84.6%	2.4%	✓

Table 4: Actual results versus KPI targets
Outcome 1: Public hospital-based services that enable effective treatment and restorative health care for Western Australians

	Calendar year			
Effectiveness KPI	**2018 Target**	**2018 Actual**	**Variation**	**Target met**
Acute myocardial infarction				
0 to 49 years	99.1%	96.9%	2.2%	x
50 to 59 years	98.9%	97.9%	1.0%	x
60 to 69 years	98.0%	97.7%	0.3%	x
70 to 79 years	96.3%	96.3%	0.0%	✓
80+ years	91.9%	91.2%	0.7%	x
Fractured neck of femur				
70 to 79 years	98.7%	95.9%	2.8%	x
80+ years	95.3%	95.2%	0.1%	x
Percentage of admitted patients who discharged against medical advice				
Aboriginal patients	≤ 0.77%	3.81%	3.04%	x
Non-Aboriginal patients	≤ 0.77%	0.75%	0.02%	✓
Percentage of liveborn term infants with an Apgar score of less than 7 at five minutes post-delivery	≤ 1.8%	2.0%	0.2%	x
Readmissions to acute specialised mental health inpatient services within 28 days of discharge	≤ 12%	16%	4%	x
Percentage of post-discharge community care within seven days following discharge from acute specialised mental health inpatient services	≥ 75%	71%	4%	x

	Financial year			
Effectiveness KPI	**2018/19 Target**	**2018/19 Actual**	**Variation**	**Target met**
Percentage of elective waitlist patients waiting over boundary for reportable procedures				
Category 1 over 30 days	0%	8%	8%	x
Category 2 over 90 days	0%	8%	8%	x
Category 3 over 365 days	0%	5%	5%	x

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

	Financial year			
Efficiency KPI	**2018/19 Target**	**2018/19 Actual**	**Variation**	**Target met**
Average admitted cost per weighted activity unit	$6,948	$7,137	$189	x
Average emergency department cost per weighted activity unit	$7,072	$6,212	$860	✓
Average non-admitted cost per weighted activity unit	$7,136	$7,018	$118	✓
Average cost per bed-day in specialised mental health inpatient services	$1,385	$1,500	$115	x
Average cost per treatment day of non-admitted care provided by mental health services	$420	$432	$12	x

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

	Calendar years			
Effectiveness KPI	**2017–18 Target**	**2017–18 Actual**	**Variation**	**Target met**
Rate of women aged 50–69 years who participate in breast screening	≥ 70%	56%	14%	x

	Financial year			
Effectiveness KPI	**2018/19 Target**	**2018/19 Actual**	**Variation**	**Target met**
Percentage of				
adults	< 7.7%	6.1%	1.6%	✓
children	< 2.6%	2.1%	0.5%	✓
who have a tooth re-treated within six months of receiving initial restorative dental treatment				
Percentage of eligible school children who are enrolled in the School Dental Service program	≥ 69%	79%	10%	✓
Percentage of eligible people who accessed Dental Health Services	≥ 15%	14%	1%	x

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

Efficiency KPI	Financial year			
	2018/19 Target	2018/19 Actual	Variation	Target met
Average cost per person of delivering population health programs by population health units	$36	$50	$14	x
Average cost per breast screening	$165	$158	$7	✓
Average cost per patient visit of WA Health-provided dental health programs for				
school children	$184	$193	$9	x
socio-economically disadvantaged adults	$283	$281	$2	✓

Performance indicator	Financial year			
	2018/19 Target	2018/19 Actual	Variation	Target met
Percentage of emergency department patients seen within recommended times				
Triage category 1 (2 minutes)	100%	100%	0%	✓
Triage category 2 (10 minutes)	≥ 80%	76%	4%	x
Triage category 3 (30 minutes)	≥ 75%	45%	30%	x
Triage category 4 (60 minutes)	≥ 70%	57%	13%	x
Triage category 5 (2 hours)	≥ 70%	85%	15%	✓

Note: Actual results versus KPI results (Table 4) are to be read in conjunction with detailed information on each KPI found in the agency performance section of this report.

"I love every minute of what I do here, it's so worthwhile. I feel lucky to enjoy the company of all the other wonderful volunteers and be part of such a lovely, friendly environment."

Osborne Park Hospital Volunteer Coordinator and President of Friends of Osborne Park Hospital, Pat.

Significant issues impacting the agency

Ageing infrastructure and new developments

Providing health services from dated infrastructure can be challenging; however, our priority is to ensure our patients, staff and those who visit our facilities are at all times safe.

Our asset planning processes consider forward investments in future years taking account of capital works, minor works and repairs and scheduled maintenance registers. For example, work has begun on a remediation strategy to replace Aluminium Composite Panel façade cladding at King Edward Memorial Hospital, which was identified following a state-wide cladding audit initiated by the Department of Mines, Industry Regulation and Safety, which followed the 2017 Grenfell Tower fire in London.

Current infrastructure upgrades and new developments progressed during 2018/19 include:

Osborne Park Hospital – $24.9 million project commenced for a new level 2A neonatal nursery, 16-bed stroke unit and a rehabilitation therapy hub. Construction is expected to be completed by the end of 2021.

Fremantle General Dental Clinic – $2.99 million project which opened to the public on 1 April 2019, providing public dental services in the City of Fremantle and surrounding areas. The new clinic suite, within Fremantle Hospital, comprises nine treatment rooms, a dental laboratory and staff support areas.

Sir Charles Gairdner Hospital – $17.5 million intraoperative MRI suite and two new operating theatres were completed, providing world-class surgical treatment to key patient groups requiring neurosurgery, allowing real-time imaging during procedures.

Joondalup Health Campus (JHC) expansion - Work has commenced on a detailed Project Definition Plan (PDP) that will inform the design and construction phases of the JHC expansion project. At the completion of the PDP, detailed design and documentation commences, followed by the tender process and the eventual award of construction contracts. Once finalised and approved by the State Government, announcements will be made clarifying the timeframes for the delivery of this investment and associated service enhancements.

Promoting a culture of integrity

The NMHS has strategies in place to prevent the misappropriation of funds and inappropriate use of public property. On 16 August 2018 the Corruption and Crime Commission (CCC) released the *Report into bribery and corruption in maintenance and service contracts within North Metropolitan Health Service*. The CCC formed opinions that the governance structures and processes in place had failed to protect the organisation from bribery, fraud and corruption. This report served as a serious wake-up call for the NMHS.

In response to the findings, the NMHS has taken the following actions with the aim of rectifying the deficiencies identified by the CCC:

- delivered targeted training to facilities management staff (July to August 2018)
- trained facilities management staff in the proper use of the procurement development and management system (PDMS) (October 2018)
- incorporated procurement training in the induction program for all new staff
- recorded all identified facilities management contracts in the PDMS
- facilitated the capture of all future procurement and contract documentation in the PDMS
- trained all facilities management staff in the use of the records management system
- appointed a document controller to monitor and maintain records management
- established a pilot procurement team
- implemented a Procurement Governance Framework (on trial until the end of December 2019 for the purposes of validation).

We have also conducted a comprehensive audit of our procurement and contract management practices, including related governance and internal controls, to assess their effectiveness. The findings from this audit will be used to further strengthen controls and to manage and monitor risks at all levels.

The CCC report also served as a catalyst for a large program of work undertaken across the Western Australian health system to strengthen the governance and accountability of the system as a whole through the Integrity, Fraud and Corruption (IFAC) Project. As part of the IFAC project, the NMHS determined to:

- resource our Integrity and Ethics Unit to enable more robust discipline management
- establish quarterly compliance reporting of gifts, conflict of interest and travel to the Area Executive Group
- strengthen communication and reporting on misconduct matters, including providing regular reports to the Board's Audit and Risk Committee.

Publication of the following policies provided additional assurance that officers are aware of their ongoing obligations and expected behaviour.

- NMHS Fraud and Corruption Control Plan (May 2019)
- Reporting of Criminal Conduct and Professional Misconduct Procedure (May 2019).

Addressing the recommendations in the CCC report remained a priority for the Board and Executive throughout 2018/19. The organisation has taken significant steps to tighten controls around facilities management and procurement as well as to strengthen the governance and lines of accountability across the NMHS in order to protect our organisation from misconduct. We recognise and acknowledge the significant efforts our staff have undertaken to improve the future of our organisation. While the work undertaken throughout the year has rectified the deficiencies identified in the CCC's report, we acknowledge it will be for the organisation as a whole to uphold the exemplary standards required of a public sector organisation and continue to promote a culture of integrity in the future.

Engagement and culture

Along with meeting our legislative obligations, we need to understand the size of the workforce, skill sets, work distribution, working patterns and aspects of employee retention. Understanding the diversity of our workforce and what keeps our employees engaged supports future workforce initiatives. At the same time, monitoring our health and safety statistics is vital in identifying emerging concerns to allow for early intervention.

In particular, we remain committed to improving two important pillars of our Organisational Development Strategy – culture and values, and employee engagement. The challenge of improving culture between staff, clinicians, patients and carers in an organisation as large as the NMHS is the focus of our new People, Engagement and Culture Advisory Council (PECAC). The Council, formed in early 2019, acts as a bridge between the Board's development strategy and staff at all levels of our organisation.

The 10 members of the PECAC are clinical staff who self-nominated via an expression of interest process that elicited 35 responses. The members were selected to represent a range of services and include a GP liaison and a representative from the Joondalup Health Campus. Nominees who were not selected for membership remain involved as ambassadors.

PECAC: Standing Row (L to R) Sam Carrello, Hadley Markus, Courtney Barnes, Hilary Fine, Peter Friedland, Theresa Marshall, Lesley Barr Sitting (L to R) Rachel Zombor, Danielle Thurlow, Linda Davies, Toni Heinemman.

The group participated in workshops in February and March 2019 to identify what is working well and what needs to change in a range of areas including staff engagement and wellbeing, facilities and environmental management and operational strategies. A comprehensive work program will be developed with the PECAC and progressed throughout the year, so that progress is shown in all areas.

In March 2019, many staff across the WA health system participated in the first annual Minister for Health 'Your Voice in Health' employee engagement survey. The survey was designed as a barometer of workplace engagement, and health and wellbeing.

NMHS staff agreed with the following general statements as areas of strength:

- I believe in the purpose and objectives of our organisation and are committed to our health service's goals.
- I feel I am able to make use of my individual skills and abilities.
- I have a sense of innovation at the employee level and feel able to apply this to my work.
- I have a strong commitment to workplace safety.
- I behave in a manner that is accepting of people from diverse backgrounds.

The survey also identified areas where staff felt there was room for improvement. Specifically, they aspired to the following:

- more open and honest communication from leadership
- clearer communication of the NMHS vision and direction to staff
- greater confidence in our ability to meet future challenges
- stronger belief in the decisions and behaviours of senior management being consistent with our organisational values
- increased recognition of their work and a feeling of being valued
- more trust in our commitment to patient and client satisfaction.

The feedback from this benchmark survey has provided an impetus for the Board and management to act to improve negative perceptions while leveraging our strengths and capabilities and continuing our journey of cultural transformation.

We take the health and safety of our workforce seriously as we regard these factors as critical to supporting engagement, productivity and the provision of high quality health care. Our vision for health and safety is for shared recognition of the importance of safety, confidence in the effectiveness of our health and safety practices and commitment to communications among co-workers that are founded on trust.

In February 2019, our Safety Climate Survey among staff revealed a generally positive safety culture across the organisation (76.8%). However, we conclude there is room for improvement in four areas:

- **Participative management** – leaders creating space to listen, understand, and involve staff in providing input into decisions in co-creation
- **Physical and psychological safety** – staff will not be punished for human errors in an unsafe system, consistent with a just culture
- **Choice and autonomy** – 'improving joy in work' as per the Healthcare Improvement Framework and the use of electronic health records to support the exchange of information across the organisation
- **Real-time management** – providing regular feedback to support continuous improvement.

Recognising that leadership plays a critical role in determining the culture of an organisation, our Executive team participated in workshops to define behaviours that underpin our organisational values, beliefs and desired culture. In addition, 200 leaders from across the NMHS attended a forum to discuss the specific leadership behaviours necessary for culture change. A 'values week' is planned to engage staff from across the organisation to refresh our organisational values. These will then be embedded within our people systems and processes such as the Performance Development Framework and the new Staff Recognition Program, as we move towards values-based recruitment.

Incidents of violence and aggression experienced by staff in the workplace have increased over recent years. Ensuring the safety of employees and service users is a key priority. While many individual actions have been taken at hospital sites over the years, an overarching approach is required. The draft *Prevention and Management of Workplace Violence and Aggression Strategy 2019–2024* has been designed with the aim of protecting our staff. It considers site risk profiles, evidence-based responses and consumer-centred care as well as staff safety and wellbeing. Broad consultation is under way to ensure the draft strategy meets the specific needs of the NMHS before finalisation, which is due later in 2019. Initial actions under the implementation plan will focus on areas of highest risk and will be tailored to the level of organisational and site risks.

Financial performance

Healthcare services must not only meet the highest quality and safety standards but also be flexible, convenient and affordable. The NMHS has a focus on strong financial and resource management in the face of complex new technology, increased community expectations for health care to be delivered differently, and higher absolute demand for services. We expect changes will largely be driven by advances in medical and information technology enabling new and innovative models of care. At the same time, we recognise the seriousness of the financial challenge that lies ahead as we commit to sustainability and accountability while continuing to provide safe, quality health care.

To demonstrate our commitment to fiscal responsibility, we have established the Sustainable and Accountable Future Program (SAFP), designed to future-proof the delivery of sustainable, quality care throughout our health service and to improve our patient and consumer experience. Over the past year, more than 30 projects have been developed under the program that reduce waste and duplication and increase efficiency. While some projects have brought direct financial savings, most are enabling activities that have improved the efficiency, effectiveness and quality of our services. Key areas have included corporate reform, reducing clinical variation, and realigning activities with revenue. Staff across the organisation have been actively engaged in developing, implementing and tracking the benefits of these projects.

By working together towards sustainability and strengthening the quality of the services we provide, we demonstrate our ability to significantly enhance our year-end position while at the same time improving our patient and consumer experience.

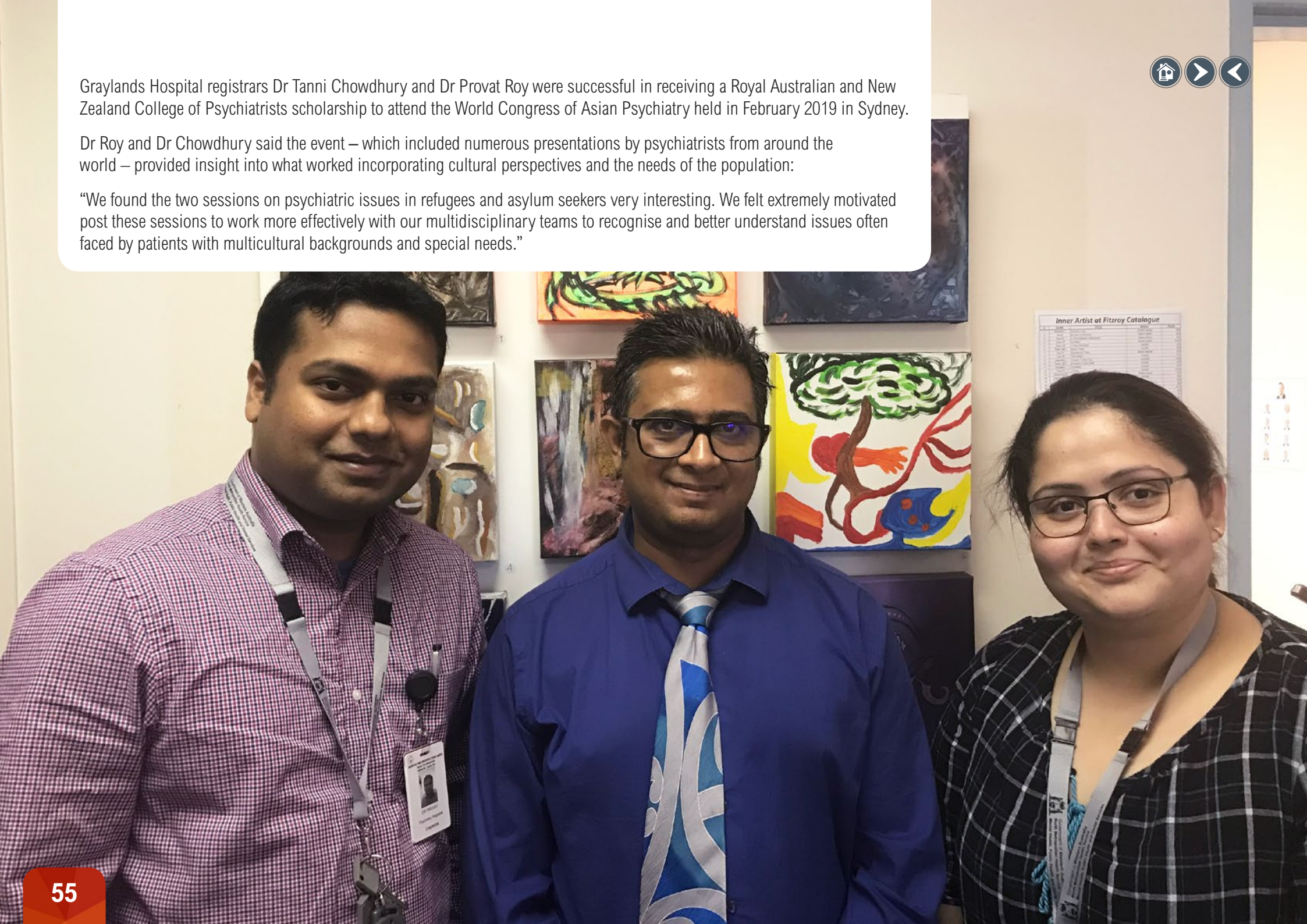
A new surgical procedure enabling tumours to be operated on in a much safer way is helping to transform the lives of cancer sufferers.

In a West Australian first, the pioneering surgery delivered out of our Sir Charles Gairdner Hospital enables the removal of previously inoperable soft tissue tumours through the use of a modified cardiac bypass machine, resulting in both improved safety and patient outcomes.

Graylands Hospital registrars Dr Tanni Chowdhury and Dr Provat Roy were successful in receiving a Royal Australian and New Zealand College of Psychiatrists scholarship to attend the World Congress of Asian Psychiatry held in February 2019 in Sydney.

Dr Roy and Dr Chowdhury said the event – which included numerous presentations by psychiatrists from around the world – provided insight into what worked incorporating cultural perspectives and the needs of the population:

"We found the two sessions on psychiatric issues in refugees and asylum seekers very interesting. We felt extremely motivated post these sessions to work more effectively with our multidisciplinary teams to recognise and better understand issues often faced by patients with multicultural backgrounds and special needs."



Disclosures and legal compliance

Audit opinion

Auditor General

INDEPENDENT AUDITOR'S REPORT

To the Parliament of Western Australia

NORTH METROPOLITAN HEALTH SERVICE

Report on the Financial Statements

Opinion
I have audited the financial statements of the North Metropolitan Health Service which comprise the Statement of Financial Position as at 30 June 2019, the Statement of Comprehensive Income, Statement of Changes in Equity, Statement of Cash Flows for the year then ended, and Notes comprising a summary of significant accounting policies and other explanatory information, including the Schedule of Income and Expenses by Service.

In my opinion, the financial statements are based on proper accounts and present fairly, in all material respects, the operating results and cash flows of the North Metropolitan Health Service for the year ended 30 June 2019 and the financial position at the end of that period. They are in accordance with Australian Accounting Standards, the *Financial Management Act 2006* and the Treasurer's Instructions.

Basis for Opinion
I conducted my audit in accordance with the Australian Auditing Standards. My responsibilities under those standards are further described in the *Auditor's Responsibility for the Audit of the Financial Statements* section of my report. I am independent of the Health Service in accordance with the *Auditor General Act 2006* and the relevant ethical requirements of the Accounting Professional and Ethical Standards Board's APES 110 *Code of Ethics for Professional Accountants* (the Code) that are relevant to my audit of the financial statements. I have also fulfilled my other ethical responsibilities in accordance with the Code. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

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

In preparing the financial statements, the Board is responsible for assessing the agency's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Western Australian Government has made policy or funding decisions affecting the continued existence of the Health Service.

Auditor's Responsibility for the Audit of the Financial Statements
As required by the *Auditor General Act 2006*, my responsibility is to express an opinion on the financial statements. The objectives of my audit are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion.

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Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with Australian Auditing Standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

As part of an audit in accordance with Australian Auditing Standards, I exercise professional judgment and maintain professional scepticism throughout the audit. I also:

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for my opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the agency's internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Board.
- Conclude on the appropriateness of the Board's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the agency's ability to continue as a going concern. If I conclude that a material uncertainty exists, I am required to draw attention in my auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify my opinion. My conclusions are based on the audit evidence obtained up to the date of my auditor's report.
- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

I communicate with the Board regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

Report on Controls

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

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

In my opinion, in all material respects, the controls exercised by the North Metropolitan Health Service are sufficiently adequate to provide reasonable assurance that the receipt, expenditure and investment of money, the acquisition and disposal of property and the incurring of liabilities have been in accordance with legislative provisions during the year ended 30 June 2019.

Audit opinion

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

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

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

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

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

Report on the Key Performance Indicators

Opinion
I have undertaken a reasonable assurance engagement on the key performance indicators of the North Metropolitan Health Service for the year ended 30 June 2019. The key performance indicators are the key effectiveness indicators and the key efficiency indicators that provide performance information about achieving outcomes and delivering services.

In my opinion, in all material respects, the key performance indicators of the North Metropolitan Health Service are relevant and appropriate to assist users to assess the Health Service's performance and fairly represent indicated performance for the year ended 30 June 2019.

Matter of Significance
The Under Treasurer has continued his approval to remove the following indicator as a key performance indicator (KPI):

- Percentage of emergency department patients seen within recommended times

The Under Treasurer's approval requires WA Health to reassess whether this indicator can be re-instated as a KPI once a new emergency department data collection system has been implemented. There is currently no set timeframe for the implementation of a new system. My opinion is not modified in respect of this matter.

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

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

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

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

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

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

Audit opinion

Matters Relating to the Electronic Publication of the Audited Financial Statements and Key Performance Indicators

This auditor's report relates to the financial statements and key performance indicators of the North Metropolitan Health Service for the year ended 30 June 2019 included on the Health Service's website. The Health Service's management is responsible for the integrity of the Health Service's website. This audit does not provide assurance on the integrity of the Health Service's website. The auditor's report refers only to the financial statements and key performance indicators described above. It does not provide an opinion on any other information which may have been hyperlinked to/from these financial statements or key performance indicators. If users of the financial statements and key performance indicators are concerned with the inherent risks arising from publication on a website, they are advised to refer to the hard copy of the audited financial statements and key performance indicators to confirm the information contained in this website version of the financial statements and key performance indicators.

CAROLINE SPENCER
AUDITOR GENERAL
FOR WESTERN AUSTRALIA
Perth, Western Australia
16 September 2019

Page 5 of 5

Certification of financial statements

For the year ended 30 June 2019

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 2019

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 2019 and financial position as at 30 June 2019.

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: Michael Hutchings
North Metropolitan Health Service
A/Chief Finance Officer

Date 13/9/19

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

Date 13/09/2019

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

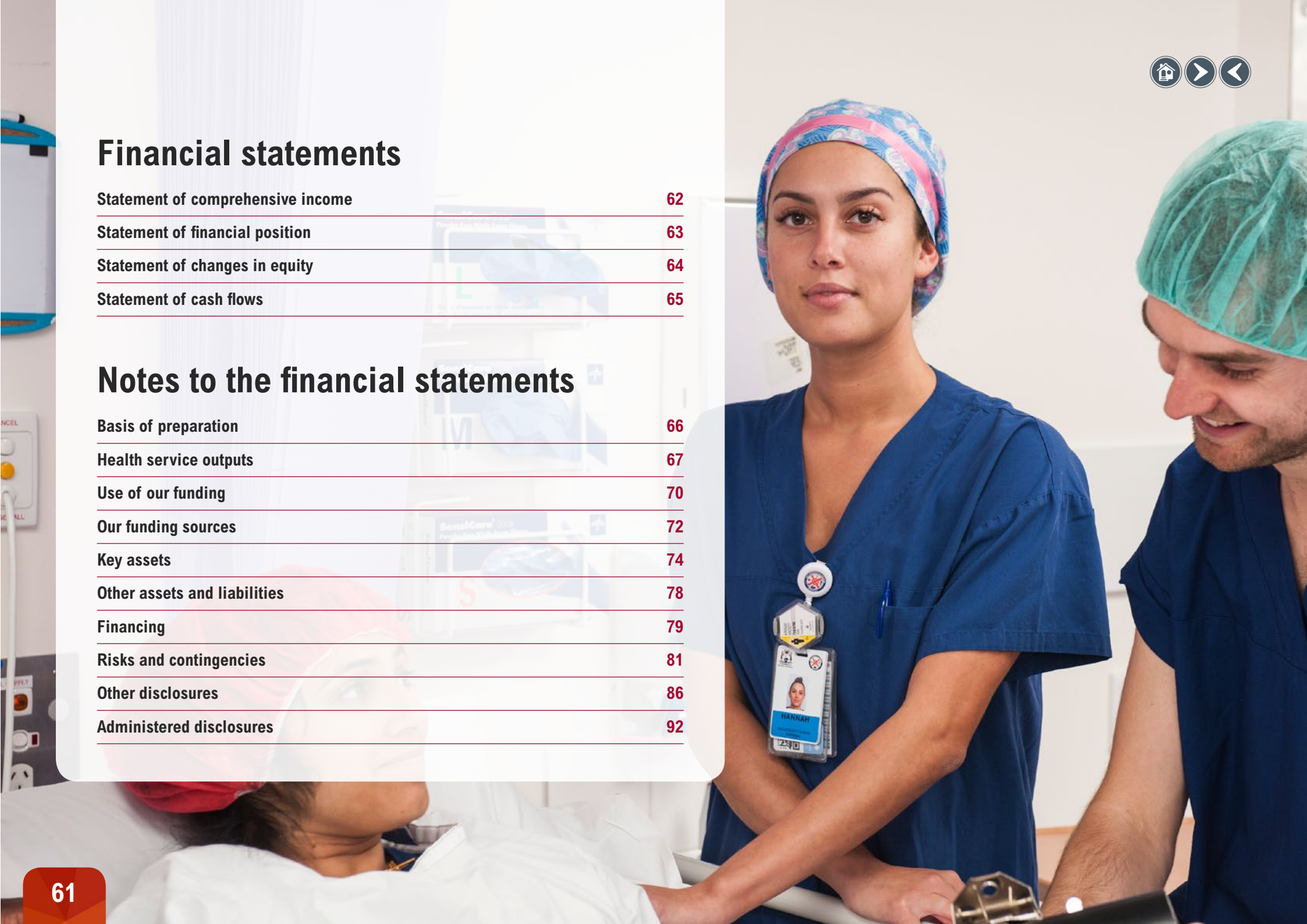
Date 13/9/19

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

OAG AUDITED 33

Financial statements

Notes to the financial statements



Financial statements

Statement of comprehensive income

For the year ended 30 June 2019

	Notes	2019 $000	2018 $000
COST OF SERVICES			
Expenses			
Employee benefits expense	3.1	1,183,905	1,388,748
Contracts for services	3.2	460,479	439,116
Patient support costs	3.3	325,396	316,789
Finance costs	7.2	39	179
Depreciation and amortisation expense	5.1, 5.2	69,628	78,825
Asset impairment losses		1,861	-
Asset revaluation decrement		-	4,337
Loss on disposal of non-current assets		166	86
Repairs, maintenance and consumable equipment	3.4	34,589	44,374
Other supplies and services	3.5	64,471	78,585
Other expenses	3.6	71,863	98,173
Total cost of services		**2,212,397**	**2,449,212**
INCOME			
Revenue			
Patient charges	4.2	74,273	119,959
Other fees for services	4.3	79,160	176,207
Commonwealth grants and contributions	4.4	635,403	668,115
Other grants and contributions	4.5	170,729	174,313
Donation revenue		386	2,170
Interest revenue		1	54
Other revenue	4.6	25,302	21,672
Total revenue		**985,254**	**1,162,490**
Gains			
Other gains	4.7	4,337	-
Total Gains		**4,337**	**-**
Total income other than income from State Government		**989,591**	**1,162,490**
NET COST OF SERVICES		**1,222,806**	**1,286,722**
INCOME FROM STATE GOVERNMENT			
Service appropriation	4.1	1,145,906	1,205,059
Assets assumed/(transferred)	4.1	45	(210)
Services received free of charge	4.1	87,830	69,973
Royalties for Regions Fund	4.1	371	382
Total income from State Government		**1,234,152**	**1,275,204**
SURPLUS/(DEFICIT) FOR THE PERIOD		**11,346**	**(11,518)**
OTHER COMPREHENSIVE INCOME/(LOSS)			
Items not reclassified subsequently to profit or loss			
Changes in asset revaluation reserve	9.10	17,505	2,868
Total other comprehensive income/(loss)		**17,505**	**2,868**
TOTAL COMPREHENSIVE INCOME/(LOSS) FOR THE PERIOD		**28,851**	**(8,650)**

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

For the year ended 30 June 2019

	Notes	2019 $000	2018 $000
ASSETS			
Current Assets			
Cash and cash equivalents	7.3	60,219	46,412
Restricted cash and cash equivalents	7.3	45,212	45,542
Receivables	6.1	53,236	63,454
Inventories	6.3	5,339	5,230
Other current assets	6.4	2,141	6,957
Total Current Assets		**166,147**	**167,595**
Non-Current Assets			
Restricted cash and cash equivalents	7.3	11,713	6,376
Amounts receivable for services	6.2	773,966	774,984
Receivables	6.1	-	3,502
Infrastructure, property, plant and equipment	5.1	1,389,163	1,517,014
Intangible assets	5.2	454	12,238
Total Non-Current Assets		**2,175,296**	**2,314,114**
TOTAL ASSETS		**2,341,443**	**2,481,709**
LIABILITIES			
Current Liabilities			
Payables	6.5	165,414	153,729
Borrowings	7.1	815	777
Employee related provisions	3.1	250,757	291,158
Other current liabilities	6.6	1,750	1,045
Total Current Liabilities		**418,736**	**446,709**
Non-Current Liabilities			
Borrowings	7.1	-	815
Employee related provisions	3.1	62,701	66,549
Total Non-Current Liabilities		**62,701**	**67,364**
TOTAL LIABILITIES		**481,437**	**514,073**
NET ASSETS		**1,860,006**	**1,967,636**
EQUITY			
Contributed equity	9.10	1,643,491	1,779,972
Reserves	9.10	163,809	146,304
Accumulated surplus/(deficit)	9.10	52,706	41,360
TOTAL EQUITY		**1,860,006**	**1,967,636**

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 2019

	Notes	Contributed equity $000	Reserves $000	Accumulated surplus/ (deficit) $000	Total equity $000
Balance at 1 July 2017		1,794,228	143,436	52,878	1,990,542
Surplus/(deficit)		-	-	(11,518)	(11,518)
Other comprehensive income	9.10	-	2,868	-	2,868
Total comprehensive income for the period		-	2,868	(11,518)	(8,650)
Transactions with owners in their capacity as owners:	9.10				
Capital appropriations		24,677	-	-	24,677
Other contributions by owners		14,938	-	-	14,938
Distributions to owners		(53,871)	-	-	(53,871)
Total		(14,256)	-	-	(14,256)
Balance at 30 June 2018		**1,779,972**	**146,304**	**41,360**	**1,967,636**
Balance at 1 July 2018		**1,779,972**	**146,304**	**41,360**	**1,967,636**
Surplus/(deficit)		-	-	11,346	11,346
Other comprehensive income	9.10	-	17,505	-	17,505
Total comprehensive income for the period		-	17,505	11,346	28,851
Transactions with owners in their capacity as owners:	9.10				
Capital appropriations		12,490	-	-	12,490
Other contributions by owners		1,765	-	-	1,765
Distributions to owners		(150,736)	-	-	(150,736)
Total		(136,481)	-	-	(136,481)
Balance at 30 June 2019		**1,643,491**	**163,809**	**52,706**	**1,860,006**

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 2019

	Notes	2019 $000 Inflows (Outflows)	2018 $000 Inflows (Outflows)
CASH FLOWS FROM STATE GOVERNMENT			
Service appropriation		1,075,155	1,125,506
Capital appropriations		11,787	39,234
Royalties for Regions Fund		371	382
Net cash provided by State Government		**1,087,313**	**1,165,122**
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Employee benefits		(1,161,798)	(1,359,108)
Supplies and services		(852,419)	(883,287)
Finance costs		-	(118)
Receipts			
Receipts from customers		65,575	115,227
Commonwealth grants and contributions		635,403	668,115
Other grants and contributions		170,729	174,313
Donations received		294	699
Interest received		2	116
Other receipts		102,603	186,117
Net cash provided by/(used in) operating activities	7.3	**(1,039,611)**	**(1,097,926)**
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments			
Purchase of non-current physical and intangible assets		(14,030)	(55,609)
Receipts			
Proceeds from sale of non-current physical assets		29	-
Net cash provided by/(used in) investing activities		**(14,001)**	**(55,609)**
CASH FLOWS FROM FINANCING ACTIVITIES			
Payments			
Repayment of finance lease liabilities		-	(2,572)
Net cash provided by/(used in) financing activities		**-**	**(2,572)**
Net increase/(decrease) in cash and cash equivalents		33,701	9,015
Cash and cash equivalents at the beginning of the period		98,330	89,315
Cash transferred to PathWest as part of demerger		(14,887)	-
CASH AND CASH EQUIVALENTS AT THE END OF THE PERIOD	7.3	**117,144**	**98,330**

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 2019

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).

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

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 various 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.

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.

	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 statewide 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.

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.

2.1 Health Service objectives (continued)

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 statewide 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. Small Rural Hospital Services
Provides emergency care and limited acute medical/minor surgical services in locations 'close to home' for country residents/visitors, by small and rural hospitals classified as block funded. Includes community care services aligning to local community needs.

9. Health System Management – Policy and Corporate Services
The provision of strategic leadership, policy and planning services, system performance management and purchasing linked to the statewide 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.

10. 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 2019

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		Public and Community Health Services	
	2019 $000	2018 $000	2019 $000	2018 $000	2019 $000	2018 $000	2019 $000	2018 $000	2019 $000	2018 $000	2019 $000	2018 $000
COST OF SERVICES												
Expenses												
Employee benefits expense	643,260	638,882	54,447	50,440	146,908	132,603	198,140	194,716	10,934	11,966	47,834	56,518
Contracts for services	304,523	298,106	85,011	84,522	23,913	22,069	22,802	21,722	2,058	5,733	20,908	5,831
Patient support costs	205,272	168,145	12,251	11,291	66,743	87,778	10,157	11,258	2,376	2,652	15,367	20,990
Finance costs	32	132	1	25	2	9	-	7	-	-	4	6
Depreciation and amortisation expense	42,105	44,515	3,698	3,985	9,379	9,727	7,546	7,651	18	14	3,662	3,604
Asset impairment losses	1,533	-	34	-	214	-	11	-	-	-	10	-
Asset revaluation decrement	-	3,539	-	56	-	169	-	-	-	-	-	-
Loss on disposal of non-current assets	80	43	5	9	3	22	-	(2)	-	-	46	(1)
Repairs, maintenance and consumable equipment	16,390	17,307	1,070	1,129	6,228	6,615	3,990	4,365	382	286	3,781	2,521
Other supplies and services	37,888	34,810	3,758	2,116	10,240	8,722	5,800	12,696	484	329	2,611	4,516
Other expenses	24,814	38,102	1,679	2,175	5,053	5,994	13,046	10,910	594	693	15,701	15,162
Total cost of services	**1,275,897**	**1,243,581**	**161,954**	**155,748**	**268,683**	**273,708**	**261,492**	**263,323**	**16,846**	**21,673**	**109,924**	**109,147**
INCOME												
Revenue												
Patient charges	55,962	52,365	1,100	1,752	10,349	14,409	1,138	-	1	-	1	-
Other fees for services	28,390	951	43	76	39,609	58,274	277	397	-	-	5,054	4,817
Commonwealth grants and contributions	400,976	403,947	53,547	58,963	86,273	103,435	73,289	72,734	4,322	6,434	4,698	7,846
Other grants and contributions	322	1,215	29	154	839	1,748	165,943	169,848	1,437	-	1,215	-
Donation revenue	5	65	-	2	8	6	3	11	-	-	370	1,701
Interest revenue	1	24	-	4	-	7	-	8	-	-	-	11
Other revenue	3,460	3,735	219	277	6,273	6,274	339	902	5	29	14,044	8,211
Total revenue	**489,116**	**462,302**	**54,938**	**61,228**	**143,351**	**184,153**	**240,989**	**243,900**	**5,765**	**6,463**	**25,382**	**22,586**
Gains												
Other gains	2,334	-	188	-	527	-	715	-	-	-	-	-
Total Gains	**2,334**	**-**	**188**	**-**	**527**	**-**	**715**	**-**	**-**	**-**	**-**	**-**
Total income other than income from State Government	**491,450**	**462,302**	**55,126**	**61,228**	**143,878**	**184,153**	**241,704**	**243,900**	**5,765**	**6,463**	**25,382**	**22,586**
NET COST OF SERVICES	**784,447**	**781,279**	**106,828**	**94,520**	**124,805**	**89,555**	**19,788**	**19,423**	**11,081**	**15,210**	**84,542**	**86,561**
INCOME FROM STATE GOVERNMENT												
Service appropriation	712,210	726,188	110,615	91,890	111,819	81,256	14,807	7,651	13,234	19,303	88,886	85,615
Assets assumed/(transferred)	-	(243)	-	(19)	-	(26)	-	(29)	5	-	-	184
Services received free of charge	57,107	31,199	5,584	1,757	14,481	7,299	4,981	11,801	406	288	1,943	3,089
Royalties for Regions Fund	-	-	-	-	-	-	-	-	-	382	-	-
Total income from State Government	**769,317**	**757,144**	**116,199**	**93,628**	**126,300**	**88,529**	**19,788**	**19,423**	**13,645**	**19,973**	**90,829**	**88,888**
SURPLUS/(DEFICIT) FOR THE PERIOD	**(15,130)**	**(24,135)**	**9,371**	**(892)**	**1,495**	**(1,026)**	**-**	**-**	**2,564**	**4,763**	**6,287**	**2,327**

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

2.2 Schedule of income and expenses by service (continued)

	Community Dental Health Services		Small Rural Hospital Services		Health System Management - Policy and Corporate Services		Health Support Services *		Total	
	2019 $000	2018 $000	2019 $000	2018 $000	2019 $000	2018 $000	2019 $000	2018 $000	2019 $000	2018 $000
COST OF SERVICES										
Expenses										
Employee benefits expense	69,913	68,934	-	-	12,469	19,637	-	215,052	1,183,905	1,388,748
Contracts for services	828	959	377	-	59	174	-	-	460,479	439,116
Patient support costs	12,931	14,481	-	-	299	194	-	-	325,396	316,789
Finance costs	-	-	-	-	-	-	-	-	39	179
Depreciation and amortisation expense	3,219	1,698	-	-	1	3	-	7,628	69,628	78,825
Asset impairment losses	59	-	-	-	-	-	-	-	1,861	-
Asset revaluation decrement	-	573	-	-	-	-	-	-	-	4,337
Loss on disposal of non-current assets	32	8	-	-	-	-	-	7	166	86
Repairs, maintenance and consumable equipment	2,506	2,722	-	-	242	105	-	9,324	34,589	44,374
Other supplies and services	3,031	3,155	9	-	650	2,290	-	9,951	64,471	78,585
Other expenses	6,378	6,814	-	-	4,598	4,206	-	14,117	71,863	98,173
Total cost of services	**98,897**	**99,344**	**386**	**-**	**18,318**	**26,609**	**-**	**256,079**	**2,212,397**	**2,449,212**
INCOME										
Revenue										
Patient charges	5,722	5,546	-	-	-	-	-	45,887	74,273	119,959
Other fees for services	5,787	5,241	-	-	-	-	-	106,451	79,160	176,207
Commonwealth grants and contributions	12,298	12,113	-	-	-	2,207	-	436	635,403	668,115
Other grants and contributions	944	689	-	-	-	-	-	659	170,729	174,313
Donation revenue	-	-	-	-	-	-	-	385	386	2,170
Interest revenue	-	-	-	-	-	-	-	-	1	54
Other revenue	962	611	-	-	-	-	-	1,633	25,302	21,672
Total revenue	**25,713**	**24,200**	**-**	**-**	**-**	**2,207**	**-**	**155,451**	**985,254**	**1,162,490**
Gains										
Other gains	573	-	-	-	-	-	-	-	4,337	-
Total Gains	**573**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**4,337**	**-**
Total income other than income from State Government	**26,286**	**24,200**	**-**	**-**	**-**	**2,207**	**-**	**155,451**	**989,591**	**1,162,490**
NET COST OF SERVICES	**72,611**	**75,144**	**386**	**-**	**18,318**	**24,402**	**-**	**100,628**	**1,222,806**	**1,286,722**
INCOME FROM STATE GOVERNMENT										
Service appropriation	71,394	71,617	6	-	22,935	24,500	-	97,039	1,145,906	1,205,059
Assets assumed/(transferred)	45	-	-	-	(5)	(6)	-	(71)	45	(210)
Services received free of charge	2,766	2,847	9	-	553	1,876	-	9,817	87,830	69,973
Royalties for Regions Fund	-	-	371	-	-	-	-	-	371	382
Total income from State Government	**74,205**	**74,464**	**386**	**-**	**23,483**	**26,370**	**-**	**106,785**	**1,234,152**	**1,275,204**
SURPLUS/(DEFICIT) FOR THE PERIOD	**1,594**	**(680)**	**-**	**-**	**5,165**	**1,968**	**-**	**6,157**	**11,346**	**(11,518)**

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

*The 2018 actual includes pathology services provided by PathWest to organisations and patients external to NMHS. PathWest demerged from the NMHS on 1 July 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	2019 $000	2018 $000
Employee benefits expense	3.1 (a)	1,183,905	1,388,748
Employee related provisions	3.1 (b)	313,458	357,707
Contracts for services	3.2	460,479	439,116
Patient support costs	3.3	325,396	316,789
Repairs, maintenance and consumable equipment	3.4	34,589	44,374
Other supplies and services	3.5	64,471	78,585
Other expenses	3.6	71,863	98,173

3.1 (a) Employee benefits expense

	2019 $000	2018 $000
Wages and salaries	1,083,989	1,272,593
Superannuation – defined contribution plans [a]	99,916	116,155
Total employee benefits expense	**1,183,905**	**1,388,748**

[a] Defined contribution plans include West State Superannuation Scheme (WSS), Gold State Superannuation Scheme (GSS), Government Employees Superannuation Board Schemes (GESBs) and other eligible funds.

Wages and salaries: Employee expenses include all costs related to employment including wages and salaries, fringe benefit tax, and leave entitlements.

Superannuation: The amount recognised in profit or loss of the Statement of Comprehensive Income comprises employer contributions paid to the GSS (concurrent contributions), the WSS, the GESBs, 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. It is however 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 the 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.

3.1 (b) Employee related provisions

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

	2019 $000	2018 $000
Current		
Annual leave [a]	118,037	129,384
Time off in lieu leave [a]	31,456	44,535
Long service leave [b]	99,980	115,665
Deferred salary scheme [c]	1,284	1,574
Total current employee related provisions	**250,757**	**291,158**
Non-current		
Long service leave [b]	62,701	66,549
	62,701	**66,549**
Total employee related provisions	**313,458**	**357,707**

3.1 (b) Employee related provisions (continued)

[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	98,665	118,265
More than 12 months after the end of the reporting period	50,828	55,654
	149,493	**173,919**

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

Health Support Services (HSS) is continuing to quantify and resolve the errors in the calculated Public Holiday Time Off in Lieu (PH TOIL) balances arising from inconsistent interpretation of employee industrial awards and configuration of the payroll system. An amount of $1.3 million is included in the TOIL leave liability to accrue for the remaining employee classes that are affected by this issue.

[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	16,997	28,916
More than 12 months after the end of the reporting period	145,684	153,298
	162,681	**182,214**

The provisions for long service leave is 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.

[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:

	2019 $000	2018 $000
Within 12 months of the end of the reporting period	770	944
More than 12 months after the end of the reporting period	514	630
	1,284	**1,574**

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
- Expected future payments

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

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

3.2 Contracts for services

	2019 $000	2018 $000
Public patients services [a]	404,280	386,518
Mental Health	33,706	37,677
Other aged-care services	8,965	12,304
Other contracts	13,528	2,617
Total contracts for services	**460,479**	**439,116**

Contracts for services are recognised as an expense in the reporting period in which they are incurred.

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

3.3 Patient support costs

	2019 $000	2018 $000
Medical supplies and services	226,689	252,412
Pathology Services [a]	32,124	-
Domestic charges	17,712	18,510
Fees for visiting medical practitioners	14,805	14,170
Fuel, light and power	14,562	12,979
Food supplies	8,681	8,611
Patient transport costs	2,653	2,433
Research, development and other grants	8,170	7,674
Total patient support costs	**325,396**	**316,789**

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

[a] Services received free of charge, see note 4.1 Income from State Government.

3.4 Repairs, maintenance and consumable equipment

	2019 $000	2018 $000
Repairs and maintenance	25,386	33,765
Consumable equipment	9,203	10,609
Total repairs, maintenance and consumable equipment	**34,589**	**44,374**

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).

3.5 Other supplies and services

	2019 $000	2018 $000
Sanitisation and waste removal services	2,817	2,770
Administration and management services	3,200	3,232
Interpreter services	2,546	2,092
Security services	114	530
Services provided by Health Support Services: [a]		
ICT services	36,490	46,686
Supply chain services	7,339	9,069
Financial services	3,176	3,845
Human resource services	8,683	10,361
Other	106	-
Total other supplies and services	**64,471**	**78,585**

Supplies and services are recognised as an expense in the reporting period in which they are incurred.

[a] Services received free of charge, see note 4.1 Income from State Government.

3.6 Other expenses

	2019 $000	2018 $000
Communications	4,613	4,938
Computer services	2,320	3,958
Workers' compensation insurance	14,220	14,656
Operating lease expenses	7,321	9,102
Other insurances	12,287	15,654
Consultancy fees	3,336	4,158
Other employee-related expenses	6,212	8,505
Printing and stationeries	3,750	5,057
Doubtful debts expense [a]	-	16,594
Expected credit losses expense [a]	2,650	-
Freight and cartage	1,136	3,635
Periodical subscriptions	2,627	2,578
Write-down of assets	346	-
Motor vehicle expenses	1,462	1,744
Licence and Regulatory Fees	2,648	2,066
Other	6,935	5,528
Total other expenses	**71,863**	**98,173**

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

[a] Doubtful debts expense was recognised as the movement in the allowance for impairment of receivables (or provision for doubtful debts). From 2018-19, **expected credit losses expense** is recognised as the movement in the allowance for expected credit losses. The allowance for expected credit losses of trade receivables is measured at the lifetime expected credit losses at each reporting date. The Health Service has established a provision matrix that is based on its historical credit losses experience, adjusted for forward-looking factors specific to the debtors and the economic environment. Please refer to note 6.1.1 Movement in the allowance for impairment of receivables.

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 incomes received by the Health Service and the relevant notes are:

	Notes	2019 $000	2018 $000
Income from State Government	4.1		
Service appropriation	4.1.1	1,145,906	1,205,059
Assets transferred from/(to) other State Government agencies during the period	4.1.2	45	(210)
Services received free of charge from other State Government agencies during the period	4.1.3	87,830	69,973
Royalties for Regions Fund	4.1.4	371	382
Patient charges	4.2	74,273	119,959
Other fees for services	4.3	79,160	176,207
Commonwealth grants and contributions	4.4	635,403	668,115
Other grants and contributions	4.5	170,729	174,313
Donation revenue		386	2,170
Interest revenue		1	54
Other revenue	4.6	25,302	21,672
Other gains	4.7	4,337	-

4.1 Income from State Government

4.1.1 Appropriation received during the period:

	2019 $000	2018 $000
Service appropriation (funding via the Department of Health) [a]	1,145,906	1,205,059
	1,145,906	**1,205,059**

[a] 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:

	2019 $000	2018 $000
– Transfers from/(to) the Department of Health	-	(21)
– Transfers from/(to) WA Country Health Service (WACHS)	45	-
– Transfers from/(to) South Metropolitan Health Service (SMHS)	-	6
– Transfers from/(to) East Metropolitan Health Service (EMHS)	-	(203)
– Transfers from/(to) Child & Adolescent Health Service (CAHS)	-	8
	45	**(210)**

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.

4.1 Income from State Government (continued)

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

	2019 $000	2018 $000
Department of Finance – government leased accommodation	18	13
PathWest – pathology services	32,124	-
Services received from Health Support Services (HSS)		
ICT services	36,490	46,685
Supply chain services	7,339	9,069
Financial services	3,176	3,845
Human resource services	8,683	10,361
	87,830	**69,973**

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.

4.1.4 Royalties for Regions Fund

	2019 $000	2018 $000
Regional Community Services Account [a]	371	382
Total Royalties for Regions Fund	**371**	**382**

[a] Represents a sub-fund within the overarching '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

	2019 $000	2018 $000
Inpatient bed charges	50,559	50,095
Inpatient other charges	6,559	7,003
Outpatient charges	17,155	16,977
Pathology services to patients	-	45,884
	74,273	**119,959**

Revenue recognition

Revenue is recognised and measured at the fair value of consideration received or receivable. Revenue is recognised for the major business activities as follows:

Provision of services
Revenue is recognised by reference to the stage of completion of the transaction.

4.3 Other fees for services

	2019 $000	2018 $000
Recoveries from the Pharmaceutical Benefits Scheme	67,386	58,141
Clinical services to other health organisations	3,272	8,982
Non-clinical services to other health organisations	8,502	7,912
Pathology services to other Health Services and other government agencies [a]	-	101,172
	79,160	**176,207**

See revenue recognition under note 4.2 Patient charges.

[a] Represents 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).

4.4 Commonwealth grants and contributions

	2019 $000	2018 $000
Capital Grants		
Project funded under the National Partnership Agreement	-	8,659
Other	4,754	129
Recurrent Grants		
National Health Reform Agreement (funding via Department of Health) [(a)]	524,642	529,639
National Health Reform Agreement (funding via Mental Health Commission) [(a)]	73,289	72,735
Other	32,718	56,953
	635,403	**668,115**

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.

Any grants and contributions monies received that remain unspent are recognised as Restricted Cash under note 7.3.1.

For **non-reciprocal grants**, the Health Services recognises revenue when the grant is receivable at its fair value as and when its fair value can be reliably measured.

Contributions of services are only recognised when a fair value can be reliably determined and the services would have been purchased if not donated.

4.5 Other grants and contributions

	2019 $000	2018 $000
Mental Health Commission – service delivery agreement	164,300	168,215
Mental Health Commission – other	1,639	1,633
Disability Services Commission – community aids and equipment program	1,416	1,483
Other	3,374	2,982
	170,729	**174,313**

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

	2019 $000	2018 $000
Use of hospital facilities	8,412	5,969
Rent from commercial properties	214	384
Rent from residential properties	335	334
Boarders' accommodation	1,839	1,583
RiskCover insurance premium rebate	5,304	4,996
Sale of radiopharmacies	1,949	1,553
Parking	4,420	2,638
Other	2,829	4,215
	25,302	**21,672**

See revenue recognition under note 4.2 Patient charges.

4.7 Other gains

	2019 $000	2018 $000
Revaluation increments (offsetting decrements)	4,337	-
	4,337	**-**

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 both the key accounting policies and financial information about the performance of these assets:

	Notes	2019 $000	2018 $000
Property, plant and equipment	5.1	1,389,163	1,517,014
Depreciation and impairment	5.1.1	69,504	78,758
Intangible assets	5.2	454	12,238
Amortisation and impairment	5.2.1	124	67

5.1 Infrastructure, property, plant and equipment

Year ended 30 June 2018	Land $000	Buildings $000	Buildings under construction $000	Site infrastructure $000	Leasehold improvements $000	Computer equipment $000	Furniture & fittings $000	Motor vehicles $000	Medical equipment $000	Other plant & equipment $000	Work In progress $000	Artworks $000	Total $000
1 July 2017													
Gross carrying amount	267,966	1,021,159	14,066	136,669	2,265	766	7,020	199	104,221	74,460	642	332	1,629,765
Accumulated depreciation	-	-	-	(4,405)	(580)	(171)	(665)	(60)	(15,851)	(3,936)	-	-	(25,668)
Accumulated impairment loss	-	-	-	-	-	-	-	-	-	-	-	-	-
Carrying amount at start of period	**267,966**	**1,021,159**	**14,066**	**132,264**	**1,685**	**595**	**6,355**	**139**	**88,370**	**70,524**	**642**	**332**	**1,604,097**
Additions	-	4,576	10,533	6	-	146	187	-	16,550	668	(293)	-	32,373
Disposal	-	-	-	-	-	-	(12)	-	(66)	(8)	-	-	(86)
Transfers to other reporting entities	(38,570)	-	-	-	-	-	-	11	(234)	12	-	-	(38,781)
Transfers from work in progress	-	9,454	(10,197)	135	-	26	20	-	572	26	(36)	-	-
Revaluation increments/(decrements)	(5,013)	3,544	-	-	-	-	-	-	-	-	-	-	(1,469)
Impairment losses	-	-	-	-	-	-	-	-	-	-	-	-	-
Impairment losses reversed	-	-	-	-	-	-	-	-	-	-	-	-	-
Depreciation	-	(51,193)	-	(4,808)	(472)	(220)	(666)	(24)	(17,489)	(3,886)	-	-	(78,758)
Write-off assets [(a)]	-	-	-	-	-	-	-	-	(362)	-	-	-	(362)
Carrying amount at 30 June 2018	**224,383**	**987,540**	**14,402**	**127,597**	**1,213**	**547**	**5,884**	**126**	**87,341**	**67,336**	**313**	**332**	**1,517,014**

The infrastructure, property, plant and equipment should be read in conjunction with the accompanying notes.

5.1 Infrastructure, property, plant and equipment (continued)

Year ended 30 June 2019	Land	Buildings	Buildings under construction	Site infrastructure	Leasehold improvements	Computer equipment	Furniture & fittings	Motor vehicles	Medical equipment	Other plant & equipment	Work In progress	Artworks	Total
	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000
1 July 2018													
Gross carrying amount	224,383	1,038,733	14,402	136,810	2,265	938	7,215	210	120,681	75,158	313	332	1,621,440
Accumulated depreciation	-	(51,193)	-	(9,213)	(1,052)	(391)	(1,331)	(84)	(33,340)	(7,822)	-	-	(104,426)
Accumulated impairment loss	-	-	-	-	-	-	-	-	-	-	-	-	-
Carrying amount at start of period prior to demerger	224,383	987,540	14,402	127,597	1,213	547	5,884	126	87,341	67,336	313	332	1,517,014
Demerger of PathWest	-	(72,352)	(12)	-	-	(258)	(76)	-	(18,941)	(809)	(144)	-	(92,592)
Carrying amount at start of period	**224,383**	**915,188**	**14,390**	**127,597**	**1,213**	**289**	**5,808**	**126**	**68,400**	**66,527**	**169**	**332**	**1,424,422**
Additions	-	525	2,463	3	2,333	79	131	-	7,089	346	-	13	12,982
Disposal	-	-	-	-	-	-	(14)	-	(161)	(20)	-	-	(195)
Transfers from other reporting entities	-	-	-	1,765	-	-	-	-	45	-	-	-	1,810
Transfers from work in progress	-	7,335	(11,336)	438	-	160	25	-	3,496	-	(118)	-	-
Revaluation increments/(decrements)	5,405	16,437	-	-	-	-	-	-	-	-	-	-	21,842
Impairment losses	-	-	-	-	-	-	(115)	-	(1,615)	(83)	-	(35)	(1,848)
Depreciation	-	(44,721)	-	(5,538)	(464)	(148)	(677)	(29)	(14,179)	(3,748)	-	-	(69,504)
Write-down of assets [(a)]	-	-	(300)	-	-	-	-	-	-	-	(46)	-	(346)
Carrying amount at 30 June 2019	**229,788**	**894,764**	**5,217**	**124,265**	**3,082**	**380**	**5,158**	**97**	**63,075**	**63,022**	**5**	**310**	**1,389,163**

(a) $0.346 million (2018: Nil) write-down of assets was recognised in other expenses (Note 3.6) and nil (2018: $0.361 million) was adjusted to contributed equity (note 9.10.1).

The infrastructure, property, plant and equipment should be read in conjunction with the accompanying notes.

5.1 Infrastructure, 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
- buildings

Land is carried at fair value.

Buildings are carried at fair value less accumulated depreciation and accumulated impairment losses.

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

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

Land and buildings were revalued as at 1 July 2018 by the Western Australian Land Information Authority (Valuations and Property Analytics). The valuations were performed during the year ended 30 June 2019 and recognised at 30 June 2019. In undertaking the revaluation, fair value was determined by reference to market values for land: $4.512 million (2018: $3.171 million) and buildings: $0.53 million (2018: $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).

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 gross carrying amount is adjusted in a manner that is consistent with the revaluation of the carrying amount of the asset and the accumulated depreciation is adjusted to equal the difference between the gross carrying amount and the carrying amount of the asset.

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.

5.1 Infrastructure, property, plant and equipment (continued)

	2019 $000	2018 $000
5.1.1 Depreciation and impairment		
Depreciation		
Buildings	44,721	51,193
Site infrastructure	5,538	4,808
Leasehold improvements	464	472
Computer equipment	148	220
Furniture and fittings	677	666
Motor vehicles	29	24
Medical equipment	14,179	17,489
Other plant and equipment	3,748	3,886
Total depreciation for the period	**69,504**	**78,758**

As at 30 June 2019 an impairment loss has been disclosed for plant and equipment identified as impaired during the 2019 Asset Stocktake. Please refer to note 5.1 for a breakdown of the disclosed impairment loss against asset categories.

All surplus assets at 30 June 2019 have either been classified as assets held for sale or have been written-off.

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

Depreciation is 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: years
Buildings	50 years
Site infrastructure	50 years
Leasehold improvements	10 years
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.

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.

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.

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

Year ended 30 June 2018	Computer software	Works in progress	Total
	$000	$000	$000
1 July 2017			
Gross carrying amount	355	6,012	6,367
Accumulated amortisation	(145)	-	(145)
Carrying amount at start of period	**210**	**6,012**	**6,222**
Additions	-	6,083	6,083
Amortisation expense	(67)	-	(67)
Carrying amount at 30 June 2018	**143**	**12,095**	**12,238**

Year ended 30 June 2019	Computer software	Works in progress	Total
	$000	$000	$000
1 July 2018			
Gross carrying amount	355	12,095	12,450
Accumulated amortisation	(212)	-	(212)
Carrying amount at start of period prior to demerger	**143**	**12,095**	**12,238**
Demerger of PathWest	(5)	(12,095)	(12,100)
Carrying amount at start of period	**138**	**-**	**138**
Additions	453	-	453
Impairment losses	(13)	-	(13)
Amortisation expense	(124)	-	(124)
Carrying amount at 30 June 2019	**454**	**-**	**454**

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.

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 Intangible assets (continued)

5.2.1 Amortisation and impairment

Charge for the period	2019	2018
	$000	$000
Computer software	124	67
Total amortisation for the period	**124**	**67**

As at 30 June 2019 an impairment loss has been disclosed for intangible assets identified as impaired during the 2019 Asset Stocktake.

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 intangible asset class is:

Computer software[(a)]	5 years

[(a)] 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.

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	2019 $000	2018 $000
Receivables	6.1	53,236	66,956
Amounts receivable for services	6.2	773,966	774,984
Inventories	6.3	5,339	5,230
Other current assets	6.4	2,141	6,957
Payables	6.5	165,414	153,729
Other current liabilities	6.6	1,750	1,045

6.1 Receivables

	2019 $000	2018 $000
Current		
Trade receivables	60,582	70,649
Allowance for impairment of trade receivables	(37,200)	(37,729)
Accrued revenue	21,475	23,141
GST receivables	8,379	7,393
Total current	**53,236**	**63,454**
Non-current		
Other receivables	-	3,502
Total non-current	**-**	**3,502**
Total receivables	**53,236**	**66,956**

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

6.1.1 Movement in the allowance for impairment of trade receivables

	2019 $000	2018 $000
Reconciliation of changes in the allowance for impairment of trade receivables:		
Balance at start of period	37,729	27,511
Demerger of PathWest	(1,135)	-
Restated balance at start of period	**36,594**	**27,511**
Doubtful debts expense	-	16,594
Expected credit losses expense	2,650	-
Net write-back adjustment	(1,913)	-
Amounts written-off during the period	(131)	(6,376)
Balance at end of period	**37,200**	**37,729**

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

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

6.2 Amounts receivable for services (Holding Account)

	2019 $000	2018 $000
Non-current	773,966	774,984
Balance at end of period	**773,966**	**774,984**

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.

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

6.3 Inventories

	2019 $000	2018 $000
Current		
Pharmaceutical stores – at cost	4,891	4,480
Engineering stores – at cost	448	750
Total inventories	**5,339**	**5,230**

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

	2019 $000	2018 $000
Current		
Prepayments	2,127	3,304
Paid parental leave scheme	-	245
Other	14	3,408
Total other current assets	**2,141**	**6,957**

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.

6.5 Payables

	2019 $000	2018 $000
Current		
Trade payables	16,482	18,399
Other payables	11,713	11,370
Accrued expenses	116,542	103,674
Accrued salaries	20,675	20,282
Accrued interest	2	4
Total current payables	**165,414**	**153,729**

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

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

6.6 Other current liabilities

	2019 $000	2018 $000
Refundable deposits	1,089	1,045
Other	661	-
Total other current liabilities	**1,750**	**1,045**

7 Financing

This section sets out the material balances and disclosures associated with financing and cash flows of the Health Service.

	Notes	2019 $000	2018 $000
Borrowings	7.1		
Department of Treasury loans	7.1.1	815	1,592
Finance costs	7.2	39	179
Cash and cash equivalents	7.3		
Cash and cash equivalents	7.3.1	60,219	46,412
Restricted cash and cash equivalents	7.3.1	56,925	51,918
Reconciliation of net cost of services to net cash used in operating	7.3.2	(1,039,611)	(1,097,926)
Commitments	7.4		
Operating lease commitments	7.4.1	24,480	19,622
Capital commitments	7.4.2	8,457	15,939
Private sector contracts for the provision of health services	7.4.3	5,098,109	5,664,470
Other expenditure commitments	7.4.4	30,263	27,559

7.1 Borrowings

7.1.1 Department of Treasury loans

	2019 $000	2018 $000
Current	815	777
Non-current	-	815
Balance at end of period	**815**	**1,592**

7.2 Finance costs

	2019 $000	2018 $000
Finance lease charges	-	118
Interest expense	39	61
	39	**179**

7.3 Cash and cash equivalents

7.3.1 Reconciliation of cash

	Notes	2019 $000	2018 $000
Cash and cash equivalents		**60,219**	**46,412**
Restricted cash and cash equivalents			
– Other capital grants from the Commonwealth Government		2,865	4,137
– Restricted cash assets held for other specific purposes [a]		41,980	41,281
– Mental Health Commission funding [b]		367	124
– Accrued salaries suspense account [c]		11,713	6,376
Balance at end of period		**56,925**	**51,918**

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 9.8 Special purpose accounts.

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

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

7.3 Cash and cash equivalents (continued)

7.3.2 Reconciliation of net cost of services to net cash flows provided by/(used in) operating activities

	Notes	2019 $000	2018 $000
Net cost of services		(1,222,806)	(1,286,722)
Non-cash items			
Doubtful debts expense	3.6	-	16,594
Expected credit losses expenses	3.6	2,650	-
Write-down of assets	3.6	346	-
Depreciation and amortisation expense	5.1, 5.2	69,628	78,825
Asset impairment losses		1,861	-
Net (gain)/loss from disposal of non-current assets		166	86
Interest paid by Department of Health		40	63
Net donation of non-current assets		(92)	(1,470)
Asset revaluation decrement / (increment)		(4,337)	4,336
Services received free of charge	4.1.3	87,830	69,973
(Increase)/decrease in assets			
GST receivable		(986)	(56)
Other current receivables		(14,034)	(9,715)
Inventories		(1,014)	1,428
Other current assets		(2,139)	(1,038)
Non-current receivables		3,502	-
Increase/(decrease)in liabilities			
Payables		21,758	3,501
Current employee related provisions		8,533	27,585
Non-current employee related provisions		8,779	(1,380)
Other current liabilities		705	64
Net cash provided by/(used in) operating activities		**(1,039,611)**	**(1,097,926)**

7.4 Commitments

The totals presented for commitments are GST inclusive.

7.4.1 Non-cancellable operating lease commitments

	2019 $000	2018 $000
Commitments for minimum lease payments are payable as follows:		
Within 1 year	4,660	6,307
Later than 1 year and not later than 5 years	11,885	12,399
Later than 5 years	7,935	916
	24,480	**19,622**

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.

The 2018 comparison figures for Non-cancellable Operating Lease commitments were amended from $15.307 million for the following:
- Additional commitment for motor vehicles totalling $5.063 million; and
- Exclusion of GROH leases totalling $0.748 million.

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 Commitments (continued)

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:

	2019 $000	2018 $000
Within 1 year	8,457	15,939
	8,457	**15,939**

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:

	2019 $000	2018 $000
Within 1 year	515,833	507,250
Later than 1 year and not later than 5 years	2,081,064	2,119,830
Later than 5 years and not later than 10 years	2,481,695	3,037,390
Later than 10 years	19,517	-
	5,098,109	**5,664,470**

The 2018 comparative figure for Private Sector contracts for the provision of health services has been amended from $5.778 billion to $5.664 billion to exclude dialysis contracts for which there is no contracted minimum payment ($113.8 million).

7.4.4 Other expenditure commitments

Other expenditure commitments contracted at the reporting period, but not recognised as liabilities are payable as follows:

	2019 $000	2018 $000
Within 1 year	28,034	26,287
Later than 1 year and not later than 5 years	2,152	1,237
Later than 5 years	77	35
	30,263	**27,559**

The 2018 comparative figure for Other expenditure contracts has been amended from $51.125 million to $27.559 million to exclude contracts for which there is no contracted minimum payment ($23.566 million).

8 Risks and contingencies

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

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

8.1 Financial risk management

Financial instruments held by the Health Service are cash and cash equivalents, restricted cash and cash equivalents, receivables, payables, and Western Australian Treasury Corporation (WATC) 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.

Credit risk associated with the Health Service's financial assets is minimal because the main receivable is the 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. Debt will be written-off against the allowance account when it is improbable or uneconomical to recover the debt. At the end of the reporting period there were no significant concentrations of credit risk.

Liquidity risk

Liquidity risk arises when the 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.

All borrowings are due to the WATC and are repayable at fixed rates with varying maturities. Other than as detailed in the interest rate sensitivity analysis table at Note 8.1(e), the Health Service is not exposed to interest rate risk because the majority of cash and cash equivalents and restricted cash are non-interest bearing and it has no borrowings other than the WATC borrowings.

(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:

	2019 $000	2018 $000
Financial assets		
Cash and cash equivalents	60,219	46,412
Restricted cash and cash equivalents	56,925	51,918
Loans and receivables [(a)]	-	834,547
Financial assets at amortised cost [(a)]	818,823	-
Total financial assets	**935,967**	**932,877**
Financial liabilities		
Financial liabilities at amortised cost	166,229	155,320
Total financial liability	**166,229**	**155,320**

[(a)] The amount of Loans and receivables/Financial assets at amortised cost excludes GST recoverable from the ATO (statutory receivable).

8.1 Financial risk management (continued)

(c) Credit risk exposure

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

		Days past due				
	Total	Current	< 30 days	31 - 60 days	61 - 90 days	> 91 days
	$000	$000	$000	$000	$000	$000
30 June 2019						
Expected credit loss rate		8.65%	13.04%	21.99%	29.69%	85.54%
Estimated total gross carrying amount at default	60,582	9,900	5,326	2,827	2,417	40,112
Expected credit losses	(37,200)	(856)	(694)	(622)	(718)	(34,310)
30 June 2018						
Expected credit loss rate		2.87%	10.55%	12.82%	32.20%	94.57%
Estimated total gross carrying amount at default	74,151	20,722	7,194	6,476	3,293	36,466
Expected credit losses	(37,729)	(594)	(759)	(830)	(1,060)	(34,486)

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	Fixed interest rate	Variable interest rate	Non-interest bearing	Nominal Amount	Up to 1 month	1–3 months	3 months to 1 year	1–5 years	More than 5 years
	%	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000
2019											
Financial assets											
Cash and cash equivalents	-	60,219	-	-	60,219	60,219	60,219	-	-	-	-
Restricted cash and cash equivalents	-	56,925	-	-	56,925	56,925	45,212	-	-	-	11,713
Receivables – non interest bearing [(a)]	-	44,857	-	-	44,857	44,857	44,857	-	-	-	-
Amounts receivable for services	-	773,966	-	-	773,966	773,966	-	-	-	-	773,966
		935,967	**-**	**-**	**935,967**	**935,967**	**150,288**	**-**	**-**	**-**	**785,679**
Financial liabilities											
Payables	-	165,414	-	-	165,414	165,414	165,414	-	-	-	-
Department of Treasury loans	3.15	815	-	815	-	841	70	140	631	-	-
		166,229	**-**	**815**	**165,414**	**166,255**	**165,484**	**140**	**631**	**-**	**-**

[(a)] *The amount of receivables excludes GST recoverable from ATO (statutory receivable).*

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 1 month $000	1–3 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**	**932,949**	**148,015**	**-**	**-**	**3,574**	**781,360**
Financial liabilities											
Payables	-	153,729	-	-	153,729	153,729	153,729	-	-	-	-
Department of Treasury loans	3.06	1,592	-	1,592	-	1,661	69	137	615	840	-
		155,321	**-**	**1,592**	**153,729**	**155,390**	**153,798**	**137**	**615**	**840**	**-**

[(a)] *The amount of receivables excludes GST recoverable from ATO (statutory receivable).*

8.1 Financial risk management (continued)

(e) Interest rate sensitivity analysis

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

		-100 basis points		+100 basis points	
	Carrying amount $000	Surplus $000	Equity $000	Surplus $000	Equity $000
2019					
Financial liabilities					
Department of Treasury loans	815	8	8	(8)	(8)
Total Increase/(Decrease)		**8**	**8**	**(8)**	**(8)**
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**

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 the best estimate.

Contingent assets and contingent 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	**2019 $000**	**2018 $000**
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	**2019 $000**	**2018 $000**
Pending litigation that is not recoverable from RiskCover insurance and may affect the financial position of the Health Service.	99	-
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 continues to undertake a review across all Health Service Providers to establish whether any building contains aluminium composite cladding that may present a fire risk under the National Construction Code 2016 and Australian Standard AS5113:2016 Fire propagation testing and classification of external walls of buildings.

At the time of reporting, one building belonging to NMHS has been identified in the Department of Mines Industry Regulation and Safety report. NMHS are as yet unable to determine the extent or likelihood of any liability arising as a result of the review.

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: **2019**	**Level 1 $000**	**Level 2 $000**	**Level 3 $000**	**Fair value at end $000**
Land				
Residential	-	22	-	22
Specialised	-	4,490	225,276	229,766
Buildings				
Residential and commercial car park	-	130	9,157	9,287
Specialised	-	400	885,077	885,477
	-	**5,042**	**1,119,510**	**1,124,552**

8.3 Fair value measurements (continued)

Assets measured at fair value: **2018**	**Level 1 $000**	**Level 2 $000**	**Level 3 $000**	**Fair value at end $000**
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**

Valuation techniques used to derive Level 2 fair values

The Health Service's residential properties, commercial car park and land are derived using the market approach. Market evidence of sales prices of comparable land and buildings (office accommodation) in close proximity is used to determine price per square metre.

Fair value measurements using significant unobservable inputs (Level 3)

2019	**Land $000**	**Buildings $000**
Fair value at start of period	221,212	986,659
Fair value of balance transferred from abolished Health Service	-	(72,352)
Additions and transfers from work in progress	-	8,273
Revaluation increments/(decrements)	5,044	16,449
Transfers from/(to) other asset class	(980)	(479)
Depreciation	-	(44,316)
Fair value at end of period	**225,276**	**894,234**

2018	**Land $000**	**Buildings $000**
Fair value at start of period	249,632	1,020,340
Fair value of balance transferred from abolished Health Service		
Additions and transfers from work in progress	-	14,028
Revaluation increments/(decrements)	(4,920)	3,467
Transfers from/(to) other asset class	(23,500)	-
Depreciation	-	(51,176)
Fair value at end of period	**221,212**	**986,659**

Valuation processes

There were no changes in valuation techniques during the period.

Land (Level 3 fair values)

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

Buildings and Infrastructure (Level 3 fair values)

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

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

9 Other disclosures

9.1 Events occurring after the end of the reporting period

From 1 July 2019, funding for the provision of Neonatal services transitioned from the North Metropolitan Health Service to the Child and Adolescent Health Service (CAHS). This was effected through the 2019-20 Service Agreement process, in which the Department of Health contracted with CAHS to deliver neonatal services from 1 July 2019. 2019-20 will be a transitional year for the neonatal service.

9.2 Initial application of Australian Accounting Standards

AASB 9 *Financial instruments*

AASB 9 *Financial instruments* replaces AASB 139 *Financial instruments: Recognition and Measurements* for annual reporting periods beginning or after 1 January 2018, bringing together all three aspects of the accounting for financial instruments: classification and measurement; impairment; and hedge accounting.

The Health Service applied AASB 9 prospectively, with an initial application date of 1 July 2018. The adoption of AASB 9 has resulted in changes in accounting policies and adjustments to the amounts recognised in the financial statements. In accordance with AASB 9.7.2.15, the Health Service has not restated the comparative information which continues to be reported under AASB 139.

The effect of adopting AASB 9 as at 1 July 2018 was assessed as not material and therefore no adjustment was required to be recognised directly in the Accumulated Surplus.

The nature of these adjustments are described below:

(a) Classification and measurement

Under AASB 9, financial assets are subsequently measured at amortised cost, fair value through other comprehensive income (fair value through OCI) or fair value through profit or loss (fair value through P/L). The classification is based on two criteria: the Health Service's business model for managing the assets; and whether the assets' contractual cash flows represent 'solely payments of principal and interest' on the principal amount outstanding.

The assessment of the Health Service's business model was made as of the date of initial application, 1 July 2018. The assessment of whether contractual cash flows on financial assets are solely comprised of principal and interest was made based on the facts and circumstances as at the initial recognition of the assets.

The classification and measurement requirements of AASB 9 did not have a significant impact to the Health Service. The following are the changes in the classification of the Health Service's financial assets:

- *Receivables and Amounts receivable for services* classified as Loans and receivables as at 30 June 2018 are held to collect contractual cash flows and give rise to cash flows representing solely payments of principal and interest. These are classified and measured as Financial assets at amortised cost beginning 1 July 2018.
- The Health Service did not designate any financial assets as at fair value through P/L.

9.2 Initial application of Australian Accounting Standards (continued)

In summary, upon adoption of AASB 9, the Health Service had the following reclassifications as at 1 July 2018:

		AASB 9 category		
		Amortised cost	Fair value through OCI	Fair value through P/L
AASB 139 category	**$000**	**$000**	**$000**	**$000**
Loans and receivables				
Trade and other receivables	59,563	59,563	-	-
Amounts receivable for services	774,984	774,984	-	-
		834,547	**-**	**-**

(b) Impairment

The adoption of AASB 9 has fundamentally changed the Health Service's accounting for impairment losses for financial assets by replacing AASB 139's incurred loss approach with a forward-looking expected credit loss (ECL) approach. AASB 9 requires the Health Service to recognise an allowance for ECLs for all financial assets not held at fair value through P/L.

9.3 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.

		Operative for reporting periods beginning on/after
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 effective 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 which 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, donations and contribution revenues, the Health Service has not yet quantified 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. It is expected that the timing of revenue recognition will not materially impact the financial statements.*	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 $**24.480** million worth of non-cancellable operating leases which will mostly be brought onto the Statement of Financial Position. Interest and amortisation expense will increase and rental expense will decrease.*	1 Jan 2019

9.3 Future impact of Australian Standards issued not yet operative (continued)

		Operative for reporting periods beginning on/after
AASB 1058	*Income for Not-for-Profit-Entities*	1 Jan 2019
	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 or other 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 anticipates that the application will not materially impact appropriations or untied grant revenues.	
AASB 1059	*Service Concession Arrangements: Grantors*	1 Jan 2020
	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 mandatory effective date of this Standard is currently 1 January 2020 after being amended by AASB 2018-5.	
	The Health Service has not identified the impact of the standard.	
AASB 2016-8	*Amendments to Australian Accounting Standards – Australian Implementation Guidance for Not-for-Profit Entities*	1 Jan 2019
	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.	
AASB 2018-4	*Amendments to Australian Accounting Standards – Australian Implementation Guidance for Not-for-Profit Public Sector Licensors*	1 Jan 2019
	This Standard amends AASB 15 to add requirements and authoritative implementation guidance for application by not-for-profit public sector licensors to transactions involving the issue of licences. There is no financial impact as the Health Service does not issue licences.	
AASB 2018-5	*Amendments to Australian Accounting Standards – Deferral of AASB 1059*	1 Jan 2019
	This Standard amends the mandatory effective date of AASB 1059 so that AASB 1059 is required to be applied for annual reporting periods beginning on or after 1 January 2020 instead of 1 January 2019. There is no financial impact.	
AASB 2018-7	*Amendments to Australian Accounting Standards – Definition of Material*	1 Jan 2020
	This Standard clarifies the definition of material and its application by improving the wording and aligning the definition across AASB Standards and other publications. There is no financial impact.	
AASB 2018-8	*Amendments to Australian Accounting Standards – Right-of-Use Assets of Not-for-Profit Entities*	1 Jan 2019
	This Standard provides a temporary option for not-for-profit entities to not apply the fair value initial measurement requirements for right-of-use assets arising under leases with significantly below-market terms and conditions principally to enable the entity to further its objectives	
	The agency will elect to apply the option to measure right-of-use assets under peppercorn leases at cost (which is generally about $1). As a result, the financial impact of this Standard is not material.	

9.4 Key management personnel

The Health Service has determined key management personnel to include Ministers, Board members (accountable authority) and senior officers of the Health Service. The Health Service does not incur expenditures to compensate Ministers and these disclosures 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	**2019**	**2018**
$0 – $10,000	1	1
$20,001 – $30,000	2	-
$30,001 – $40,000	1	2
$40,001 – $50,000	5	6
$70,001 – $80,000	1	1
	10	**10**

	2019	**2018**
	$000	**$000**
Short-term employee benefits	329	360
Post-employment benefits	33	34
Total compensation of members of the accountable authority	**362**	**394**

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 the CEO and the heads of services reporting to the 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:

	2019	**2018**
$60,001 – $70,000	1	1
$110,001 – $120,000	1	1
$120,001 – $130,000	1	-
$140,001 – $150,000	1	1
$150,001 – $160,000	1	-
$170,001 – $180,000	-	1
$180,001 – $190,000	1	3
$200,001 – $210,000	1	-
$210,001 – $220,000	2	1
$220,001 – $230,000	1	1
$230,001 – $240,000	-	1
$240,001 – $250,000	-	1
$260,001 – $270,000	1	1
$310,001 – $320,000	-	1
$320,001 – $330,000	-	1
$350,001 – $360,000	1	-
$420,001 – $430,000	-	1
$490,001 – $500,000	-	1
$510,001 – $520,000	1	-
	13	**16**

	2019	**2018**
	$000	**$000**
Short-term employee benefits	2,281	2,890
Post employment benefits	228	313
Other long-term benefits	271	348
Termination benefits	-	241
Total compensation of senior officers	**2,780**	**3,792**

9.5 Related party transactions

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

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

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, and pathology services free of charge from PathWest. The Health Service also leases accommodation free of charge from the Department of Finance.

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 other related parties

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

Significant transactions with other related parties

The Health Service makes superannuation payments to GESB as nominated by employees.

9.6 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.

9.7 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.

9.8 Special purpose accounts

Mental Health Commission Fund Account

The purpose of the 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.

	2019 $000	2018 $000
Balance at the start of period	124	124
Add Receipts		
Service delivery agreement:		
Commonwealth contributions	73,289	72,734
State contributions	164,299	168,215
Other	1,639	1,633
	239,227	242,582
Less Payments	(238,984)	(242,582)
Balance at the end of period	**367**	**124**

The special purpose accounts are established under section 16(1)(d) of the FMA.

9.9 Remuneration of auditors

Remuneration paid or payable to the Auditor General in respect of the audit for the current financial year is as follows:

	2019 $000	2018 $000
Auditing the accounts, financial statements, controls, and key performance indicators	**292**	**288**

9.10 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 9.10.2 Asset revaluation reserve).

9.10.1 Contributed equity

	2019 $000	2018 $000
Balance at start of period	1,779,972	1,794,228
Contributions by owners		
Capital appropriation	12,490	24,677
Write-down of net assets transferred from abolished Health Service	-	(361)
Transfer of infrastructure from Health Ministerial Body (HMB)	1,765	15,300
Transfers of other assets from other agencies	-	(1)
Total contributions by owners	**1,794,227**	**1,833,843**
Distributions to owners		
Transfer of lands and buildings to Health Ministerial Body (HMB):		
Selby Reserve in Shenton Park	-	(38,800)
Perth Chest Clinic	-	(4,071)
Middle Swan land	-	(11,000)
Demerger of PathWest	(150,736)	-
Total distributions to owners	**(150,736)**	**(53,871)**
Balance at end of period	**1,643,491**	**1,779,972**

9.10 Equity (continued)

9.10.2 Asset revaluation reserve [a]

	2019 $000	2018 $000
Balance at start of period	146,304	143,436
Net revaluation increments/(decrements):		
Land	1,068	(676)
Buildings	16,437	3,544
Balance at end of period	**163,809**	**146,304**

[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
	-	**4,337**

9.10.3 Accumulated surplus/(deficit)

	2019 $000	2018 $000
Balance at start of period	41,360	52,878
Result for the period	11,346	(11,518)
Balance at end of period	**52,706**	**41,360**

9.11 Supplementary financial information

(a) Write-offs

	2019 $000	2018 $000
Revenue and debts written-off under the authority of the Accountable Authority	131	6,376
	131	**6,376**

(b) Losses through theft, defaults and other causes

Losses of public money, and public and other property through theft or default	102	40
Amounts recovered	(78)	(14)
	24	**26**

(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:

	2019 $000	2018 $000
Department of Corrective Services – dental treatment	1,949	1,788
Disability Services Commission – dental treatment	1,568	1,805
East Metropolitan Health Service – pathology services [a]	-	14,433
South Metropolitan Health Service – pathology services [a]	-	22,514
WA Country Health Services – pathology services [a]	-	23,482
Child and Adolescent Health Service – pathology services [a]	-	4,878
	3,517	**68,900**

[a] Represent the cost of providing pathology services above the amounts billed to other Health Services.

9.12 Other statement of receipts and payments

Commonwealth Grant – Christmas and Cocos Island	2019 $000	2018 $000
Balance at the start of period	-	-
Receipts		
Commonwealth grant	-	72
Payments		
Purchase of health services	-	(72)
Balance at the end of period	**-**	**-**

Notes to the financial statements

For the year ended 30 June 2019

9.13 Explanatory statement (Controlled Operations)

For the year ended 30 June 2019

All variances between estimates (original budget) and actual results for 2019, and between the actual results for 2019 and 2018 are shown below. Narratives are provided for key major variances, which are generally greater than 5% and $25 million.

9.13.1 Statement of Comprehensive Income Variances

	Variance note	2019 Estimate $000	2019 Actual $000	2018 Actual $000	Variance between estimate and actual $000	Variance between actual 2019 and 2018 $000
COST OF SERVICES						
Expenses						
Employee benefits expense	a	1,161,028	1,183,905	1,388,748	22,877	(204,843)
Contracts for services		443,167	460,479	439,116	17,312	21,363
Patient support costs		316,087	325,396	316,789	9,309	8,607
Finance costs		42	39	179	(3)	(140)
Depreciation and amortisation expense		60,606	69,628	78,825	9,022	(9,197)
Asset impairment losses		-	1,861	-	1,861	1,861
Asset revaluation decrement		-	-	4,337	-	(4,337)
Loss on disposal of non-current assets		-	166	86	166	80
Repairs, maintenance and consumable equipment		35,599	34,589	44,374	(1,010)	(9,785)
Other supplies and services		67,599	64,471	78,585	(3,128)	(14,114)
Other expenses	b	64,332	71,863	98,173	7,531	(26,310)
Total cost of services		**2,148,460**	**2,212,397**	**2,449,212**	**63,937**	**(236,815)**
INCOME						
Revenue						
Patient charges	c	77,484	74,273	119,959	(3,211)	(45,686)
Other fees for services	d	61,280	79,160	176,207	17,880	(97,047)
Commonwealth grants and contributions		639,609	635,403	668,115	(4,206)	(32,712)
Other grants and contributions		168,450	170,729	174,313	2,279	(3,584)
Donation revenue		354	386	2,170	32	(1,784)
Interest revenue		-	1	54	1	(53)
Other revenue		16,162	25,302	21,672	9,140	3,630
Total Revenue		**963,339**	**985,254**	**1,162,490**	**21,915**	**(177,236)**
Gains						
Other gains		-	4,337	-	4,337	4,337
Total Gains		**-**	**4,337**	**-**	**4,337**	**4,337**
Total income other than income from State Government		**963,339**	**989,591**	**1,162,490**	**26,252**	**(172,899)**
NET COST OF SERVICES		**1,185,121**	**1,222,806**	**1,286,722**	**37,685**	**(63,916)**
INCOME FROM STATE GOVERNMENT						
Service appropriation		1,094,888	1,145,906	1,205,059	51,018	(59,153)
Assets assumed/(transferred)		-	45	(210)	45	255
Services received free of charge		89,843	87,830	69,973	(2,013)	17,857
Royalties for Regions Fund		390	371	382	(19)	(11)
Total income from State Government		**1,185,121**	**1,234,152**	**1,275,204**	**49,031**	**(41,052)**
SURPLUS/(DEFICIT) FOR THE PERIOD		**-**	**11,346**	**(11,518)**	**11,346**	**22,864**
OTHER COMPREHENSIVE INCOME/(LOSS)						
Items not reclassified subsequently to profit or loss						
Changes in asset revaluation reserve		-	17,505	2,868	17,505	14,637
Total other comprehensive income/(loss)		**-**	**17,505**	**2,868**	**17,505**	**14,637**
TOTAL COMPREHENSIVE INCOME/(LOSS) FOR PERIOD		**-**	**28,851**	**(8,650)**	**28,851**	**37,501**

9.13 Explanatory statement (Controlled Operations) (continued)

9.13.2 Statement of Financial Position Variances

	Variance note	2019 Estimate $000	2019 Actual $000	2018 Actual $000	Variance between estimate and actual $000	Variance between actual 2019 and 2018 $000
ASSETS						
Current Assets						
Cash and cash equivalents		17,313	60,219	46,412	42,906	13,807
Restricted cash and cash equivalents		42,480	45,212	45,542	2,732	(330)
Receivables		56,809	53,236	63,454	(3,573)	(10,218)
Inventories		4,325	5,339	5,230	1,014	109
Other current assets		-	2,141	6,957	2,141	(4,816)
Total Current Assets		**120,927**	**166,147**	**167,595**	**45,220**	**(1,448)**
Non-Current Assets						
Restricted cash and cash equivalents		9,635	11,713	6,376	2,078	5,337
Amounts receivable for services		763,934	773,966	774,984	10,032	(1,018)
Receivables		-	-	3,502	-	(3,502)
Property, plant and equipment	e	1,424,513	1,389,163	1,517,014	(35,350)	(127,851)
Intangible assets		139	454	12,238	315	(11,784)
Total Non-Current Assets		**2,198,221**	**2,175,296**	**2,314,114**	**(22,925)**	**(138,818)**
TOTAL ASSETS		**2,319,148**	**2,341,443**	**2,481,709**	**22,295**	**(140,266)**
LIABILITIES						
Current Liabilities						
Payables		144,343	165,414	153,729	21,071	11,685
Borrowings		777	815	777	38	38
Employee related provisions	f	237,690	250,757	291,158	13,067	(40,401)
Other current liabilities		496	1,750	1,045	1,254	705
Total Current Liabilities		**383,306**	**418,736**	**446,709**	**35,430**	**(27,973)**
Non-Current Liabilities						
Borrowings		38	-	815	(38)	(815)
Employee related provisions		53,922	62,701	66,549	8,779	(3,848)
Total Non-Current Liabilities		**53,960**	**62,701**	**67,364**	**8,741**	**(4,663)**
TOTAL LIABILITIES		**437,266**	**481,437**	**514,073**	**44,171**	**(32,636)**
NET ASSETS		**1,881,882**	**1,860,006**	**1,967,636**	**(21,876)**	**(107,630)**
EQUITY						
Contributed equity		1,747,146	1,643,491	1,779,972	(103,655)	(136,481)
Reserves	1	134,736	163,809	146,304	29,073	17,505
Accumulated surplus /(deficit)		-	52,706	41,360	52,706	11,346
TOTAL EQUITY		**1,881,882**	**1,860,006**	**1,967,636**	**(21,876)**	**(107,630)**

9.13 Explanatory statement (Controlled Operations) (continued)

9.13.3 Statement of Cash Flows Variances

	Variance note	2019 Estimate $000	2019 Actual $000 Inflows (Outflows)	2018 Actual $000 Inflows (Outflows)	Variance between estimate and actual $000	Variance between actual 2019 and 2018 $000
CASH FLOWS FROM STATE GOVERNMENT						
Service appropriation		1,034,241	1,075,155	1,125,506	40,914	(50,351)
Capital appropriations	2, g	60,698	11,787	39,234	(48,911)	(27,447)
Royalties for Regions Fund		390	371	382	(19)	(11)
Net cash provided by State Government		**1,095,329**	**1,087,313**	**1,165,122**	**(8,016)**	**(77,809)**
Utilised as follows:						
CASH FLOWS FROM OPERATING ACTIVITIES						
Payments						
Employee benefits	h	(1,156,142)	(1,161,798)	(1,359,108)	(5,656)	197,310
Supplies and services		(836,942)	(852,419)	(883,287)	(15,477)	30,868
Finance costs		-	-	(118)	-	118
Receipts						
Receipts from customers	i	77,484	65,575	115,227	(11,909)	(49,652)
Commonwealth grants and contributions		639,609	635,403	668,115	(4,206)	(32,712)
Other grants and contributions		168,450	170,729	174,313	2,279	(3,584)
Donations received		354	294	699	(60)	(405)
Interest received		-	2	116	2	(114)
Other receipts	3, j	77,441	102,603	186,117	25,162	(83,514)
Net cash provided by/(used in) operating activities		**(1,029,746)**	**(1,039,611)**	**(1,097,926)**	**(9,865)**	**58,315**
CASH FLOWS FROM INVESTING ACTIVITIES						
Payments						
Payment for purchase of non-current physical and intangible assets	4, k	(60,698)	(14,030)	(55,609)	46,668	41,579
Receipts						
Proceeds from sale of non-current physical assets		-	29	-	29	29
Net cash provided by/(used) in investing activities		**(60,698)**	**(14,001)**	**(55,609)**	**46,697**	**41,608**
CASH FLOWS FROM FINANCING ACTIVITIES						
Payments						
Repayment of finance lease liabilities		-	-	(2,572)	-	2,572
Net cash provided by/(used) in financing activities		**-**	**-**	**(2,572)**	**-**	**2,572**
Net increase/(decrease) in cash and cash equivalents		4,885	33,701	9,015	28,816	24,686
Cash and cash equivalents at the beginning of the period		69,427	98,330	89,315	28,903	9,015
Cash and cash equivalents transferred to other agencies		(4,885)	-	-	4,885	-
Cash transferred to PathWest as part of demerger		-	(14,887)	-	(14,887)	(14,887)
CASH AND CASH EQUIVALENTS AT END OF THE PERIOD		**69,427**	**117,144**	**98,330**	**47,717**	**18,814**

9.13 Explanatory statement (Controlled Operations) (continued)

Major Estimate and Actual (2019) Variance Narratives

1 **Reserves**
Variation in Reserves is largely as a result of a $17.5M increment in the Asset Revaluation Reserve in 2018-19. A decrement of $11.6M was estimated.

2 **Capital appropriations**
The variance largely reflects the 2019 Estimate including appropriations for the *Reconfiguring the Western Australian Spinal Cord Injury Service* capital project ($38.5M). A Memorandum of Understanding is being prepared to transfer this administered capital appropriation to transferee agencies. The NMHS retains control over the quality of the project delivery, but will not hold the resulting assets.

3 **Other receipts**
The variance predominantly reflects an increase in Other fees for services revenue ($17.8M) largely reflecting additional Pharmaceutical Benefits Scheme recoveries from the Commonwealth ($9.2M), and higher than estimated Other revenue ($9.1M) largely resulting from an increase in revenue relating to the use of hospital and parking facilities.

4 **Payment for purchase of non-current physical and intangible assets**
The variance largely reflects the 2019 Estimate including payments for *Reconfiguring the Western Australian Spinal Cord Injury Service* capital project ($38.5M). A Memorandum of Understanding is being prepared to transfer this administered capital appropriation to transferee agencies. The NMHS retains control over the quality of the project delivery, but will not hold the resulting assets.

Major Actual (2019) and Comparative (2018) Variance Narratives

a **Employee benefits expense**
The 2018 actual includes $214.8M of PathWest expenditure. PathWest demerged from the NMHS on 1 July 2018.

b **Other expenses**
Other expenses in 2018 includes $14.1M of PathWest expenditure. PathWest demerged from the NMHS on 1 July 2018. The variance excluding PathWest is an improvement of $12.2M. This predominantly relates to a decrease in doubtful debts/expected credit loss expenditure ($9.5M).

c **Patient charges**
The variance is predominantly as a result of the 2018 actual including $45.9M of PathWest revenue. PathWest demerged from the NMHS on 1 July 2018.

d **Other fees for services**
Other fees for services revenue in 2018 includes $106.3M of PathWest revenue. PathWest demerged from the NMHS on 1 July 2018. The variance excluding PathWest is an improvement of $9.3M (13%). This relates to an increase of $9.2M in Pharmaceutical Benefits Scheme recoveries from the Commonwealth.

e **Property, plant and equipment**
The reduction in property, plant and equipment is largely the result of the demerger of PathWest on 1 July 2018 ($92.6M) and 2019 depreciation ($69.5M). This is partially offset by 2019 additions ($13.0M) and the increased revaluation of land and buildings ($21.8M).

f **Employee related provisions**
The reduction in employee related provisions predominantly reflects the demerger of PathWest on 1 July 2018 ($48.9M).

g **Capital appropriations**
The decrease in capital appropriations receipts is predominantly the result of reduced activity within the Asset Investment Program resulting from a delay in projects, and the 2018 actual including receipts for PathWest which demerged from NMHS on 1 July 2018.

h **Employee benefits**
The reduction in cash payments for employee benefits is largely as a result of the 2018 actual including payments for PathWest, which demerged from NMHS on 1 July 2018.

i **Receipts from customers**
The reduction in cash receipts from customers is predominantly as a result of the 2018 actual including the receipt of PathWest patient revenue. PathWest demerged from NMHS on 1 July 2018.

j **Other receipts**
The 2018 actual includes the receipt of PathWest fees for service ($106.4M). PathWest demerged from NMHS on 1 July 2018. The reduction in 2019 is partially offset by the receipt of additional Pharmaceutical Benefits Scheme recoveries from the Commonwealth in 2019 ($9.2M).

k **Payment for purchase of non-current physical and intangible assets**
The reduction in cash payments for the purchase of non-current physical and intangible assets is predominantly the result of reduced activity within the Asset Investment Program resulting from a delay in projects, and the 2018 actual including payments for PathWest asset purchases ($11.0M). PathWest demerged from NMHS on 1 July 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:

	2019 $000	2018 $000
Balance at the start of period	157	176
Add Receipts	1,154	1,127
Less Payments	(1,131)	(1,146)
Balance at the end of period	**180**	**157**

b) Other trust accounts not controlled by the Health Service:

RF Shaw Foundation	1,166	1,226
King Edward Memorial Clinical Staff Association	45	53
	1,211	**1,279**
Balance at the start of period	1,279	1,249
Add Receipts	17	30
Less Payments	(85)	-
Balance at the end of period	**1,211**	**1,279**

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.

Certification of key performance indicators

For the year ended 30 June 2019

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

Disclosures and Legal Compliance

Key Performance Indicators

Certification of Key Performance Indicators

For the reporting period ended 30 June 2019

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's (NMHS) performance, and fairly represent the performance of the NMHS for the financial year ended 30 June 2019.

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

Date 13/09/2019

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

Date 13/9/19

OAG AUDITED 33

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

Detailed information in support of key performance indicators

Comparative results will not be reported for previously reported KPIs where there have been material changes in KPI definitions and cost allocation methodologies as per the framework. The KPIs are prepared based on the latest available information.

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 and 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

Please see the 2018 targets for each surgical procedure in Table 5. Maintained performance is demonstrated by a result below, or equal to, the target.

Results

In 2018, the rate of unplanned readmissions within 28 days was equal to target for cataract surgery and below target for hip replacement (see Table 5). All other surgical procedure indicators for unplanned hospital readmissions within 28 days were above target. The number of readmission cases for all procedures were small and results should be interpreted with caution.

Of the 23 tonsillectomy and adenoidectomy patients that readmitted, some were admitted for observation only and did not require further surgical intervention and were discharged the following day. Reviews have been undertaken for all cases and have not identified any trends or systemic issues.

Of the hysterectomy readmissions, some were admitted for pain management and observation only and did not require further surgery. Case reviews for hysterectomy readmissions have been completed and with the exception of case complexity, no trends have been identified. Performance continues to be monitored for any trends or systemic issues.

In total, there were nine readmissions for prostatectomy procedures across four sites. Case reviews have not identified any trends or systemic issues relating to the readmissions.

Table 5: Unplanned hospital readmissions for patients within 28 days for selected surgical procedures (per 1000 separations), 2016–18

	Calendar year				
Surgical procedure	2016 (per 1000)	2017 (per 1000)	2018 (per 1000)	Target (per 1000)	Target met
Knee replacement	21.9	36.1	27.0	≤ 26.2	x
Hip replacement	16.5	21.3	14.4	≤ 17.2	✓
Tonsillectomy and adenoidectomy	142.9	112.4	102.7	≤ 61.0	x
Hysterectomy	34.9	45.5	51.9	≤ 41.3	x
Prostatectomy	48.1	45.5	48.9	≤ 38.8	x
Cataract surgery	3.6	2.0	1.1	≤ 1.1	✓
Appendicectomy	28.0	18.4	33.5	≤ 32.8	x

Data sources: WA Data Linkage System; Hospital Morbidity Data Collection.

Rationale

Elective surgery refers to planned surgery that can be booked in advance following specialist assessment that results in placement on an elective surgery waiting list.

Elective surgery wait lists should be actively managed by hospitals to ensure fair and equitable access to the limited elective services available within the public health system.

Elective services delivered in the WA health system are those deemed to be clinically necessary procedures, and potential negative impacts of excessive waiting times for these services include the likelihood of a worsening of the patient's condition and/or quality of life or even death[2]. Therefore, waiting lists must be 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 new statewide performance target for the provision of elective services. For reportable procedures, the target requires that no patients (0%) on the elective waiting lists wait longer than the clinically recommended time for their procedure, according to their urgency category.

Reportable cases are defined as:

> All waiting list cases that are not listed on the Elective Services Wait List Data Collection 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 2018/19 target is 0 per cent. Performance is demonstrated by a result equal to the target.

Results

In 2018/19, all urgency categories for elective waitlist patients waiting over boundary were above target (see Table 6). During the year, NMHS encountered challenges associated with increased demand on service, particularly in Category 1. The increase in Category 1 led to a delay in Category 2 and 3 patients being undertaken. Strategies to address the challenges are in progress and monitored.

Table 6: Percentage of elective waitlist patients waiting over boundary for reportable procedures, 2016/17–2018/19

	Financial year				
Urgency category	**2016/17 (%)**	**2017/18 (%)**	**2018/19 (%)**	**Target (%)**	**Target met**
Category 1 over 30 days	5	6	8	0	x
Category 2 over 90 days	7	7	8	0	x
Category 3 over 365 days	2	3	5	0	x

Data source: Elective Services Wait List Data Collection.

[2] Derrett, S., Paul, C., Morris, J.M. (1999). Waiting for Elective Surgery: Effects on Health-Related Quality of Life, International Journal of Quality in Health Care, Vol 11 No. 1, 47-57.

Rationale

Staphylococcus aureus bloodstream infection 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 a preventable adverse event associated with the provision of health care.

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

Target

The 2018 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 2018, HA-SABSI per 10 000 occupied bed-days in public hospitals was equal to target (see Table 7). This indicator primarily included cases that were determined to be not preventable. All remaining cases were investigated via a clinical incident investigation process and some cases were declassified as they were found to have no healthcare-associated causative factors. Cases that were not declassified were found to be largely associated with certain specialties and may indicate location specific factors causing HA-SABSI.

Ongoing reviews have been undertaken on investigations to identify system trends across specialties. Recommendations and actions to prevent health care associated infections have been implemented.

Table 7: Healthcare-associated *Staphylococcus aureus* bloodstream infections (HA-SABSI) per 10 000 occupied bed-days, 2017–18

	Calendar year			
	2017 (per 10 000)	2018 (per 10 000)	Target (per 10 000)	Target met
HA-SABSI	0.7	1.0	≤ 1.0	✓

Data source: Healthcare Infection Surveillance WA Data Collection.

Rationale

This indicator measures performance in relation to restoring the health of people who have suffered a sentinel condition – specifically a stroke, acute myocardial infarction or a fractured neck of femur.

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 the admission and complications that may have developed while in hospital. However, survival is more likely when there is early intervention and appropriate care on presentation to an emergency department and on admission to hospital.

By reviewing and analysing survival rates, targeted strategies can be developed that aim to increase patient survival after being admitted for a sentinel condition. Therefore, this indicator can potentially assist hospitals in monitoring changes over time to facilitate effective restoration of patients' health.

Target

Please see the targets for each condition in Table 8, Table 9 and Table 10. Maintained performance is demonstrated by a result above, or equal to, the target.

Results

In 2018, the survival rate for patients with a stroke was above target for patients in age groups cohorts of 60 to 69 years and 80+ (see Table 8); 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. Strategies to enhance outcomes include improvements to models of care and staff education and training.

Table 8: Survival rate for stroke, 2016–18

	Calendar year				
Age group (years)	2016 (%)	2017 (%)	2018 (%)	Target (%)	Target met
0 to 49	87.7	93.5	92.8	94.4	x
50 to 59	87.5	91.8	92.2	93.3	x
60 to 69	92.4	92.0	93.1	92.9	✓
70 to 79	90.6	91.2	88.7	90.0	x
80+	84.4	86.1	84.6	82.2	✓

Data source: Hospital Morbidity Data Collection.

The survival rate for patients with an acute myocardial infarction was equal to target for the age group 70 to 79 years (see Table 9); however, the survival rate was below target for all other age groups. Survival rates are impacted by severity of disease on admission and patients with multiple comorbidities. Strategies to enhance outcomes include staff education and training.

Table 9: Survival rate for acute myocardial infarction, 2016–18

	Calendar year				
Age group (years)	2016 (%)	2017 (%)	2018 (%)	Target (%)	Target met
0 to 49	100.0	99.1	96.9	99.1	x
50 to 59	99.2	98.9	97.9	98.9	x
60 to 69	97.9	96.9	97.7	98.0	x
70 to 79	93.3	96.6	96.3	96.3	✓
80+	90.1	91.6	91.2	91.9	x

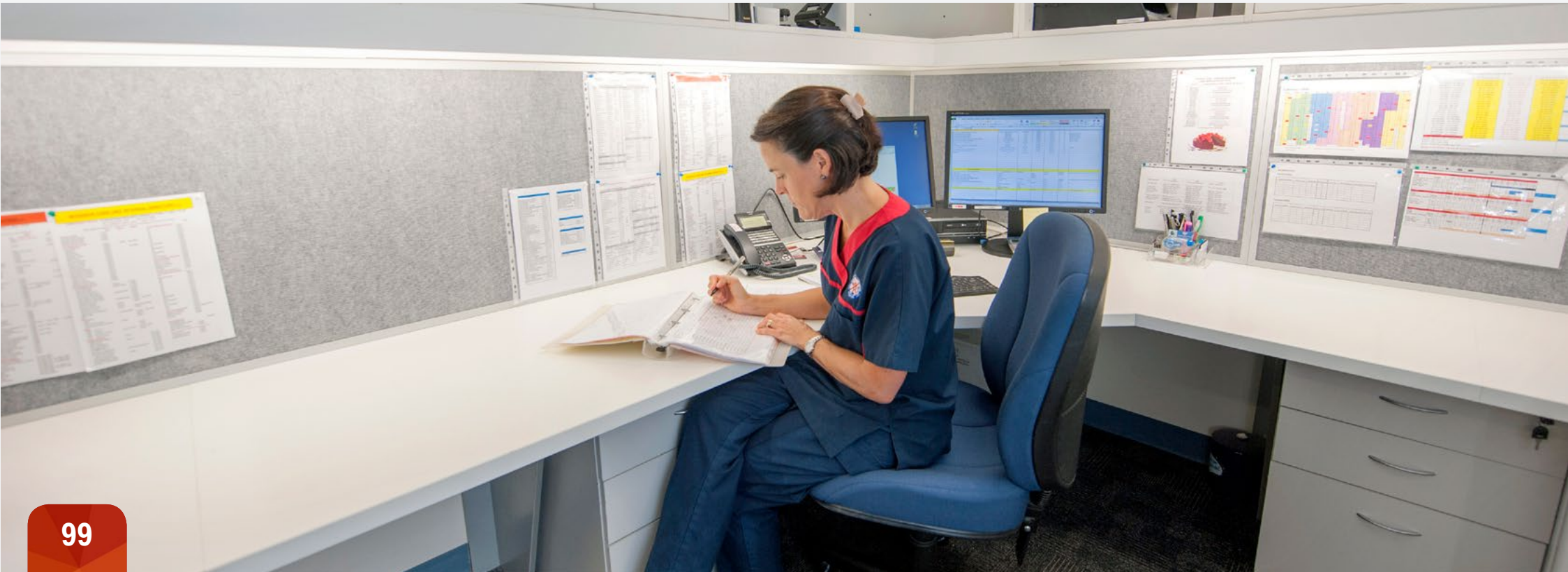
Data source: Hospital Morbidity Data Collection.

The survival rate for patients with a fractured neck of femur was below target for all age groups (see Table 10). Survival rates are impacted by severity of disease on admission and patients with multiple comorbidities. Best practice care pathways have been implemented to enhance outcomes.

Table 10: Survival rate for fractured neck of femur, 2016–18

	Calendar year				
Age group (years)	2016 (%)	2017 (%)	2018 (%)	Target (%)	Target met
70 to 79	93.8	100.0	95.9	98.7	x
80+	97.4	96.6	95.2	95.3	x

Data source: Hospital Morbidity Data Collection.



Rationale

Discharge against medical advice (DAMA) refers to patients leaving hospital against the advice of their treating medical team or without advising hospital staff (i.e. absconding or missing and not found). Patients who DAMA have a higher risk of readmission and mortality[3] and have been found to cost the health system 50 per cent more than patients who are discharged by their physician.[4]

Between July 2013 and June 2015 Aboriginal patients in WA were almost 12.7 times more likely than non-Aboriginal patients to discharge against medical advice, compared with seven times nationally.[5] This statistic indicates a need for improved responses by the health system to the needs of Aboriginal patients.

This indicator provides a measure of the safety and quality of inpatient care. Reporting the results by Aboriginality assists in measuring the effectiveness of initiatives within the WA health system to deliver culturally secure services to Aboriginal people and address underlying factors in achieving an equitable treatment outcome for Aboriginal patients compared with non-Aboriginal patients.

Target

The 2018 target is ≤ 0.77 per cent. Maintained performance is demonstrated by a result below, or equal to, the target.

Results

In 2018, the percentage of admitted patients who DAMA was below target for non-Aboriginal patients (see Table 11); however, the DAMA percentage for Aboriginal patients was above target. Outcomes of reviews identified that patients commonly DAMA due to family and community responsibilities and to be closer to family during difficult periods. To actively manage this, strategies to assess and engage high risk patients and their families as early as possible are in place and are assisted by Aboriginal Health Liaison Officers.

Table 11: Percentage of admitted patients who discharged against medical advice, 2017–18

	Calendar year			
	2017 (%)	2018 (%)	Target (%)	Target met
Aboriginal	3.36	3.81	≤ 0.77	x
Non-Aboriginal	0.76	0.75	≤ 0.77	✓

Data source: Hospital Morbidity Data Collection.

[3] Yong et al. Characteristics and outcomes of discharges against medical advice among hospitalised patients. Internal medicine journal 2013:43(7):798-802.

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

[5] Commonwealth of Australia. (2017). Aboriginal and Torres Strait Islander Health Performance Framework 2017 Report, Commonwealth of Australia, Canberra.

Rationale

This indicator of the condition of newborn infants immediately after birth provides an outcome measure of intrapartum care and newborn resuscitation.

The Apgar score is an assessment of an infant's health at birth based on breathing, heart rate, colour, muscle tone and reflex irritability. An Apgar score is applied at one, five and (if required by the protocol) 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 ten. The higher the Apgar score the better the health of the newborn infant.

This outcome measure can lead to the development and delivery of improved care pathways and interventions to improve the health outcomes of Western Australian infants and aligns to the National Core Maternity Indicators (2018) Health, Standard 06/09/2018.

Target

The 2018 target for liveborn term infants with an Apgar score of less than 7 at five minutes post-delivery is ≤ 1.8 per cent. Maintained performance is demonstrated by a result below, or equal to, the target.

Results

In 2018, the percentage of liveborn infants with an Apgar score of less than 7 at five minutes post-delivery was above target (see Table 12). Cases that have contributed to this result have been reviewed and did not highlight any key trends. Investigation into potential causative factors continues, and further reviews are planned in consultation with specialties. Work processes are currently being reviewed.

Table 12: Percentage of liveborn term infants with an Apgar score of less than 7 at five minutes post-delivery, 2016–18

	Calendar year				
Live births	2016 (%)	2017 (%)	2018 (%)	Target (%)	Target met
Apgar Score < 7	1.6	1.6	2.0	≤ 1.8	x

Data sources: Midwives Notification System.

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.[6] 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.

International literature identifies the concept of one month as an appropriate defined time period for the measurement of readmissions following separation from an acute inpatient mental health service. Based on this, a timeframe of 28 days for this indicator has been set and endorsed by the Australian Health Ministers' Advisory Council (AHMAC) Mental Health Information Strategy Standing Committee (as at 24 March 2011).

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 the mental health and quality of life of Western Australians.

Target

The 2018 target is ≤ 12 per cent readmissions within 28 days to an acute specialised mental health inpatient service. Maintained performance is demonstrated by a result below, or equal to, the target.

Results

In 2018, the rate of readmissions to acute specialised mental health inpatient services within 28 days of discharge was above target (see Table 13). This indicator looks at total readmissions and it should be noted that some readmission cases are warranted as part of accepted best practice protocols. During the year, a range of strategies and processes were implemented to actively manage this indicator and has resulted in a two per cent improvement compared to the prior period (2017). These strategies are continually being monitored and refined.

Table 13: Readmissions to acute specialised mental health inpatient services within 28 days of discharge, 2017–18

	Calendar year			
	2017 (%)	2018 (%)	Target (%)	Target met
Readmission rate	18	16	≤ 12	x

Data source: Hospital Morbidity Data Collection.

"I am fortunate to have healthy grown up children and grandchildren. So I retired wanting to give time and support to those that may need a friendly face or a little extra help, to help them on their way."

Women and Infants Research Foundation (WIRF) Volunteer, Lesley.

[6] Pearson, B., Skelly, R., Wileman, D., Masud, T. (2002). Unplanned readmission to hospital: a comparison of the views of general practitioners and hospital staff. Age and Ageing, Vol. 31 No. 2, 141-143.

Rationale

In 2014/15 there were 4.0 million Australians (17.5%) who reported having a mental or behavioural condition.[7] Therefore, it is crucial to ensure effective and appropriate care is provided not only in a hospital setting but also in the community.

Discharge from hospital is a critical transition point in the delivery of mental health care. People leaving hospital after an admission for an episode of mental illness have 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 for persons who have experienced a psychiatric episode requiring hospitalisation is essential to maintain their clinical and functional stability and to minimise the need for hospital readmissions. Patients leaving hospital after a psychiatric admission with a formal discharge plan, 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 2018 target is ≥ 75 per cent. Maintained performance is demonstrated by a result above, or equal to, the target.

Results

In 2018, the percentage of post-discharge community care within seven days following discharge from acute specialised mental health inpatient services was below target (see Table 14). During the year, a range of strategies and processes were implemented to actively manage this indicator and has resulted in a five per cent increase compared to prior period (2017). Performance continues to be reviewed and monitored on an ongoing basis.

Table 14: Percentage of post-discharge community care within seven days following discharge from acute specialised mental health inpatient services, 2016–18

	Calendar year				
	2016 (%)	2017 (%)	2018 (%)	Target (%)	Target met
Post-discharge community care	53	66	71	≥ 75	x

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

[7] National Health Survey 2014-15

Rationale

This indicator is a measure of the cost per weighted activity unit compared with the state (aggregated) target, as approved by the Department of Treasury and published in the 2018/19 Budget Paper No. 2, Volume 1.

The measure ensures that a consistent methodology is applied to calculating and reporting the cost of delivering inpatient activity against the State's funding allocation. As admitted services received nearly half of the overall 2018/19 budget allocation, it is imperative that efficiency of this service delivery is accurately monitored and reported.

Target

The 2018/19 target is $6,948 per weighted activity unit. Maintained performance is demonstrated by a result below, or equal to, the target.

Results

In 2018/19, the average admitted cost per weighted activity unit was above target (see Table 15).

Table 15: Average admitted cost per weighted activity unit, 2017/18–2018/19

	Financial year			
	2017/18 ($)	2018/19 ($)	Target ($)	Target met
Average cost	7,087	7,137	6,948	x

Data sources: OBM Allocation application; Oracle 11i financial system; Hospital Morbidity Data Collection; The Open Patient Administration System (TOPAS); Web-Based Patient Administration System (webPAS); Contracted Health Entities (CHEs) discharge extracts.

The Global Health Alliance Western Australia (GHAWA) partnership – formed between five Western Australian universities and the Nursing and Midwifery Office within the Department of Health, WA – aims to promote transcultural health improvements via education and training.

Public Health Clinical Nurse Specialist Lance Jarvis undertook a four week volunteer placement in Tanzania to share his experience, knowledge and skills with attendees. Delivered to nursing and midwifery professionals, Lance's role was to enhance their capability and capacity in developing world settings by demonstrating evidence-based practice and key skills like leadership and critical thinking through workshops.

This year the project is a structured Leadership and Management program that teaches senior nursing and midwifery staff leadership and management skills such as team building, communication, conflict management, critical thinking, problem solving, evidence-based practice and quality improvement. Through a series of workshops, Lance will share his experience, knowledge and skills with attendees.

Rationale

This indicator is a measure of the cost per weighted activity unit compared with the state (aggregated) target as approved by the Department of Treasury, which is published in the 2018/19 Budget Paper No. 2, Volume 1.

The measure ensures that a consistent methodology is applied to calculating and reporting the cost of delivering emergency department (ED) activity against the State's funding allocation. With the increasing demand on EDs and health services, it is imperative that ED service provision is monitored to ensure the efficient delivery of safe and high quality care.

Target

The 2018/19 target is $7,072 per weighted activity unit. Maintained performance is demonstrated by a result below, or equal to, the target.

Results

In 2018/19, the average emergency department cost per weighted activity unit was below target (see Table 16). The target was based on emergency department budgets and allocated overheads at a state level. The variation between the actual cost per weighted activity at the health service level and the target indicates that the ED cost per weighted activity unit at NMHS is lower than the state average.

Table 16: Average emergency department cost per weighted activity unit, 2017/18–2018/19

	Financial year			
	2017/18 ($)	2018/19 ($)	Target ($)	Target met
Average cost	6,095	6,212	7,072	✓

Data sources: OBM Allocation application; Oracle 11i financial system; Emergency Department Data Collection.

Rationale

This indicator is a measure of the cost per weighted activity unit compared with the state (aggregated) target, as approved by the Department of Treasury, which is published in the 2018/19 Budget Paper No. 2, Volume 1.

The measure ensures that a consistent methodology is applied to calculating and reporting the cost of delivering non-admitted activity against the State's funding allocation. Non-admitted services play a pivotal role within the spectrum of care provided to the WA public, therefore it is imperative that non-admitted service provision is monitored to ensure the efficient delivery of safe and high-quality care.

Target

The 2018/19 target is $7,136 per weighted activity unit. Maintained performance is demonstrated by a result below, or equal to, the target.

Results

In 2018/19, the average non-admitted cost per weighted activity unit was below target (see Table 17).

Table 17: Average non-admitted cost per weighted activity unit, 2017/18–2018/19

	Financial year			
	2017/18 ($)	2018/19 ($)	Target ($)	Target met
Average cost	7,224	7,018	7,136	✓

Data sources: OBM Allocation application; Oracle 11i financial system; Non-Admitted Patient Activity and Wait list (NAPAAWL) Data Collection; Interim Collection of Aggregate Data (ICAD).

A new exercise program for Aboriginal participants aged 45 years was established to improve the balance, mobility, strength and confidence of our community in performing daily tasks.

Recognising that falls are a major cause of poor health and injury among older people, the Healthway-funded project, led by Curtin University in partnership with NMHS Public Health and Wadjak Northside Aboriginal Community Centre, introduced a program that offered weekly strength training exercises in a culturally safe environment.

As well as providing participants with opportunities to socialise and enhance their confidence through the learning of new skills, the program also focused on producing physical benefits including improved bone strength, muscle mass and reduced risk of falls.

Rationale

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

Target

The 2018/19 target is $1,385 per bed-day in specialised mental health inpatient services. Maintained performance is demonstrated by a result below, or equal to, the target.

Results

In 2018/19, the average cost per bed-day in specialised mental health inpatient services was above target (see Table 18).

Table 18: Average cost per bed-day in specialised mental health inpatient services, 2016/17–2018/19

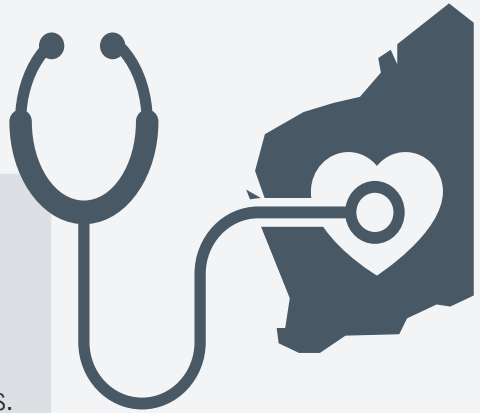
	Financial year				
	2016/17 ($)	2017/18 ($)	2018/19 ($)	Target ($)	Target met
Average cost	1,501	1,482	1,500	1,385	x

Data sources: OBM Allocation application; Oracle 11i financial system; BedState.

The Osborne Park Mental Health Community Clinic launched its first Carers Support Group meeting in October to provide an opportunity for carers of consumers and their family members to enjoy social connection and support, and share their stories and experienced in a supportive environment.

Recognising that carers function best when supported to deliver their caring responsibilities, the group was established to provide a network of connection and reference for people with caring duties.

The event was launched by the 2018 WA Senior Australian of the Year Kathleen Mazzella OAM who shared her story of starting a support group for women with gynaecological challenges in 2000 that went on to become the Gynaecological Information Awareness Network, now known as GAIN Inc.



Rationale

Public community mental health services consist of a range of community-based services such as emergency assessment and treatment, case management, day programs, rehabilitation, psychosocial, residential services and continuing care. The aim of these services is to provide the best health outcomes for the individual through the provision of accessible and appropriate community mental health care. Efficient functioning of public community mental health services is critical to ensure that finite funds are used effectively to deliver maximum community benefit.

Public community-based mental health services are generally targeted towards people in the acute phase of a mental illness who are receiving post-acute care. This indicator provides a measure of the cost effectiveness of treatment for public psychiatric patients under public community mental healthcare (non-admitted/ambulatory patients).

Target

The 2018/19 target is $420 per treatment day of non-admitted care provided by mental health services. Maintained performance is demonstrated by a result below, or equal to, the target.

Results

In 2018/19, the average cost per treatment day of non-admitted care provided by mental health services was above target (see Table 19).

Table 19: Average cost per treatment day of non-admitted care provided by mental health services, 2017/18–2018/19

	Financial year			
	2017/18 ($)	2018/19 ($)	Target ($)	Target met
Average cost	465	432	420	x

Data sources: OBM Allocation application; Oracle 11i financial system; Mental Health Information Data Collection.

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 a tumour is discovered at a later stage. Mass screening using mammography can improve early detection by as much as 15–35 per cent.[8]

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 2017–18 target is ≥ 70 per cent of women aged 50–69 years who participate in breast screening. Maintained performance is demonstrated by a result above, or equal to, the target.

Results

From 2017–2018, the rate of women aged 50–69 years who participate in breast screening was below target (see Table 20). Population growth in the outer metropolitan and coastal rural regions has increased the demand on resources and capacity shortfalls were experienced. A *Future Service Plan* is under development to identify and address future service gaps. BreastScreen WA has developed a number of strategies to improve access to breast screening. This includes the award winning program '*Mobile in the suburbs*'.

Table 20: Rate of women aged 50–69 years who participate in breast screening, 2016–17–2017–18

	Calendar years			
	2016–2017 (%)	2017–2018 (%)	Target (%)	Target met
Participation rate	56	56	≥ 70	x

Note: This measure counts the women screened within a 24-month period (1 January 2017 to 31 December 2018) as it is recommended that women in the cohort attend the free screening every two years.
Data sources: BreastScreen WA Register; Australian Bureau of Statistics.

[8] 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.

Rationale

This KPI is used to assess, compare and determine the potential to improve dental care for clients. This KPI 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 KPI will provide opportunity for benchmarking across jurisdictions.

Target

Please see the targets for adults and children in Table 21. Maintained performance is demonstrated by a result below the target.

Results

In 2018/19, the percentage of adults and children who have a tooth re-treated within six months of receiving initial restorative dental treatment was below target (see Table 21). Performance for this indicator remained consistent to the prior year and was attributable to training, regular monitoring of clinic/clinician re-treatment rates and quality assurance of equipment and materials used statewide.

Table 21: Percentage of adults and children who have a tooth re-treated within six months of receiving initial restorative dental treatment, 2017/18–2018/19

	Financial year			
	2017/18 (%)	2018/19 (%)	Target (%)	Target met
Adults	6.0	6.1	< 7.7	✓
Children	2.2	2.1	< 2.6	✓

Data source: Dental Information Management Patient Management System (DenIM PMS).

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 in order 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 2018/19 target is ≥ 69 per cent. Maintained performance is demonstrated by a result above, or equal to, the target.

Results

In 2018/19, the percentage of eligible school children who are enrolled in the School Dental program was above target (see Table 22). Performance for this indicator remained consistent to prior years as the Dental Health Service continues to actively enroll children into the service.

Table 22: Percentage of eligible school children who are enrolled in the School Dental Service program, 2016/17–2018/19

	Financial year				
	2016/17 (%)	2017/18 (%)	2018/19 (%)	Target (%)	Target met
Eligible school children who are enrolled in the School Dental program	80	79	79	≥ 69	✓

Note: Eligible school children are all school children aged 5 to 16 or until the end of year 11 (whichever comes first) who attend a Western Australian 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 sources: Dental Information Management Patient Management System (DenIM PMS); Department of Education WA.

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 Western Australians in need. This indicator measures the level of access to these subsidised dental health services by monitoring the proportion of all eligible people receiving the services.

Through measuring the use and amount of dental health services provided to eligible people, the percentage of eligible people proactively involved in publicly funded dental care can be determined. This in turn can help identify areas that require more focused intervention and prevention and health promotion strategies to help ensure the improved dental health and wellbeing of Western Australians with the greatest need.

Target

The 2018/19 target is ≥ 15 per cent. Maintained performance is demonstrated by a result above, or equal to, the target.

Results

In 2018/19, the percentage of eligible people who accessed Dental Health Services was below target (see Table 23).

Table 23: Percentage of eligible people who accessed Dental Health Services, 2017/18–2018/19

	Financial year			
	2017/18 (%)	2018/19 (%)	Target (%)	Target met
Eligible people who accessed Dental Health Services	15	14	≥ 15	x

Note: Eligible people are defined as those who hold a current Pension Concession Card (Centrelink) or Health Care Card.

Data sources: Dental Information Management (DenIM) database; Commonwealth Department of Social Services (DSS) Payment Demographic data.

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 2018/19 target is $36. Maintained performance is demonstrated by a result below, or equal to, the target.

Results

In 2018/19, the average cost per person of delivering population health programs by population health units was above target (see Table 24). The budget target for the year was based on a realignment of the budget parameters for hospital and non-hospital services. It excluded a significant component of costs related to public health and community services that the health service continues to provide.

Table 24: Average cost per person of delivering population health programs by population health units, 2017/18–2018/19

	Financial year			
	2017/18 ($)	2018/19 ($)	Target ($)	Target met
Average cost	50	50	36	x

Data sources: OBM Allocation application; Oracle 11i financial system; WA Department of Health Epidemiology Branch.

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 2018/19 target is $165 per breast screening. Maintained performance is demonstrated by a result below, or equal to, the target.

Results

In 2018/19, the average cost per breast screening was below target (see Table 25). Targeted strategies to maximise the use of resources and access to clients have contributed to this result.

Table 25: Average cost per breast screening, 2017/18–2018/19

	Financial year			
	2017/18 ($)	2018/19 ($)	2017/18 Target ($)	Target met
Average cost	165	158	165	✓

Data sources: OBM Allocation application; Oracle 11i financial system; Mammography Screening Register; BreastScreen WA.

Health Minister Roger Cook officially opened the Joondalup Community Midwifery Program (CMP) bringing maternity care closer to home for women in the northern suburbs. The program is the only publicly-funded home birth program of its kind in Australia.

Located in the Lakeside Joondalup Shopping Centre, the CMP provides women with access to the same quality of care they would receive in a hospital environment, with the bonus of a more personalised relationship with their allocated midwife.

Operating under our Women and Newborn Health Service, the CMP offers the option of birthing at home, at the Family Birth Centre, in stand-alone birthing rooms or at a public hospital with a known midwife, providing more choices for expectant mothers.

Average cost per patient visit of WA Health-provided dental health programs for school children and socio-economically disadvantaged adults
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

Please see the targets for patient groups in Table 26. Maintained performance is demonstrated by a result below, or equal to, the target.

Results

In 2018/19, the average cost per patient visit of WA Health-provided dental health programs was above target for school children and below target for socio-economically disadvantaged adults (see Table 26). Performance for this indicator was impacted by a one-off back payment to Dental Clinical assistants relating to a reclassification claim.

Table 26: Average cost per patient visit of WA Health-provided dental health programs for school children and socio-economically disadvantaged adults, 2017/18–2018/19

	Financial year			
Average cost	**2017/18 ($)**	**2018/19 ($)**	**Target ($)**	**Target met**
School children	198	193	184	x
Socio-economically disadvantaged adults	272	281	283	✓

Data sources: OBM Allocation application; Oracle 11i financial system; Dental Information Management (DenIM) database.

Rationale

The Australasian College for Emergency Medicine developed the Australasian Triage Scale (ATS) to ensure that patients presenting to emergency departments are medically assessed and treated in a timely manner and prioritised according to their clinical urgency.[9]

This performance indicator measures the percentage of patients being assessed and treated within the required ATS timeframes. This provides an overall indication of the effectiveness of WA's emergency departments and will assist in driving improvements in patient access to emergency care.

Target

The 2018/19 targets for ED patients seen within recommended times by triage category as per the 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 2018/19, 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 (see Table 27). The results are impacted by challenges associated with greater demand for services and patient flow. Reviews have been completed and strategies to address these challenges include improvements to models of care, discharge planning and staff education and training.

Table 27: Percentage of emergency department patients seen within recommended times, by triage category, 2016/17–2018/19

	Financial year				
Triage category	2016/17 (%)	2017/18 (%)	2018/19 (%)	Target (%)	Target met
1	100	100	100	100	✓
2	77	80	76	≥ 80	x
3	40	43	45	≥ 75	x
4	57	59	57	≥ 70	x
5	93	92	85	≥ 70	✓

Data source: Emergency Department Data Collection.

[9] Australasian College for Emergency Medicine. (2013) Policy on the Australasian Triage Scale, Australasian College for Emergency Medicine, Melbourne. Available from: https://acem.org.au/getmedia/484b39f1-7c99-427b-b46e-005b0cd6ac64/P06- Policy-on-the-ATS-Jul-13-v04.aspx

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, section 60 of the *Health Services Act 2016*, the 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 the NMHS Board, as well as its accountabilities and priorities. The 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 (WA)*.

The majority of hospital fees and charges for public hospitals are set under Schedule 1 of the Health Services (Fees and Charges) Order 2016 and are reviewed annually. The following informs WA public hospital 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 Medicare 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 Medicare ineligible hospital accommodation fees is set close to, or at, full cost recovery.

Private patients (Medicare eligible Australian residents)

The Commonwealth Department of Health regulates the Minimum Benefit payable by health funds to privately insured patients for private shared ward and same day accommodation. 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 for 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 Health Care Card or Pensioner Concession Card
- 25 per cent of the treatment fee if the patient is the current holder of one of the above cards and receives a near full pension or an allowance from Centrelink or the Department of Veterans' Affairs.

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

Capital works

We have a substantial Asset Investment Program that facilitates remodelling and development of health infrastructure. Program initiatives include the continuation of major projects to reconfigure infrastructure and investment in metropolitan general and tertiary hospitals (see Table 28 and Table 29).

Table 28: Major Asset Investment Program works completed, 2018/19

Initiative	Estimated total cost $000
Adult Mental Health Unit overrun	3,352
BreastScreen WA – digital mammography technology	12,639
Graylands Hospital – development – high priority ligature risk remediation	96
JHC Telethon Paediatric Ward	12,037
JHC Mental Health Unit – anti-ligature point rectification	865
KEMH – maternal fetal assessment	5,379
OPH – additional parking facility	3,252
SCGH and KEMH – upgrade of PABX infrastructure	2,131
SCGH – Catheter Laboratory 2 upgrade	584
QEII Medical Centre – new central plant facility	211,797
Total	**252,132**

Note: The information above is based upon the 2018/19 published budget papers.

Table 29: Major capital works in progress, 2018/19

Initiative	Estimated total cost 2018/19 (a) $000	Reported in 2017/18 (b) $000	Variation (b)–(a) $000	Expected completion date
Graylands Hospital – redevelopment planning[1]	528	600	72	Completed
JHC development stage 2[1,3,4]	158,000	2,650	(155,350)	Ongoing
Joondalup Mental Health Observation Area[1,3]	6,754	6,648	(106)	Completed
KEMH – holding[1]	1,380	1,056	(324)	N/A
OPH reconfiguration stage 1[1,2]	273	261	(12)	N/A
OPH additional parking facility[1,3]	3,279	3,330	51	Completed
WA Spinal Cord Injury Service – reconfiguration[1,2]	43,298	4,166	(39,132)	Ongoing
Sarich Neuroscience[1,2,3]	35,422	32,515	(2,907)	Aug. 2019
SCGH – redevelopment stage 1[1]	7,565	3,565	(4,000)	N/A
Infection prevention and control system[1,2]	2,382	258	(2,124)	Ongoing
Fremantle Dental Clinic[1,2,3]	2,990	1,495	(1,495)	Mar. 2020
KEMH – Neonatal Intensive Care Unit[1,2,3]	1,115	987	(128)	Completed

Notes:

[1] The information above is based upon the:
i) 2018/19 published budget papers.
ii) 2017/18 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 2018/19 budget papers.

Employment profile

Government agencies are required to report the number of employees, by category.
Table 30 shows the year-to-date (June 2019) number of NMHS full-time equivalent (FTE) employees for 2018/19.

Table 30: NMHS total full-time equivalent employees by category, 2018/19

Category	Definition	2017/18	%
Nursing and midwifery	All nursing and midwifery occupations, excluding agency nurses and midwives	3445	38.0
Administration and clerical	All clerical-based occupations including patient-facing (ward) clerical support employees (83 FTE from Department of Health Health Services Union in specific cost centres)	1542	17.0
Medical support	All allied health and scientific/ technical related occupations	1362	15.0
Medical salaried and sessional	All medical occupations including interns, registrars and specialist medical practitioners	1271	14.0
Hotel services	Includes catering, cleaning, stores/supply laundry and transport occupations	759	8.4
Dental clinic assistants	Dental clinic assistants	311	3.4
Site services	Engineering, garden and security-based occupations	182	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	79	0.9
Assistants in nursing	Support registered nurses and enrolled nurses in delivery of general patient care	76	0.8
Agency nursing and midwifery	Workers engaged on a ‘contract for service’ basis. Does not include workers employed by NurseWest	40	0.4
Other occupations	Including, but not limited to, Aboriginal and ethnic health employees	8	0.1
Total FTE employees		**9073**	**100**

Note: Total FTE, excluding Department of Health, is 8991.
For comparison with 2017/18, the total FTE should be reduced by 1654 to remove PathWest, which was established as a statutory authority on 1 July 2018. The resulting total FTE from 2017/18 is 9128, equivalent to a reduction of 55 FTE in 2018/19.

Data source: Human Resource (HR) Data Warehouse via Pulse Enterprise Data Warehouse, data extracted on 15 July 2019.

Industrial relations

The Industrial Relations team provide expert advice and support to enable us to deliver our strategic priorities and strive to foster productive relationships between the NMHS and our employees, unions and other key stakeholders.

Major activities in 2018/19 included:

- providing representation and advocacy in matters before the WA Industrial Relations Commission, Fair Work 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 preparation and renegotiation of all WA Health industrial agreements including the WA Health System Engineering and Building Services Industrial Agreement 2019; WA Health System – Australian Nursing Federation – Registered Nurses, Midwives, Enrolled (Mental Health) and Enrolled (Mothercraft) Nurses – Industrial Agreement 2018
- providing support and feedback to the System Manager in preparation for the renewal of the WA Health System – Medical Practitioners – AMA Industrial Agreement 2016
- providing ongoing support and advice to implement large scale workforce initiatives and change management programs
- providing advice and ongoing management of claims and disputes related to investigations, disciplinary matters, and contractual/agreement claims (e.g. pay, rosters and conditions)
- contributing to the development, review and implementation of workforce related policies, strategies, systems and processes.

Employee development

We are committed to enhancing organisational capability and performance by developing our employees and providing learning and career development opportunities. We provide education and mandatory skills training to support the delivery of excellence in health care for our community.

Each NMHS site delivers 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, My Health Record and Management of Aggression.

We have over 2000 managerial and supervisory staff, and the provision of front-line manager skills is a priority. Training focuses on the skills necessary to recruit, manage and develop our staff, and the practical skills required to successfully manage operational services. The nationally-recognised qualification, the Diploma of Leadership and Management (100 current participants) provides a high-quality and substantial training opportunity in this area.

In 2018/19 we provided a wide range of undergraduate, graduate training and leadership development programs to employees.

The NMHS has developed a learning and development framework based on the 70:20:10 development model to incorporate with our performance development planning processes. This model encourages a range of development options to build internal capability including formal training and education programs, on the job learning, coaching and mentoring opportunities. This approach will ensure development needs and opportunities are aligned to strategic priorities and will be implemented in 2019/20.

Workers' compensation

We have a standardised injury management system that enables systematic management of workers' compensation claims and the provision of injury management services that are administered in accordance with the *Workers' Compensation and Injury Management Act 1981*.

Injury management consultants manage the relevant system and processes and are accessible to all staff and managers to ensure high levels of specialist support are provided for staff with work-related injuries or illnesses. The consultants provide advice and services to ensure best practice case management strategies including timely opportunities for staff to return to productive duties when it is medically appropriate. The NMHS adopts a multidisciplinary case management approach to facilitate the early and safe return to work of injured workers which involves the injury management consultant, line managers, injured workers and their treating medical providers. This approach ensures the programs are appropriate to the employees' capacity and workplace.

Employee rehabilitation programs also extend to non-compensable injuries where there is a risk of exacerbating factors and/or a requirement to provide expert advice to facilitate the employee's safe return to work. This is facilitated by occupational health physicians who provide expert advice.

In 2018/19 a total of 246 workers' compensation claims were made (see Table 31).

Table 31: Number of NMHS workers' compensation claims, 2018/19

Employee category	Number
Nursing services/dental clinic assistants	121
Administration and clerical	23
Medical (support)	27
Hotel services	49
Maintenance	16
Medical (salaried)	10
Total	**246**

Note: The workers' compensation total claims made and employee categories were obtained from RiskCover all claims monthly spreadsheet as at 30 June 2019 and filtered by FY 2018/19.

Governance disclosures

Pecuniary interests

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

NMHS Board member David Forbes received a payment of $16,500 (GST inclusive) in 2019 for completing a review of the Department of Urology for Royal Perth Hospital, East Metropolitan Health Service.

NMHS Board member Selma Alliex is an employee of the University of Notre Dame, which has an agreement with the Public Sector Commission. No direct benefits are received, but Selma Alliex receives payments as a senior staff member of the University of Notre Dame.

NMHS Board member Grant Robinson is a Bethesda Health Care Board member. Bethesda Health Care has a service contract with NMHS for the provision of specialist palliative care services. Grant Robinson is also a Board member for Juniper – a Uniting Church community, which provides some services to the NMHS on an ad hoc basis. No financial benefit is received from either position.

NMHS Acting Area Executive Director Medical Services Donald Coid holds the position of Director of Donald Coid Consultants. Donald Coid Consultants received payments of $8,007 (GST inclusive) in 2018 for consultancy work related to the review of the Statewide Obstetric Support Unit. The consultancy review was completed prior to Donald Coid's appointment to his current NMHS position.

Unauthorised use of credit cards

NMHS officers are issued with corporate credit cards (Purchasing Cards) when their functions require this facility. The credit cards provide a clear audit trail for the purchase of goods and services and are not to be used for personal (unauthorised) purposes. If a cardholder makes a personal purchase, they must give written notice to the NMHS within five working days and refund the total amount of expenditure.

Ten NMHS cardholders recorded personal purchases on their Purchasing Card. All of these cardholders declared a personal expenditure and all monies were refunded in full (see Table 32).

Table 32: Personal use credit card expenditure by NMHS cardholders, 2018/19

Credit card personal use expenditure	Aggregate amount ($)
Reporting period	846
Settled by the due date (within 5 working days)	376
Settled after the period (after 5 working days)	470
Outstanding at balance date	0

Board and committee remuneration

The total annual remuneration for each board or committee is listed in Table 33. For details of individual board or committee members, please refer to Appendix B.

Table 33: Summary of State Government boards and committees within NMHS, 2018/19

Board/Committee name	Total remuneration ($)
NMHS Board	362,449
Graylands Hospital Management Team Meeting	Nil
KEMH Community Advisory Committee (renamed Women and Newborn Health Service Community Advisory Council)	7,910
North Metropolitan Area Health Service Community Advisory Committee (ceased)	Nil
OPH Community Advisory Council	4,325
Sir Charles Gairdner Hospital Mental Health Unit Project Working Group (ceased)	Nil
State Perinatal Mental Health Reference Group (ceased)	Nil

We continued to expand the use of telehealth throughout our hospital and health service network as means of using innovations in technology to better meet the needs of our patients.

As a joint initiative with NMHS Osborne Park Hospital (OPH) and WA Country Health Service Midwest, the TeleStroke-Rehab Project was set up to enable Midwest patients to access stroke rehabilitation services locally. This saw the Geraldton Hospital rehabilitation team work 'virtually' with OPH stroke service specialist allied health staff and consultants to deliver services, as they did for Geraldton stroke survivor Janet Cozens, who was able to undertake stroke rehabilitation closer to home.

Other legal requirements

Advertising and sponsorship

In accordance with section 175Z of the *Electoral Act 1907*, we are required to report our total advertising expenditure. In 2018/19 the total expenditure was $328,620. The organisations from which advertising services were procured and the amount paid to each organisation are shown in Table 34.

Table 34: Summary of NMHS advertising expenditure by provider, 2018/19

Category	Provider	$
Advertising agencies	303 MullenLowe	10,000
	Adcraft Promotional Products	10,238
	Badge-A-Minit	262
	Confectionery Corner	330
	Discus Print and Signage	395
	Dynamic Gift International	240
	Richard Lochland Beilby	500
	Picton Press	45,387
	Sensis Pty Ltd	3,753
	Telstra Corporation Limited	12,709
	White Wall Group	144,500
	Wristband Monkey	262
	Subtotal	**228,575**
Market research organisations	Patient Opinion	24,500
	Press Ganey Associates Pty Ltd	16,909
	Subtotal	**41,409**
Media advertising organisations	Carat Australia Media Services	52,245
	Optimum Media Decisions (WA) Limited	6,391
	Subtotal	**58,636**
Total		**328,620**

Disability Access and Inclusion Plan

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

We are committed to ensuring people with disability have the same opportunities as other people to fully access the range of health services and facilities, employment, consultation and information. Our Disability Access and Inclusion Plan (DAIP) 2017–2022 focuses on supporting people living with a disability, their carers and significant others.

General services and events

This year, the *SCGH Induction Manual* and Program were updated in relation to disability and the program includes a video to reflect the carer's perspective.

Customer Service pamphlets at King Edward Memorial Hospital have been designed as information sheets to be uploaded onto the intranet hub for staff to print on behalf of patients, and to be placed online for easy public access and use. Feedback boxes are placed throughout the hospital at the correct height for accessibility and in spaces of easy access.

BreastScreen WA ensures all community events are held in venues with disability access.

Buildings and facilities

New facilities are selected or built with the needs of those living with a disability in mind. The NMHS Mental Health Subiaco Adult Community Mental Health Service relocated to a new, more accessible site in February 2019. It is located on the main bus route from the nearest train station and has an accessible entrance, internal lift and disabled parking with same level access.

The newly constructed Fremantle Dental Clinic includes a larger surgery to allow wheelchair access and care of those with special needs.

Information and communication

BreastScreen WA has updated all braille notes on screening mammograms and consent forms for each clinic and mobile service while the Dental Health Services has information and resources available in various formats including audio tape and braille for those with literacy or vision difficulties, upon request.

Our Public Health Unit developed a computerised, self-administered survey to capture inpatient experience of CaLD people. The pilot demonstrated that the survey was useful for CaLD patients and had potential for use by others within the community such as those with vision and hearing impairment.

Quality of service

The National Disability Insurance Scheme (NDIS) is Australia's first national scheme for people with disability. When it is fully rolled out, the NDIS will provide about 460 000 Australians aged under 65, who have permanent and significant disability with funding for supports and services. This year, we set up a group to help patients transition to NDIS, provided education to staff and added information added about NDIS to the online staff hub. These actions were in response to concerns about equipment and services for people with disabilities who will transition from state-based disability services (including the Community Aids and Equipment Program) to the federally funded NDIS or My Aged Care.

The NMHS has been represented on the NDIS Health Reference Group. For inpatients needing to register for NDIS, staff are supporting patients by providing advice, preparing access request forms and collecting evidence for the NDIS pre-planning meetings. Information packs for inpatients are in development.

Complaints and safeguarding

A range of feedback mechanisms is available to enable patients to make a complaint, including established patient liaison services which are well promoted through accessible hard copy and online information. Complaints may be made in writing, in person or over the phone. In 2018/19, KEMH used the services of an AUSLAN interpreter for a patient wishing to make a complaint.

We also subscribe to Patient Opinion, an anonymous online platform for patient stories – positive and negative.

The Dental Health Services conducted an audit of its complaints processes to ensure that people with a disability have the same opportunities as others to provide feedback.

Consultation and engagement

The Community Advisory Councils at our hospitals aim to be reflective of our consumers and include members who are living with a disability or caring for someone who has a disability. Work is under way to improve the governance around the councils to better support them into the future and increase their involvement on hospital committees.

Training in engagement has been undertaken by a range of staff throughout 2018/19 to ensure the needs of people living with a disability are considered when engagement activities are being planned. How to ensure their voices are heard was a key component of the course.

Employment, people and culture

We comply with WA health system's Recruitment, Selection and Appointment Policy. We provide staff access to training to ensure that they are fully aware of relevant legislation, regulations and standards, including those that relate to the consideration of people with disability in an effort to ensure all recruitment and selection is undertaken in a consistent, inclusive, open and transparent manner.

We ensure job descriptions 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.

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

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 the NMHS intranet, which includes external links to the Public Sector Commission's website.

Onsite 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 2018/19, 10 breach of standard claims were lodged regarding the recruitment, selection and appointment process, or the management process of an employee's performance. Of these, four claims were finalised internally and five (5) were sent to the Public Sector Commission for review and subsequently dismissed. There is one claim ongoing.

We use a central recruitment and selection process through Health Support Services 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.

We inform and educate 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, we are required to review, assess and investigate all complaints alleging breaches of the Code of Conduct. All alleged breaches of the code are considered breaches of discipline under the *Health Services Act 2016*. In 2018/19 a total of 183 matters were lodged and investigated internally as an allegation of a breach of discipline.

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.

Our Recordkeeping Plan (RKP) was endorsed by the State Records Commission in 2015. 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 RKP, including the rollout of the EDRMS, was completed in August 2017 and endorsed by Executive, with a commitment to ensuring the rollout of compliant recordkeeping systems continues.

The RKP will be reviewed and evaluated in 2019/20 and submitted for endorsement by the State Records Commission by August 2020. Evaluation will include a review of the efficiency and effectiveness of the recordkeeping training program.

Pursuant to section 16(3) of the *State Records Act 2000*, records managers across WA Health Service Providers have developed the sector disposal authority for Health Services to support the authorised disposal of government health information. It is due to be submitted to the State Records Commission in August 2019. Once endorsed, the disposal authority will be installed into the EDRMS system and training materials developed for staff.

We have established training options for staff in the use of the EDRMS, which include classroom training, eLearning tools and ongoing support. In addition, an intranet site for records management incorporates advice, policies and guidelines that staff must adhere to when undertaking recordkeeping activities.

Our induction program addresses employee roles and responsibilities for compliance with the RKP. The Records Awareness Training eLearning package is mandatory for our employees.

Annual estimates

Our annual operational budget estimates for the following financial year are reported to the Minister for Health under section 40 of the *Financial Management Act 2006*, and Treasurer's Instruction (TI) 953.

The annual estimates for 2019/20, as approved by the Minister for Health, are provided in Table 35.

Table 35: 2019/20 Budget estimates for NMHS

Part A: Statement of comprehensive income	Note	2019/20 Estimate $000
COST OF SERVICES		
Expenses		
Employee benefits expense		1,138,117
Contracts for services		460,383
Patient support costs		273,592
Finance costs		2,225
Depreciation and amortisation expense		71,977
Repairs, maintenance and consumable equipment		37,027
Other supplies and services		98,850
Other expenses		46,776
Total cost of services		**2,128,947**
INCOME		
Revenue		
Patient charges		68,361
Other fees for services		70,134
Commonwealth grants and contributions		645,382
Other grants and contributions		170,829
Donation revenue		13
Other revenues	3	21,795
Total revenue		**976,515**
Gains		
Other gains	1	-
Total gains		**-**
Total income other than income from State Government		**976,515**
NET COST OF SERVICES		**1,152,432**
INCOME FROM STATE GOVERNMENT		
Service appropriations		1,062,809
Services received free of charge		89,223
Royalties for Regions Fund		400
Total income from State Government		**1,152,432**
SURPLUS / (Deficit) for the period		**-**
OTHER COMPREHENSIVE INCOME		
Items not reclassified subsequently to profit or loss		-
Changes in asset revaluation reserve		3,083
Total other comprehensive income		**3,083**
TOTAL COMPREHENSIVE (LOSS) / INCOME FOR THE PERIOD		**3,083**

Table 35: 2019/20 Budget estimates for NMHS *continued*

Part B: Statement of financial position	Note	2019/20 Estimate $000
ASSETS		
Current assets		
Cash and cash equivalents		62,847
Restricted cash and cash equivalents		41,800
Inventories		5,339
Receivables		46,071
Other current assets	3	1,764
Total current assets		**157,820**
Non-current assets		
Restricted cash and cash equivalents	2	18,546
Amounts receivable for services		845,943
Property, plant and equipment		1,364,333
Right-of-use assets		49,526
Intangible assets		467
Other non-current assets	1	-
Total non-current assets		**2,278,815**
Total assets		**2,436,635**
LIABILITIES		
Current liabilities		
Payables		148,329
Provisions		243,635
Borrowings	4	815
Other current liabilities		17,145
Total current liabilities		**409,924**

Part B: Statement of financial position	Note	2019/20 Estimate $000
Non-current liabilities		
Provisions		55,967
Borrowings		46,443
Other non-current liabilities	1	-
Total non-current liabilities		**102,410**
Total liabilities		**512,334**
NET ASSETS		**1,924,301**
EQUITY		
Contributed equity		1,768,977
Reserves		152,241
Accumulated (deficit)/surplus	4	3,083
TOTAL EQUITY		**1,924,301**

Table 35: 2019/20 Budget estimates for NMHS *continued*

Part C: Statement of cash flows	Note	2019/20 Estimate $000 Inflows / (Outflows)
CASH FLOWS FROM STATE GOVERNMENT		
Service appropriations		990,814
Capital appropriations		45,299
Equity contribution		3,083
Royalties for Regions Fund		400
Net cash provided by State Government		**1,039,596**
CASH FLOWS FROM OPERATING ACTIVITIES		
Payments		
Employee benefits		(1,131,284)
Supplies and services		(827,404)
Finance Costs		(2,208)
Other payments	1	-
Receipts		
Receipts from customers		74,361
Commonwealth grants and contributions		645,382
Other grants and contributions		170,829
Donations received		13
Other receipts		91,930
Net cash used in operating activities		**(978,381)**
CASH FLOWS FROM INVESTING ACTIVITIES		
Payments		
Payment for purchase of non-current physical and intangible assets		(45,299)
Receipts		
Proceeds from sale of non-current physical assets	1	-
Net cash used in investing activities		**(45,299)**
CASH FLOWS FROM FINANCING ACTIVITIES		
Repayment of lease liabilities	4	(3,083)
Repayment of other liabilities	1	-
Net cash used in financing activities		**(3,083)**
Net increase in cash and cash equivalents		**12,833**
Cash and cash equivalent at the beginning of the period		**117,193**
Cash and cash equivalents transferred to other agencies	**2**	**(6,833)**
Cash and cash equivalents at the end of the period		**123,193**

Notes:

Note 1: No balance forecasted as at 30 June 2019.

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.

Note 3: Volunteer services are NOT included in revenue and non-current assets as the benefit from those services cannot be measured reliably (AASB 1058).

Note 4: Impact of AASB 16 Leases.

Government policy

Substantive equality

We are committed to substantive equality for Western Australia by eliminating systemic forms of discrimination in the provision of public services and promoting awareness of the different needs of our client groups. We seek to ensure the Western Australian health system's Substantive Equality Policy Framework is reflected in all operational and strategic planning, policy development, employment (recruitment and retention) and training strategies.

A key focus is to contribute towards substantive equality for the Aboriginal population (as a major user group of our services) through a coordinated approach to the planning, funding and delivery of Aboriginal health programs and the development of a workplace environment that values the employment and retention of Aboriginal employees through a range of initiatives, including:

- Implementation of section 51of the *Equal Opportunity Act 1984* to increase the Aboriginal workforce across all occupational groups and levels through a variety of career pathways and employment opportunities. Recently, four Aboriginal applicants successfully gained positions in the Enrolled Nurse Graduate Program – Mental Health. An education and training officer was recruited under section 51 to implement the Family and Domestic Violence Training and Education Programs specifically for culturally and linguistically diverse and Aboriginal patients.
- Offering Aboriginal sponsorships and traineeships to provide learning opportunities to increase Aboriginal employment. The continuation of the Aboriginal Dental Clinic Assistant sponsorship has led to the recent sponsorship of three suitably identified Aboriginal people.
- Creation of an Aboriginal Volunteer Program at King Edward Memorial Hospital that provides a culturally supportive environment for Aboriginal mothers and families who have travelled to KEMH from rural and remote areas.
- Increased vaccination coverage for Aboriginal people through the Metropolitan Communicable Disease Control program that was established to identify families who are overdue for their immunisation and to help get their immunisations up to date. Immunisation rates have increased in the target group of children aged 12 to 15 months since the program was introduced.
- Partnerships with 10 Aboriginal Medical Services in regional locations to provide oral health care in a culturally safe environment to reduce barriers for Aboriginal people in accessing dental services.
- Engaging with Aboriginal patients and families to improve access and pathways for Aboriginal people in hospital through Aboriginal Health Liaison Officers located throughout NMHS sites.
- Creation of an Aboriginal Patient Coordination Group to provide coordinated care and improve the patient journey for Aboriginal patients at SCGH.
- Piloting a new referral program for counselling and recovery in partnership with three Aboriginal service providers, to improve access to the Sexual Assault Resource Centre by Aboriginal people.
- Development of a set of Aboriginal-specific cervical screening brochures to complement the Aboriginal women's flipchart resources.

We are also committed to contributing to substantive equality for the CaLD population and people with disabilities by:

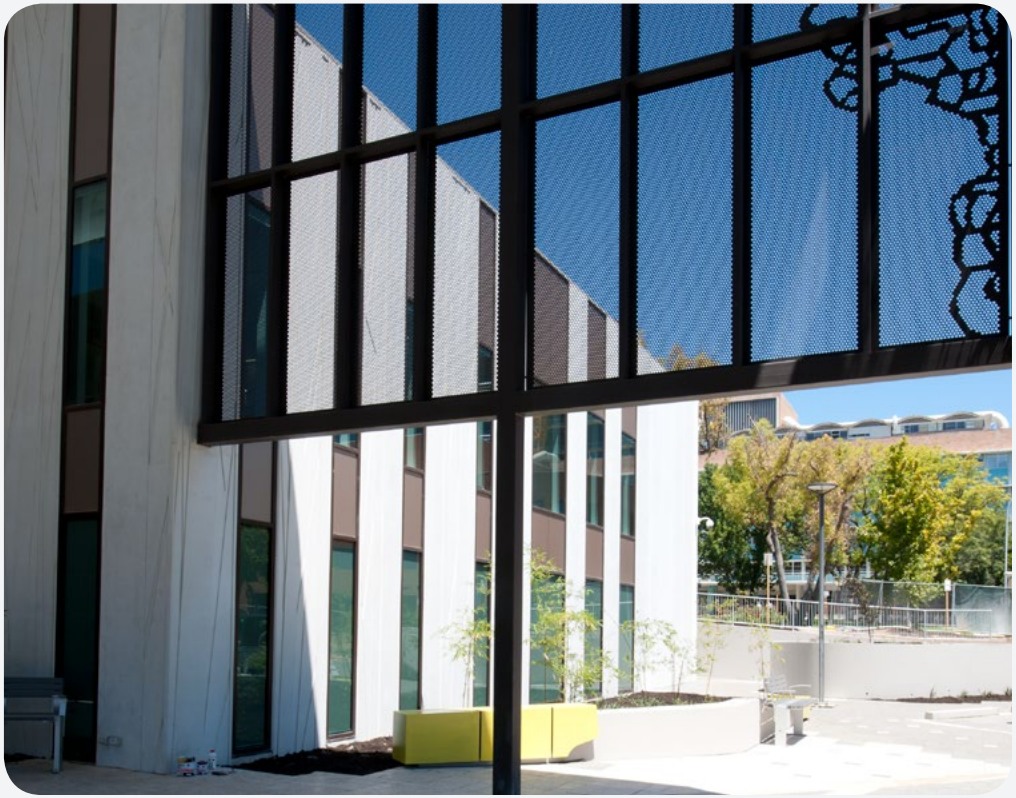
- Undertaking a stakeholder mapping and consultation exercise through the WA Cervical Cancer Prevention Program (WACCPP) to identify service gaps and opportunities for collaboration. In addition, WACCPP are conducting a scoping activity and literature review to inform the design of cervical screening health promotion activities to target CaLD communities in WA.
- Executing the implementation plan for the Sir Charles Gairdner Hospital Disability Access and Inclusion Plan to improve access for people with disability to information, services and events.
- Uploading a '*Disability equipment and services*' page on the Sir Charles Gairdner and Osborne Park Health Care Group intranet. This was in response to the concerns and issues of equipment and service use for people with disabilities with the transition from state based disability services to the federally funded National Disability Insurance Scheme (for under 65s) and My Aged Care (65 years and over).

Further, to ensure continuous improvement towards achieving substantive equality and addressing systemic discrimination, we have surveyed patients, stakeholders and employees throughout 2018/19 to determine their experience with our service delivery. Results have been evaluated and action plans devised to ensure our services are able to meet the needs of different people and groups of people.

Government building contracts

We are committed to complying with the Government Building Training Policy. In 2018/19 we included appropriate clauses in our tender documentation and commenced increased monitoring of compliance of in-scope building, construction and maintenance contractors for projects with a duration of greater than three months and a value of greater than $2 million.

As at 30 June 2019, no service, maintenance or labour component contracts had been awarded of $2 million or above. The only project was for Dental Health Services and the labour component of that project was under the threshold.



Occupational safety and health, and injury management

We are committed to providing a safe workplace and achieving high standards in safety and health for our employees, contractors and visitors. To achieve this, we have in place an integrated risk management approach to occupational safety and health (OSH) that is underpinned by policies and procedures in accordance with the *Occupational Safety and Health Act 1984*, the Occupational Safety and Health Regulations 1996 and the Code of Practice on Occupational Safety and Health in the Western Australian Public Sector 2007.

The establishment of clear OSH policies, goals and strategies, the articulation of employee responsibilities and the development of preventive programs allows us to take a proactive approach to OSH to achieve best practice outcomes. Hazard and risk management processes include the use of incident report forms, workplace inspections, risk assessments and job safety analyses. We also adopt a consultative approach to the resolution of safety risks in order to ensure that hazards are addressed and incidents are investigated, thereby promoting a positive safety culture.

We regularly provide information about safety and health and promote activities to ensure that all staff have access to current and relevant information, particularly when it applies to their roles and the healthcare environment. Safety and health policies, procedures, guidelines and other related information are available to all staff through HealthPoint and intranet pages.

All NMHS sites facilitate OSH management and consultation through:

- the election of OSH representatives
- the establishment of OSH committees and working groups
- hazard/incident reporting and investigation
- routine workplace inspections
- resolution of issues process
- implementation of regular audits, risk assessments and control measures to prevent incidents occurring.

Our OSH committees meet regularly to discuss and resolve occupational safety and health issues. Committee members are available to management and employees to support discussion and resolution of OSH issues. This ensures issues are formally recognised and actions are communicated back to the employee and OSH representative. Our OSH assessment and performance indicators are summarised in Table 36.

Table 36: Occupational safety and health assessment and performance indicators, 2018/19

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]	2.82%	x
Lost time injury severity rate	0 or 10% reduction (26.7)[2]	32.70%	x
Percentage of injured workers returned to work within 13 weeks	Greater than or equal to 80% return to work within 13 weeks	71%	x
Percentage of injured workers returned to work within 26 weeks	Greater than or equal to 80% return to work within 26 weeks	85%	✓
Percentage of managers and supervisors trained in OSH and injury management responsibilities	Greater than or equal to 80%	69%[3]	x

Notes:

[1] Target is 10% improvement on 2016/17 LTI/D, as per RiskCover data for NMHS.

[2] Target is 10% improvement on 2016/17 severity rate, as per RiskCover data for NMHS.

[3] Managers and supervisors requiring training are determined from our HR records.

Appendices

A. 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.nmahs.health.wa.gov.au

Sir Charles Gairdner Hospital

Street address: Queen Elizabeth II Medical Centre, Hospital Ave, 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

Street and postal 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
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

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

Street and postal 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)*

Street and postal 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

B. Board and committee remuneration, 2018/19

NMHS Board

Position	Name	Type of remuneration	Period of membership (months)	Gross/actual remuneration ($)
Chair	The Hon. Jim McGinty AM	Per annum	12	72,745
Deputy Chair	Professor David Forbes	Per annum	10	35,065
Member	Professor Selma Alliex	Per annum	12	42,579
Member	Angela Edwards	Per annum	6	20,872
Member	Associate Professor Christopher Etherton-Beer	Per annum	12	-
Member	Dr Hilary Fine	Per annum	12	42,579
Member	Carol Innes	Per annum	12	42,579
Member	Grant Robinson	Per annum	12	42,579
Member	Rebecca Strom	Per annum	12	42,579
Member	Steve Toutountzis	Per annum	6	20,872
			Total	**362,449**

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	11	Nil
Member	Karen Elliott	Per hour	1	Nil
Member	Hazel McLean	Per hour	12	Nil
Member	Dannielle Orifici	Per hour	12	Nil
Member	Azlee Sultan	Per hour	12	Nil
Member	Ann Brown	Per hour	12	Nil
Member	Tony Jonikis/Naomi Oliver	Per hour	12	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/Heidi Lauri	Per hour	12	Nil
Member	Janie Ingram	Per hour	12	Nil
Member	Fr Kevin Cummins	Per hour	12	Nil
Member	Robyn Vogel	Per hour	12	Nil
Member	Patricia Tran	Per hour	12	Nil
Member	Ron Deng	Per hour	12	Nil
			Total	**Nil**

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	890
Vice Chair	Sonja Whimp	Per meeting	12	950
Member	Alison Vaughan	Per meeting	12	330
Member	Amanda Hocking	Per meeting	12	830
Member	Ann McRae	Per meeting	12	645
Member	Caitlin Kameron	Per meeting	12	545
Member	Gail Yarran	Per meeting	12	460
Member	Gemma Cadby	Per meeting	12	630
Member	Jane Jones	Per meeting	12	620
Member	Joanne Beedie	Per meeting	12	580
Member	Maryam Aghamohammadi	Per meeting	12	230
Member	Maureen Helen	Per meeting	12	420
Member	Nicole Woods	Per meeting	12	640
Member	Sirad Elmi	Per meeting	12	140
			Total	**7,910**

OPH Community Advisory Council

Position	Name	Type of remuneration	Period of membership (months)	Gross/actual remuneration ($)
Chair	Joan Varian	Per hour	12	295
Deputy Chair	Tom Benson	Per hour	12	278
Member	Pam Van Omme	Per hour	12	502
Member	Joey McAuley	Per hour	12	105
Member	Beverley Port Louis	Per hour	12	233
Member	Dianne Glenister	Per hour	12	512
Member	Sue Haydon	Per hour	12	410
Member	Diane Yappo	Per hour	12	233
Member	Merrianne Soloway	Per hour	12	572
Member	Margaret Erneste	Per hour	9	425
Member	Oluseywen Bakare	Per hour	9	368
Member	Peter Wilson	Per hour	7	392
			Total	**4,325**

C. NMHS Board member meetings, 2018/19

The number of Board and Board committee meetings, and the number of meetings attended by each Board member, 2018/19.

	Board		Audit & Risk		Safety & Quality		Finance		People, Culture and Engagement	
Number of meetings held	**10**		**6**		**11**		**12**		**12**	
	Attended	**Eligible to attend**	**Attended**	**Eligible to attend**	**Attended**	**Eligible to attend**	**Attended**	**Eligible to attend**	**Attended**	**Eligible to attend**
The Hon. Jim McGinty	9	10								
Professor David Forbes (Deputy Chair)	10	10			10	11	11	12		
Professor Selma Alliex	9	10			10	11			11	12
Angela Edwards	4	5	1	1					4	5
Associate Professor Christopher Etherton-Beer	8	10			11	11			12	12
Dr Hilary Fine	8	10			11	11			12	12
Carol Innes	2	10							4	12
Grant Robinson	9	10	6	6			11	12		
Rebecca Strom	10	10	6	6			11	12		
Steve Toutountzis	5	5	3	3			5	6		
Pip Brennan									9	12

North Metropolitan Health Service

ANNUAL REPORT 2019

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

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This document can be made available in alternative formats on request for a person with a disability.