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

North Metropolitan Health Service

ANNUAL REPORT 2017

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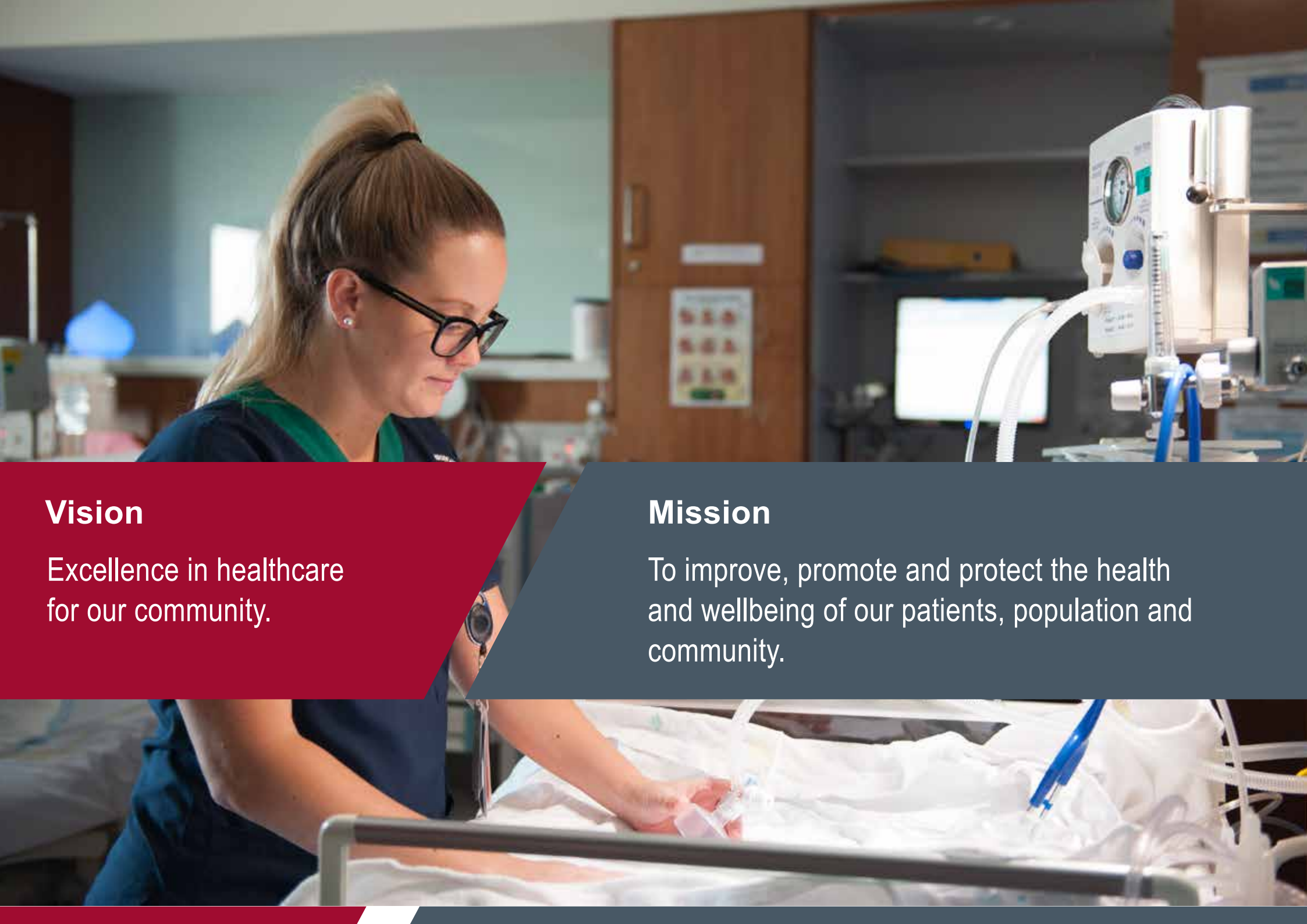
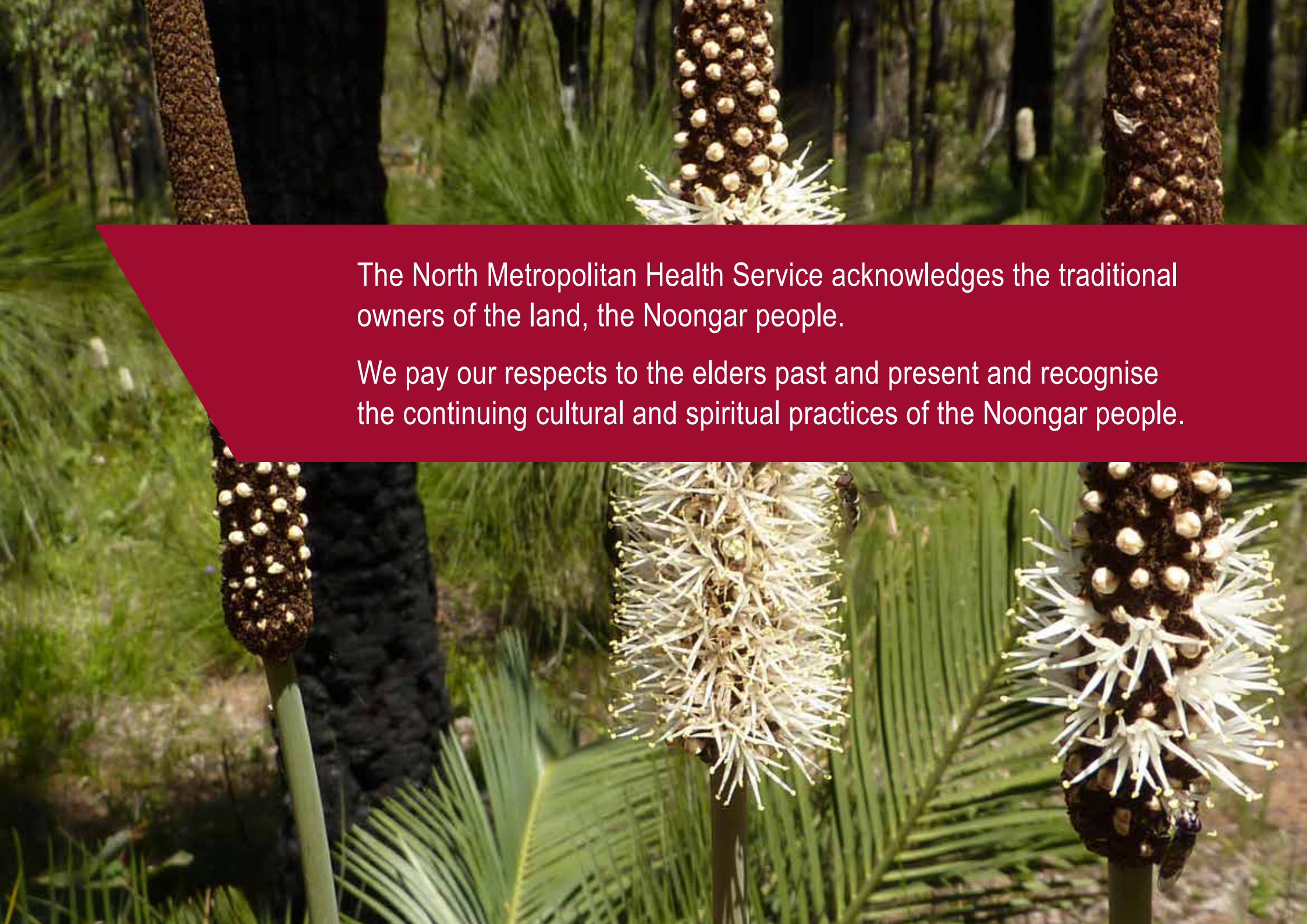


Vision

Excellence in healthcare for our community.

Mission

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



The North Metropolitan Health Service acknowledges the traditional owners of the land, the Noongar people.

We pay our respects to the elders past and present and recognise the continuing cultural and spiritual practices of the Noongar people.

Statement of Compliance

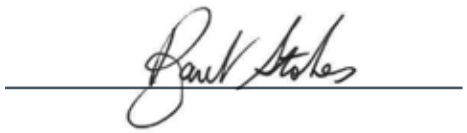
For the year ended 30 June 2017

HON. MR ROGER H COOK, BA GradDipBus MBA MLA

DEPUTY PREMIER; MINISTER FOR HEALTH; MENTAL HEALTH

In accordance with section 63 of the *Financial Management Act (FMA) 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 2017.

The Annual Report has been prepared in accordance with the provisions of the *FMA 2006.*



Professor Bryant Stokes AM
Board Chair
North Metropolitan Health Service
28 September 2017

Wayne Salvage
Chief Executive
North Metropolitan Health Service
28 September 2017

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Board Chair Foreword

The North Metropolitan Health Service (NMHS) Board statutory authority became effective on 1 July 2016, assuming all the responsibilities and challenges associated with leading a large and complex organisation. It has become actively involved in setting the strategic direction of the Health Service and increased the level of governance and oversight of its operations.

While a key focus of the Board has been to ensure the efficiency and effectiveness of the Health Service, our priority is patient safety. At the same time, we are enabling a competent and flexible workforce to meet the current and future health needs of the North Metropolitan catchment area.

Over the past 12 months, the Board was charged by the Minister for Health to implement his Statement of Expectations to ensure the Government's key strategic priorities for NMHS are realised. As a Board, we have met all expectations as outlined by the Minister.

We have:

- Carried out our functions as prescribed by the *Health Services Act 2016 (WA)* s 70(1b).
- Established working parties, made up of Board members, in four key areas of finance, safety and quality, audit and risk, and community, clinician and stakeholder engagement.
- Drafted the NMHS Strategic Plan 2017–2021, which is out for consultation with employees.
- Commenced development of the NMHS Operational Plan 2017/18.
- Ensured appropriate systems are in place to maintain and monitor clinical safety and quality, including forming a Clinical Advisory Council comprising 18 clinical employees from all NMHS sites and services. It provides an avenue for clinicians to advise the Board, as well as an opportunity for the Board to seek clinician input into their deliberations and decision-making.
- Established a NMHS Board Code of Conduct that outlines the expected behaviours applicable to all Board members in their official capacity.

It has been a challenging first 12 months for the Board as we have become familiar with one another professionally, embedding ourselves as a team and grasping the complexity of issues that confronts the Health Service on a daily basis.

During this time, we have also had an opportunity to appreciate the absolute commitment of NMHS employees to improving the patient experience at any opportunity. It has been humbling and reassuring to witness such a commitment by our workforce.

Over the next 12 months, the Board will continue to strengthen the Health Service's existing ties with the community, including primary health and GP networks, to ensure our patients receive safe and quality care at every stage of their hospital or service journey.

Professor Bryant Stokes AM
Board Chair
North Metropolitan Health Service

Executive Summary

NMHS has had an exciting and challenging year. We have continued to provide safe and innovative clinical services and concurrently embedded new governance arrangements throughout the organisation, as prescribed by the new *Health Services Act 2016 (WA)*.

The Health Service has embraced the greater accountability and strategic governance that has been provided by our Board, which is demonstrated in this detailed and expansive Annual Report.

The Board has been resolute in setting its expectations and holding the Health Service to account. Throughout the year, the Board purposefully focussed our attention on the safe care and support of our patients and employees, listening to the patient experience, and enhancing our teaching, training and research across the Health Service. Priority was placed on performance that directly affects patient care, including emergency and elective surgery access and better community follow-up for patients who are discharged from mental health inpatient care. The Board further emphasised the need to deliver a balanced budget.

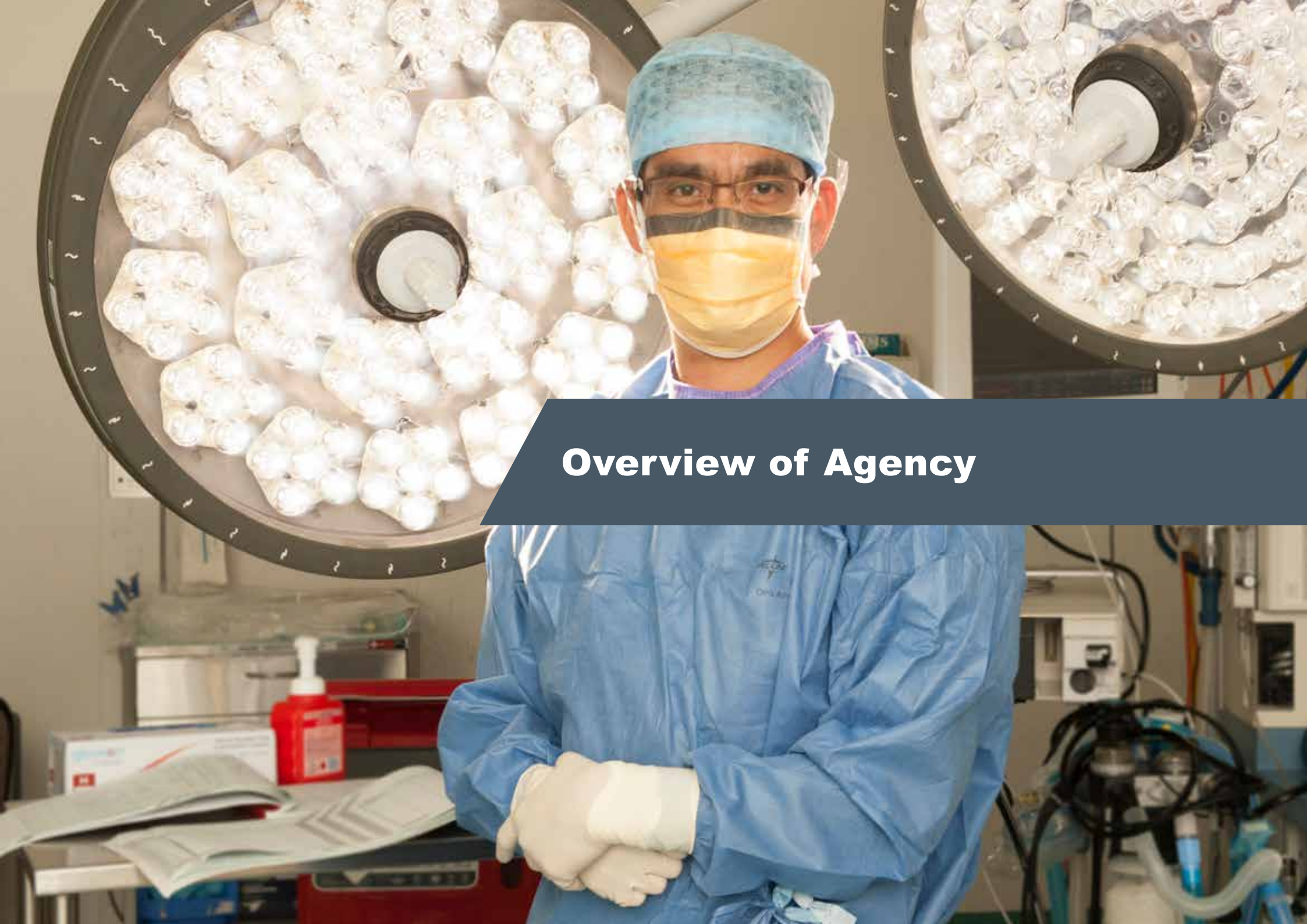
There are many wonderful achievements outlined in this report, which are a testament to our skilled and dedicated employees and volunteers. Their success is, of course, based on the invaluable support that we receive from our patients, carers and our partners in care. Healthcare excellence is truly a team effort.

Importantly, this report does not shy away from our challenges or the significant issues we face. Delivering healthcare is a high risk environment and unfortunately things can and do go wrong, including unintended errors, accidents, injury, system failures and communication errors. These are always regrettable and we therefore endeavour to learn and take responsibility to ensure they are not repeated and that we prevent harm from occurring while people are in our care or employ.

The next year will see us more actively engage with our patients, carers, employees and the broader community to improve the care we provide. We will continue to focus on patient outcomes, safety and quality as well as meeting all of our performance targets and ensuring that we are financially sustainable.

As Chief Executive, I would like to thank the Chair and Board members for their leadership and support throughout the year. In addition, I extend my appreciation to all employees who have worked hard to improve, promote and protect the health and wellbeing of our patients, population and community.

Wayne Salvage
Chief Executive
NMHS



Overview of Agency

Operational Structure

Who we are

NMHS network covers a catchment area that totals almost 1,000 square kilometres and provides hospital and healthcare to a population of more than 720,000 people. This population represents 28 per cent of Western Australia's (WA) total population.

Our fully accredited health services deliver a broad range of specialised services to our local community and for the State, providing healthcare for all levels and stages of care.

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)
  231-bed general hospital

- Graylands Hospital
  176-bed tertiary psychiatric and teaching hospital

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

- Joondalup Health Campus (JHC, Public Private Partnership (PPP) with Ramsay Health Care)
  514-public bed and 146-private bed hospital.

We provide a broad range of specialist mental health (MH) services that care for youth, adults and older adults through community clinics, hospital, day therapy and outreach programs.

We also provide Statewide services such as Genetic Services of WA, which is the sole provider of comprehensive, clinical genetics diagnostic and counselling services in WA; the Newborn Emergency Transport Service WA that transports newborns across the State; and, other services such as the Comprehensive Cancer Centre, Neurological Intervention & Imaging Service of WA (NIISwa), State Neurosciences Centre, and State Liver Transplant Service to name a few.

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

We also provide prevention, health promotion and intervention programs and services, including Statewide services such as BreastScreen WA (BSWA), WA Cervical Cancer Prevention Program, DonateLife, WoundsWest, Tuberculosis Control Program and the Humanitarian Entrant Health Service.

We support a wide range of research and innovation programs that focus on improving patient care and health outcomes, and inform clinical practice. We are proud that we undertake approximately one third of the research that is conducted in WA public hospitals.

Our values

We place our patients at the centre of what we do and our values guide how our employees behave.

Care - is demonstrated by our commitment to ensuring consideration is given to everyone as we work.

Respect - is demonstrated when we support the right of everyone to make choices and preserve the individual dignity of our patients and their families, carers, the community and each other.

Excellence - is demonstrated by our ability to work in partnership to improve the health of our patients and community through providing high quality, innovative, accessible, integrated and safe healthcare to the community. We believe in working in partnership with patients to improve their health.

Equity - is demonstrated when we understand the causes of differences in health and access to healthcare across different populations and that we actively work to mitigate these differences.

Integrity - is demonstrated by acting honestly and transparently, being accountable for our actions and decision-making and remaining transparent when we communicate with our stakeholders and each other.

Teamwork - is demonstrated by our willingness to accept and value the contributions made by others, ensuring our work environment is safe for everyone and we communicate respectfully and effectively at all times.

Leadership - is demonstrated by leading by example and by motivating and inspiring us to grow, develop and excel.

How we care

To care for our patients, it is important that we care for one another and ensure our workplaces are safe, welcoming and supportive.

Our attention is focused on providing safe patient care by encouraging our employees to embrace research, education and clinical innovation. We invest significant time and resources to develop initiatives that support our staff and help them engage at work.

NMHS values the work of more than 500 volunteers who make such a fundamental, positive difference to our patients' health journey each and every day. Our volunteer groups provide valuable services across the Health Service, including:

- refreshment services, including cafes, kiosks and gift shops for all visitors, employees and patients, with all proceeds being returned to our hospitals and services
- transport services that enable tens of thousands of patients to attend hospital appointments every year
- on-site transport services to assist patients and visitors with limited mobility to attend their appointments and wards
- support, information and integrated complementary therapies for cancer patients
- Chaplaincy and spiritual services
- consumer advisory services.

How we made a difference in 2016/17

75,561 elective surgery patients
serviced by our hospital network

Treated and provided care to
807,152 outpatient clinic patients

Treated and provided care to
172,433 Emergency Department patients

Each year around
183,283 patients are admitted to our wards

62 transplant patients
(42 kidney and 18 liver)

Our hospital network was proud to be part of
10,254 new births

20,654 cancer patients
received valuable treatment and support in our Cancer Centre

166,291 School Dental Service patients
288,253 Occasions of Service (visits and screenings) to individuals

Provided advice to
39,757 Poisons Information Centre callers

Support, treatment and care was provided to
28,896 Community (or hospital) mental health patients

Our priorities

The Board has identified that its primary objectives are:

1. patient **safety and quality** of care
2. **fiscal responsibility** at all levels of the organisation
3. continuous safety and **wellbeing of our staff**
4. **community engagement**
5. **capital works**, including the maintenance of our current buildings and equipment and to develop a replacement program where feasible.

To achieve these objectives, the Board has identified a number of strategic priorities and goals to be included in the NMHS Strategic Plan 2017–2021. This document is currently being finalised, with implementation to be reported in future Annual Reports.

There are four specific priorities that the Board has identified as important, which are not captured in detail within the Performance Management Framework or Key Performance Indicators: Patient voice and experience, teaching and training, research and innovation, and learning from clinical incidents. The following provides further information regarding NMHS' performance in these areas.

Patient voice and experience

Patient experience information is captured throughout NMHS in a number of ways including:

- online and hard copy surveys
- online feedback opportunities
- Consumer Advisory Councils
- face-to-face and written via Patient Liaison Services
- patient-employee interactions
- focus groups
- consumer representation on committees.

All NMHS websites include an option for consumers to provide feedback. Online feedback forms enable NMHS to gather information and use it to enhance the patient experience.

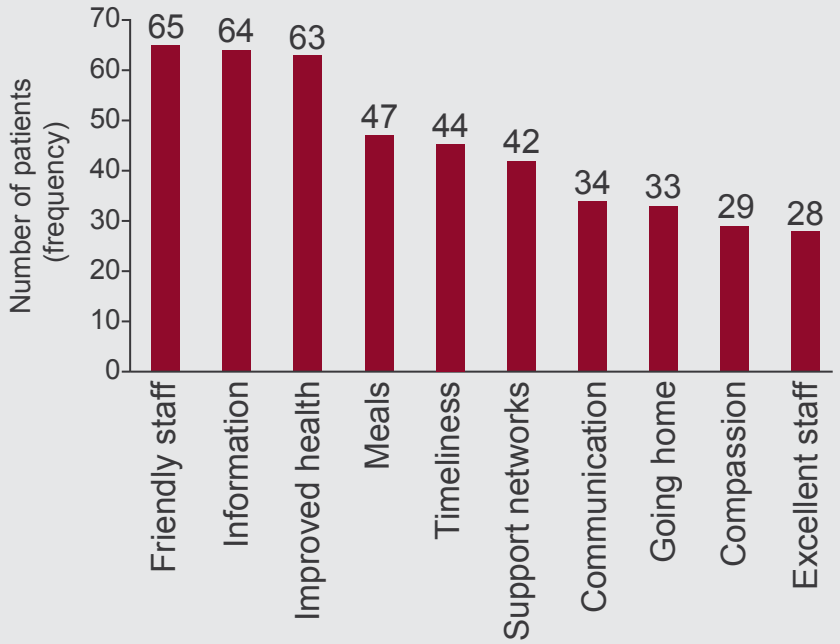
The Sir Charles Gairdner Osborne Park Health Care Group (SCGOPHCG) engaged survey leaders Press Ganey Associates to capture patient feedback about their hospital experience. During 2016/17, 1,843 inpatients and 420 outpatients were surveyed, with qualitative and quantitative data being made available to Divisions and wards. Deputy nurse co-directors discussed results with the Clinical Nurse Specialist on each ward and action plans were developed to address gaps.

Based on feedback received via quarterly patient surveys, a SCGOPHCG Patient Experience Strategy was drafted and will be implemented in July 2017.

SCGH has developed an online survey for culturally and linguistically diverse patients, which will be piloted in early July 2017 and implemented across SCGH and OPH in August 2017.

A number of specialities throughout the Health Service conduct their own in-house annual patient experience surveys. Such initiatives included the *SCGH What Matters to You Day*, which was designed to capture what is important to patients while they are in hospital. In one day, 239 patients were surveyed at their bedside, with the top ten themes identified and presented in Figure 1.

Figure 1: SCGH What matters to you day - Top 10



Every two years, the Dental Health Service conducts a consumer survey for its general dental clinics (adults) and School Dental Service. The paper-based surveys were distributed to all clinics and analysed. In 2016/17, the satisfaction rate was greater than 90 per cent (from 2,687 responses) and 100 per cent (from 1,652 responses) respectively.

A patient experience survey was undertaken within the WA Tuberculosis Control Program between September and October 2016. One hundred patients were interviewed with the results leading to a review of the current appointment process and wait times. Changes were made to clinic appointment times, with categorisation and wait times analysed every three months.

The Metropolitan Communicable Disease Control (MCDC) team conducted a survey for clients and external providers that work in collaboration with the MCDC team on disease control matters. The survey evaluated knowledge of employees, information provided, satisfaction of the patient / other provider, their professionalism and suggestions for service improvement for the service. This resulted in the creation of a ‘1300’ number and dedicated phone roster for employees to improve access to the service.

Seventeen patient satisfaction surveys were provided to patients and carers of the State Head Injury Unit, which resulted in improvements to the distribution and availability of information regarding community resources.

Several patient experience improvements have been made throughout the Women and Newborn Health Service (WNHS) in response to patient complaints and feedback, including:

- Amendment to the WNHS' discharge/transfer guidelines for parent/legal guardian's consent to be obtained before a baby is transferred to another hospital.
- Fertility clinic patient letters were reworded to ensure clarity about what the service can offer and adherence to the strict criteria.
- Policies were reviewed and guidelines developed to better inform patients about what to expect if they are found to have certain infections, and how to continue to look after their babies.

Increased consumer and carer representation on committees throughout NMHS has led to improved awareness of the perspectives, needs and relevant information required by patients and carers. This has enabled NMHS to form partnerships with patients and carers to improve the patient experience and outcomes.

Teaching and training

NMHS is committed to developing a healthcare workforce of the highest quality and recognises the important role it plays in supporting the training and education of its future health professionals, through partnerships with the State's academic institutions.

The following is a snapshot of the wide range of clinical and non-clinical teaching and training that occurred this year.

Medicine

In 2016/17, NMHS provided more than 40 per cent of the State's total clinical placements for postgraduate medical students from the Universities of Western Australia (UWA) and Notre Dame (UND). Practicums were offered across a range of interprofessional disciplines including, emergency medicine, surgery, internal medicine (renal medicine, gastroenterology, hepatology, respiratory medicine, cardiology, endocrinology), psychiatry, palliative care, geriatrics, rheumatology, obstetrics/gynaecology and anaesthesiology. In addition, NMHS employed more than 1,000 medical graduates, providing training and education for prevocational hospital medical officers from intern to senior registrar.

PathWest

In 2016/17, PathWest provided 144 seven-week clinical laboratory placements to Bachelor of Science (Laboratory Medicine) students from Curtin University's Australian Institute of Medical Scientists accredited course. Through a graduate program, 12 months of internship training in its finance department were provided to three interns (four months each). Twenty-five postgraduate students, who undertook study via project and coursework in honours, masters and PhD programs, were hosted and supervised. In addition, 12 Vocational Education and Training level traineeships in Certificate IV or Diploma in Laboratory Operations to Technical staff, 19 courses for accredited First Aid Training to phlebotomy staff and 23 students in the accredited Certificate III in Pathology Collection course were offered.

Dentistry

NMHS Dental Health Service provided 257 dental clinic assistant placements, 138 trainee dental therapist positions and 95 dental student placements.

Allied Health

NMHS provides teaching and training for allied health students at a certificate, undergraduate, postgraduate and intern level. During 2016/17, more than 750 students from local universities (Curtin, UND, UWA and Edith Cowan University (ECU)), TAFEs (North Metropolitan, Private Registered training organisation), Eastern States (University of Newcastle) and international universities (Pittsburgh, USA) completed clinical placements. Students spent an average of 20 days on clinical placement in NMHS hospitals, with nearly 15,000 clinical placement days recorded across allied health disciplines.

Nursing

NMHS provided more than 460 enrolled nurse clinical placements from Mar Mooditj and Central and West Coast TAFEs and 2,250 registered nurse clinical placements were offered to students from ECU, UND, Curtin and Murdoch Universities in 2016/17. Postgraduate programs in Critical Care and Emergency Nursing were conducted in partnership with ECU, supporting students from SCGH and JHC. The vocational Graduate Certificate in Infection Prevention and Control was run collaboratively with Hands on Infection Control and supported by NMHS Learning and Development Centre as the Registered Training Organisation. A total of 78 nurses participated in postgraduate programs over 2016/17.

Almost 200 nurses participated in post registration graduate nursing programs throughout the Health Service last year. These programs included a 12-month program located at SCGH, a 12-month program encompassing placements at both KEMH and SCGH, and 18-month programs encompassing placements at SCGH and NMHS MH Services.

A comprehensive professional development calendar offering 80 face-to-face short courses in clinical or professional skills and knowledge development was run throughout the year, with 2,842 attendees. A further 1,989 nurses attended mandatory training events scheduled for nursing.

In addition to face-to-face learning and training opportunities, nursing education was delivered using eLearning resources developed by the SCGOPHCG Centre for Nursing Education in collaboration with subject matter experts.

Midwifery

NMHS provided more than 30 midwifery undergraduate and approximately 50 midwifery postgraduate placements for ECU and Curtin University students. Graduate Midwife Programs were completed by 24 new midwives. The Midwifery Refresher Pathway was completed by two midwives returning to practice.

WNHS offered a range of maternity and neonatal nursing education courses to more than 45 students. These included the post registration neonatal level two Neonatal Nursery Certificate course for 12 students and the Graduate Certificate in Clinical Nursing (majoring in Neonatal Intensive Care Nursing) in collaboration with Curtin University. New courses were introduced for midwives to expand their role and improve consumer experiences in the areas of basic ultrasound scanning and full physical examination of the newborn. A Statewide eLearning package for Newborn Blood Spot Screening, aimed at improving test reliability, was developed in collaboration with the Department of Health (DoH). During 2016/17, there was a strong focus on simulation-based education for obstetric, gynaecological and neonatal emergencies. In addition, continuous professional development activities for midwives, neonatal and gynaecology nurses included 124 sessions for 2,461 participants internal and external to WNHS.

Mental Health (MH)

NMHS MH is committed to the ongoing training and mentorship of undergraduate and graduate nurses who are interested in working within the mental health setting. Working in partnership with tertiary and vocational institutions, the service provided 940 clinical placements to undergraduate student during 2016/17. In addition, NMHS MH has continued to participate in the Get Real Experience and Try (GREaT) Nursing and Midwifery Work Experience program, which was developed to encourage high school students to experience clinical nursing prior to making a choice to study at a tertiary or vocational institution. In 2016/17, NMHS MH supported 21 year ten students during the week-long GREaT work experience program, receiving excellent feedback from students and facilitators alike.

Currently, NMHS MH works in partnership with SCGH to support an 18-month collaborative graduate nursing program where newly qualified registered nurses spend six months within a mental health setting. In addition, two mental health-specific graduate programs for nurses who have chosen a career in mental health are coordinated by NMHS MH. This includes a 12-month MH enrolled nurse program where the service facilitates ongoing theoretical learning that is supported by inpatient-based clinical placements. NMHS MH also coordinates the 12-month Statewide MH Graduate Program (SWMHGP). This program oversees and coordinates the ongoing and theoretical learning and clinical placement of graduates in each of the Health Service Providers. This includes working in collaboration with WA Country Health Services (WACHS), where graduates spend six months in a rural setting and six months in a metropolitan service. A pilot program to establish a six-month graduate rotation within a community setting will be trialled in NMHS MH during 2017/18. It is envisaged that this will be a strong attraction and retention strategy and provide an alternative career pathway for newly qualified nurses who are interested in working within a mental health setting. During 2016/17, a total of 20 participated in the mental health rotation of the SCGH collaborative program, 20 graduates participated in the NMHS MH enrolled nurse program and 27 graduates who participated in the SWMHGP undertook their clinical placements with NMHS MH.

Corporate Services

NMHS hosted two graduates from the WA Health Corporate Graduate Program, Finance and Business Stream.

Research and innovation

NMHS is focused on improving patient outcomes and the quality and safety of healthcare. This is achieved through innovation, leadership, and research.

NMHS has a strategic priority to maintain centres of excellence to retain and build upon its strong research, teaching, training and innovation reputation. This is achieved by supporting employees to undertake a wide range of research and innovation projects, including research studies that encompass large-scale trial design, data management and registries, biostatistics and epidemiology, and local/bedside service improvement and innovation studies.

NMHS is a member of the consortium that is the WA Health Translation Network, which was recently recognised by the National Health and Medical Research Council as an Advanced Health Research and Translation Centre. Importantly, this accreditation acknowledges that we provide international-level health and medical research that is translated into excellent patient care.

In 2016/17, NMHS supported 57 discovery science studies, 28 translational projects, 80 clinical trials and 39 service delivery/ patient related studies. In addition, there were over 235 local quality assurance projects undertaken across the Health Service. NMHS is proud to have had over 900 peer-reviewed publications attributed to NMHS researchers in 2016/17.

Innovation: a new high-tech medical device to make brain surgery safer. Used in a trial of 12 patients who underwent neurosurgery at SCGH, the ‘smart needle’ was collaboratively developed by the Universities of Adelaide and WA, and SCGH teams. It is expected the device will be ready for formal clinical trials in 2018.

Several areas within the Health Service produce and publish high quality research including the Centre for Clinical Interventions (specialist MH service), statewide Dental Health Service, PathWest and Allied Health. In addition, NMHS provides support to Cancer and Palliative Care Network researchers.

NMHS has three dedicated research centres, each of which has strong research capabilities that attract external funding, has relationships with universities, and well-developed areas of research excellence.

SCGOPHCG Research

SCGOPHCG has a national and international reputation for ground-breaking research and is the largest public sector research hospital in WA. The hospital is home to highly-acclaimed researchers in a number of fields including cardiology, diabetes, neuroscience, oncology and sleep and respiratory medicine. Currently, there are over 800 open research projects and approximately 150 new trials. There were approximately 345 publications attributed to authors from SCGOPHCG in 2016 and there have been 255 to June 2017. The SCGH Centre for Nursing Research demonstrates excellent outcomes in terms of leading multidisciplinary research, with significant grant success and 24 peer-reviewed publications in 2016.

NMHS MH Clinical Research Centre (CRC)

The CRC conducts clinical audits, service evaluations, service analysis, and other projects. Employees undertake research supervision of psychiatry registrars, and supervise academic higher degrees. In 2016, the CRC completed 16 research projects, with 22 new or ongoing in 2017. Since its inception in 2012, the CRC has published 79 papers in peer-reviewed journals.

WNHS Research

WNHS has recognised research expertise in the areas of women's and newborn's health, including, midwifery, obstetrics and gynaecology, and neonatology. Researchers at WNHS produced more than 150 peer-reviewed publications.

Learning from clinical incidents

NMHS supports a strong patient safety culture that establishes a just, transparent, risk-based approach for recognising human and system errors. This patient safety culture has a non-punitive approach to reporting and learning from adverse events.

With over a million occasions of service in NMHS (e.g. inpatient, emergency, community, dental, etc.) we regret that a very small percentage of patients have suffered from a lack of clinical care, or complications of clinical care.

In the interests of transparency, and in support of the recommendations of the recent WA Health Safety and Quality Review led by Professor Hugo Mascie-Taylor, NMHS is sharing the number of serious clinical incidents that occurred in 2016/17 at our hospitals and services.

The annual report *Your Safety in Our Hands in Hospital 2016* is published by the DoH and provides detailed information about the quality of health care in Western Australia. (http://ww2.health.wa.gov.au/Reports-and-publications/Your-safety-in-our-hands-in-hospital).

The clinical incident management process is undertaken in accordance with the WA Clinical Incident Management Policy and the WA Open Disclosure Policy. The principles of Open Disclosure ensure the patient, their family and carers are provided with information in a timely, open and honest manner, and that they receive an apology, or expression of regret, for any harm that resulted as early as possible.

Each clinical incident is assigned a Severity Assessment Code (SAC) rating that guides the type of investigation method that is to take place and is recorded on an online incident management system. Clinical incidents that result in serious harm or death (SAC 1) require a detailed, rigorous investigation to be undertaken. The investigation of SAC 1 incidents requires the formation of an expert panel to guide the identification of factors that contributed to the incident. This panel supports the development of recommendations for service improvement that will reduce clinical risk and improve patient safety in the clinical area concerned. Clinical incident reporting also includes the requirement to notify near miss incidents, which are incidents that may have, but did not cause harm.

During 2016/17, 111 SAC 1 clinical incidents were reported by NMHS employees (Table 1). At the time of reporting (7 August 2017), investigation of 107 of the SAC 1 clinical incidents had been completed, with four ongoing. Of the 107 SAC 1 clinical incidents, 58 were declassified as the healthcare provided was determined not to have contributed to the poor patient outcome and only factors related to the patient's clinical condition were identified. The remaining 49 cases were confirmed as SAC 1 clinical incidents, since the healthcare provided (or in some cases not provided) to the patient contributed to their poor clinical outcome.

While it is known that all healthcare carries risk, it is with deep regret that NMHS acknowledges that 13 patients died and 32 patients sustained serious harm where our healthcare was a contributing factor. We recognise the distress this has caused the surviving patients, their relatives and carers. The importance of learning from these incidents, and supporting families, carers and our employees through this process is paramount.

Some of the examples in which harm has occurred have been with mental health patients who have unexpectedly suicided, despite recent contact and assessment with clinical services. There have also been some deaths in procedures, in which an underlying comorbidity had not been correctly recognised and the comorbidity was a contributing factor in the death of the patient.

Four patients sustained no harm, but the event was considered to have had the potential for harm, and was therefore notified and investigated as a near miss clinical incident.

The total number of SAC 1 incidents for 2016/17 is shown in Table 1.

Table 1: SAC 1 incidents 2016/17

SAC 1 Incident	Number
Notified	111
Investigated	107
Ongoing investigation	4
Declassified*	58
Total confirmed	49
Confirmed with patient outcome of death	13
Confirmed with patient outcome of serious harm	32
Confirmed with patient outcome of no harm	4

* Declassification of a reported SAC 1 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 DoH senior clinicians who have extensive experience in the area of safety and quality in healthcare. Declassification means that the event is no longer considered to be a clinical incident.

Note: The number of SAC1 incidents excludes JHC, which reviews its own SAC 1s and reports directly to DoH.

The reporting of SAC 1 near miss incidents is greatly valued as it provides an opportunity for lessons to be learned and practices to be improved in a situation where the patient was not harmed. To assist employees with identifying opportunities for near-miss reporting, NMHS has added a policy definition for 'near miss' to the online clinical incident management system.

Example: Learning from a serious clinical incident

Situation:

A patient presented to an Emergency Department (ED) after five days of gastrointestinal bleeding. A blood test undertaken in the ED revealed their blood type as O positive, while a subsequent test undertaken on the ward revealed it was A positive. A third blood test yielded an O positive result. The patient then received the correct blood transfusion of O positive red blood cells.

Clinical Incident:

The Incident Investigation Panel conducted a thorough investigation of the near miss incident and concluded the second blood test (from the ward) had been performed on the wrong patient.

Contributory Factors:

The panel determined that the blood collector had not followed the hospital Blood Transfusion Policy. The policy requires that patient identity must be confirmed and the sample tube must not be pre-labelled prior to blood collection and positive identification of the patient. Further, the sample must be labelled at the patient's bedside and the sample must not be given to another person to label.

Recommendations:

1. A monthly, random observational audit of all employees who collect blood to ensure adherence with the blood transfusion policy.
2. Development of a mandatory BloodSafe eLearning clinical transfusion practice module to be completed by all medical and nursing employees in clinical areas with high blood use.

Lessons Learned:

Safety systems must be in place to ensure that high clinical risk areas are kept as harm-free as possible. Hospital policies identify best practice; however, training, education and clinical audit assist in ensuring that best practice is maintained at all times.

Achievements

NMHS and its employees celebrated many achievements during 2016/17. Some of the most significant achievements are highlighted in the following pages.

Clinical achievements:

- NIISwa, at SCGH, provides the endovascular clot retrieval service, which is a highly effective treatment to restore blood flow to the brain in patients affected by ischaemic stroke thereby reducing disability.
- BSWA expanded its operations with a new fixed clinic service in Mandurah. As one of the first breast screening services in Australia to have a 24/7 online booking system, BSWA also provides text message appointment reminders for clients. BSWA social media presence is recognised as an important tool for health messages. In addition, BSWA has introduced electronic GP notification of results and overdue reminders.
- The opening of additional theatre capacity at OPH has allowed for more surgery cases to be undertaken, including patients transferred from SCGH. This resulted in a significant reduction for over boundary patients for non-reportable surgeries (a range of surgery that is undertaken that we don't report to the Commonwealth, for example, biopsy, organ or tissue transplant, and endoscopy). This meant the proportion of elective wait list patients who waited longer than the target time period went from 68.5% for Category 1 non-reportable surgery to 39%. This is a big turnaround in one year, and means that we can improve even further in 2017/18.
- The importance of childhood vaccination is represented in our success with vaccination rates in children. Over 92% of children (aged 12–15 months) in the metropolitan catchment area are fully immunised.
- Ongoing strengthening of the Aboriginal Hospital Liaison Officer Program to provide cultural support and clinical advocacy to patients across NMHS hospitals.
- An increasing number of adults in our hospitals reported satisfaction with our services. This meant over 80% of our patients were satisfied with our care.
- Our staff were audited to determine their hand hygiene. Our overall performance at 84%, which is greater than the target of 80%. This is important, as hand hygiene is a key way to reduce hospital acquired infections. Our work on this is demonstrated with our healthcare associated *staphylococcus aureus* infection reducing further to 0.45 per 10,000 occupied bed-days. The target is less than or equal to 1 per 10,000 occupied bed-days.

Awards:

- The **OPH Surgical Ambulatory Service team** received the *Australian Council on Healthcare Standards (ACHS) Healthcare Standards Healthcare Measurement Award* for sustained improvement in the management of the endoscopy wait list, reducing it from approximately 3,000 to around 700 cases within a year.
- The **WA Youth Cancer Advisory Committee**, based at SCGH, was awarded the *Organisational Achievement Award* at the WA Youth Awards. Established in 2011, the WA Youth Cancer Advisory Committee was commended for its empowering endeavours towards young people undergoing cancer treatment. The WA Youth Awards target high-achieving West Australians aged 12 to 25 years for their contributions to the community and support of the State's young people.
- *WA Nursing and Midwifery Excellence Awards 2017*
  - **Amy Wallace**, Graylands Hospital Physical Healthcare Clinical Nurse Specialist was named Nurse/Midwife of the Year. Amy also received the Excellence in Registered Nursing Award.
  - **Elena Adams**, OPH Clinical Nurse won the Consumer Appreciation Award.
  - **Ashleigh Joy**, OPH Registered Nurse, who won the Graduate of the Year Award.
  - **Professor Di Twigg**, Dean of the School of Nursing and Midwifery and SCGH Research Consultant won the Lifetime Achievement Award.
- *WA Health Excellence Awards 2016*
  - **Clinical Professor Jack Goldblatt AM**, Director of Genetic Services WA, was awarded the *Minister for Health's Award* for his contribution to genetic services in WA.
  - **Susan Kitchen**, SCGH A/Clinical Nurse Specialist Falls Management and Clinical Nurse Consultant, received the *Jill Porteous Memorial Award* for her passion and commitment to keeping patients safe from falls, the most common adverse event in hospitals.
  - **Debra Thornborough-Owen**, NMHS Human Resource Manager, received the *Peter Baldwin Award* for her workforce transition work leading up to the closure of Swan District Hospital in 2015.
  - **NMHS YouthReach South and Life Without Barriers team** was awarded the *Improving Health Service Delivery Award* for their work on the Ngatti House project, an accommodation and rehabilitation service that assists homeless youth to improve their social, recreational and occupational functioning.

- **NMHS and SolarisCare** received the *Engaging with Consumers, Carers and the Community Award* for their joint work in providing cancer patients and carers with access to safe, free and credentialed complementary therapies.
- The **SCGH Adult Cystic Fibrosis (CF)** team received the *Overcoming Inequities Award* for their project 'Telehealth: Improving care for adults with CF in rural and remote WA'.

Employees:

- **Kris Clifford**, SCGH Sterilisation Education Supervisor, received the *Nita Perry Memorial Award* for his 40-year service and commitment to national and international best practice. The Nita Perry Memorial Award recognises significant contribution to sterilisation services and is owned by the Sterilisation Research Advisory Council of WA.
- SCGH's **Professor Gary Lee** was awarded the *2016 Harasawa Memorial Research Medal* by the Asian Pacific Society of Respirology for his contribution to pleural research and training the next generation of pleural specialists in the Australasia and Asian Pacific region.
- **Sue Morey OAM**, SCGH Nurse Practitioner in Respiratory Medicine, was officially honoured by the City of Nedlands for her community service in respiratory medicine nursing by appointing her as one of six *Freemen of the City of Nedlands*. Sue is the longest serving registered nurse at SCGH with 40 years of continuous service.
- **Rachel Zombor**, Graylands Hospital Neuroscience Unit Acting Director and Senior Clinical Neuropsychologist was selected from a field of 1,000 female scientists to join the *2018 Homeward Bound Program* for global leadership, a strategic and science initiative and outreach program for women.

Infrastructure:

- NMHS is extremely grateful for the generosity and philanthropic donation by Ralph and Patricia Sarich, which enabled construction of the Ralph and Patricia Sarich Neuroscience Research Institute (SNRI). The SNRI, which was designed to accommodate four of the State's premier neurological research organisations, was officially opened by Her Excellency, the Hon Kerry Sanderson AC, Governor of WA on 26 April 2017. Situated on the Queen Elizabeth II (QEII) Medical Centre site, the new $37.7 million research facility will accommodate Curtin University's Neuroscience Research Laboratory, the Ear Science Institute of Australia, Perron Institute for Neurological and Translational Science and Australian Alzheimer's Research Foundation.
- As part of a State Government election commitment, a new 300-bay car park for visitors and employees was opened at OPH, increasing the number of bays to eight hundred and easing congestion on site.

New Services:

- SCGH is now home to WA's first comprehensive and integrated specialist eating disorders service for adults and youth aged 16 years and older. The WA Eating Disorders Outreach and Consultation Service provides statewide consultation and education services to clinicians who care for people with eating disorders.
- Following a successful trial, the Preterm Birth Prevention Clinic is now part of business as usual at KEMH. Approximately 2,800 babies in WA require special care each year due to preterm birth. KEMH is Australia's largest preterm birth referral hospital and the clinic has contributed to an eight per cent reduction in preterm births in WA over the past 12 months.
- The WA Adult Epilepsy Service (WAAES) commenced its inpatient service at SCGH in August 2016. The new, centralised service is part of the State Centre for Neurosciences, which is based at the QEII Medical Centre. Epilepsy affects at least 20,000 people in WA each year.
- The opening of a fixed location Breast Screening Clinic in August 2016 has the potential to increase capacity by up to 15,000 screens per year. The new Mandurah-based clinic is enabling the previously used mobile van to spend 15 more months during each two-year testing cycle to screen women in remote and regional areas.
- The Youth Hospital in the Home program was launched on 1 March 2017 and offers an alternative to hospital admission for people aged 16 to 24 years who reside within the NMHS catchment area.

- SCGH became a *Choosing Wisely* champion after successful pilot projects, including the Proton Pump Inhibitor De-prescribing Project and the Optimising Pathology Testing Project, were rolled out across SCGH. The *Choosing Wisely Australia*® initiative demonstrates SCGH's commitment to starting conversations between patients and health providers about unnecessary tests, treatments and procedures, enhancing the quality of care and, where appropriate, reducing unnecessary care.

Milestone:

- KEMH, WA's main public obstetrics, gynaecology, perinatal mental health and neonatal hospital, celebrated 100 years of service on 6 July 2016.

Enabling legislation

NMHS was established as a Health Service provider governed by a Board and Chief Executive in the *Health Services (Health Service Provider) Order 2016* made by the Minister under section 32 of the *Health Services Act 2016 (WA)*. NMHS is responsible to the Minister for Health and the Chief Executive Officer of the Department of Health (System Manager) for the efficient and effective management of the organisation.

Responsible Minister

NMHS is responsible to the Minister for Health.

From 1 July 2016 to 17 March 2017, the Hon. John Howard Dadley Day, MLA held the portfolio for Health.

Following the March 2017 State election, the Hon. Roger Cook MLA was appointed as the Minister for Health and Mental Health.

Administered legislation

Acts administered as at 30 June 2017:

- *Anatomy Act 1930*
- *Blood Donation (Limitation of Liability) Act 1985*
- *Cremation Act 1929*
- *Fluoridation of Public Water Supplies Act 1966*
- *Food Act 2008*
- *Health (Miscellaneous Provisions) Act 1911*
- *Health Legislation Administration Act 1984*
- *Health Practitioner Regulation National Law (WA) Act 2010*
- *Health Professionals (Special Events Exemption) Act 2000*
- *Health Services (Quality Improvement) Act 1994*
- *Health Services Act 2016*
- *Human Reproductive Technology Act 1991*
- *Human Tissue and Transplant Act 1982*
- *Medicines and Poisons Act 2014*
- *National Health Funding Pool Act 2012*
- *Nuclear Waste Storage and Transportation (Prohibition) Act 1999*
- *Pharmacy Act 2010*
- *Private Hospitals and Health Services Act 1927*
- *Prostitution Act 2000 (except s.62 & Part 5, which are administered by the Department of the Attorney General)*
- *Public Health Act 2016*
- *Radiation Safety Act 1975*
- *Royal Perth Hospital Protection Act 2016*
- *Surrogacy Act 2008*
- *Tobacco Products Control Act 2006*
- *University Medical School, Teaching Hospitals, Act 1955*
- *Western Australian Health Promotion Foundation Act 2016*

Acts passed during 2016/17

- *Royal Perth Hospital Protection Act 2016*

Bills in Parliament as at June 2017

Nil.

Amalgamation and establishment of Boards

Seven Boards were established and no Boards were amalgamated in 2016/17:

- North Metropolitan Health Service Board
- Child and Adolescent Health Service (CAHS) Board
- East Metropolitan Health Service (EMHS) Board
- Quadriplegic Centre Board
- South Metropolitan Health Service Board
- WA Country Health Service (WACHS) Board
- Health Support Services (HSS) Board

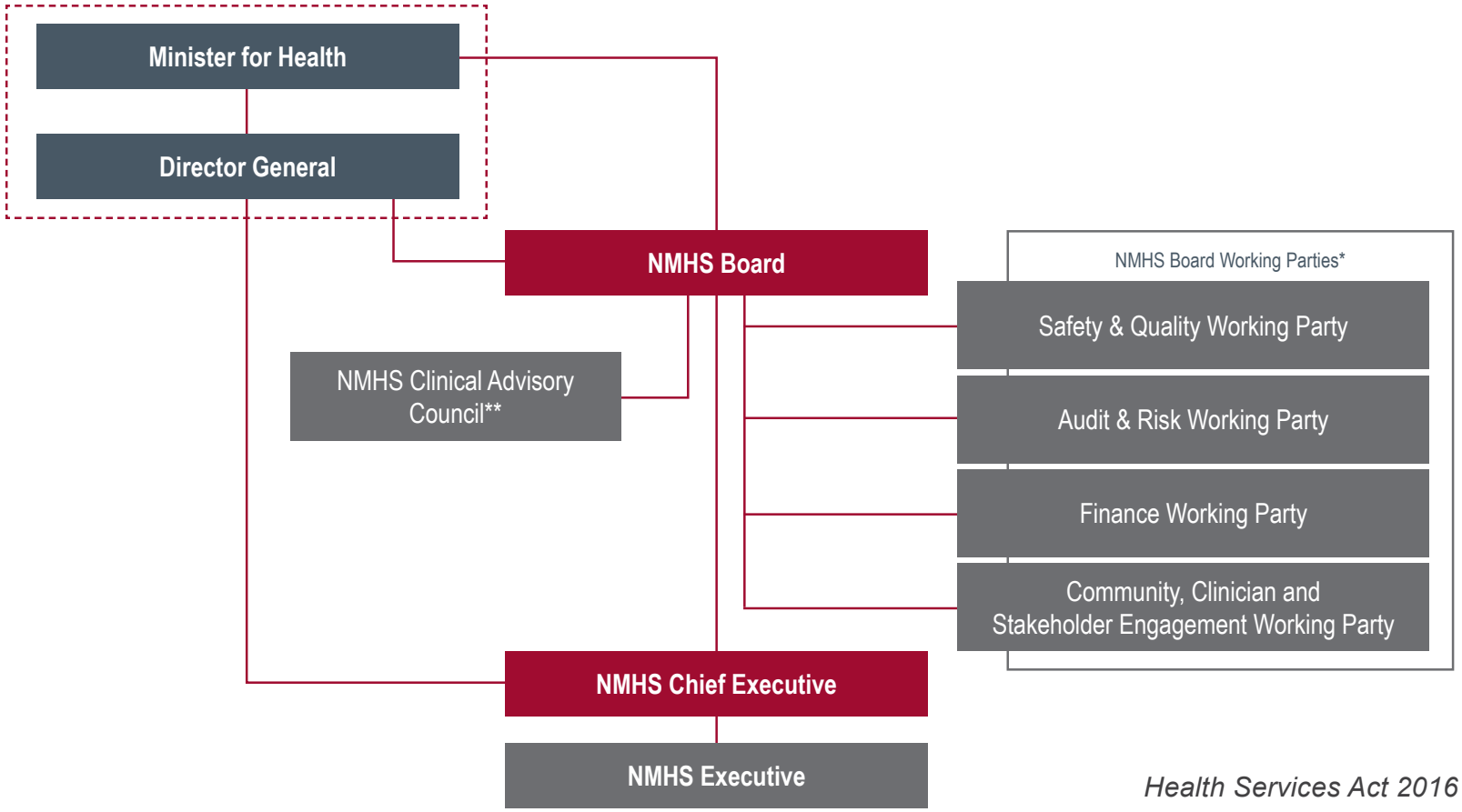
Accountable authority

NMHS Board Chair, Professor Bryant Stokes AM, was the accountable authority for NMHS in 2016/17.

Board of Authority

Under Section 34 of the *Health Services Act 2016 (WA)*, the Board is responsible for the stewardship of NMHS, 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 DoH.

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



Health Services Act 2016 (WA)

* NMHS Board Working Parties (effective as at 30 June 2017) report to the Board and provide advice on matters of specific interest. The Working Parties have been delegated roles and responsibilities and make recommendations to the Board for its consideration.

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

Board profiles

Professor Bryant Stokes AM

Board Chair

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

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

Associate Professor Rosanna Capolingua

Deputy Board Chair

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

Chair of the former Child and Adolescent Health Service Governing Council, Associate Professor Capolingua has served on many health boards and committees and is currently Chair of the WA Immunisation Strategy Committee, Board Member of SJGHC, Member of the Board of Governors of University of Notre Dame and State Councillor for the Australian Medical Association.

Dr Margaret Crowley

Board Member

Dr Margaret Crowley has extensive experience as a Chief Executive Officer in the community sector and held senior executive positions in State and Federal government and universities.

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

Dr Felicity Jefferies

Board Member

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

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

Ms Michele Kosky AM

Board Member

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

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

Mr Geoff Mather

Board Member

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

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

Mr Graham McHarrie

Board Member

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

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

Ms Maria Saraceni

Board Member

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

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

Dr Simon Towler

Board Member

Dr Simon Towler is Medical Co-Director at Fiona Stanley Hospital and played a key role in the commissioning of the hospital's intensive care unit and emergency department, which he continues to oversee, among other critical services.

Formerly the Chief Medical Officer for WA Health, Dr Towler has been on numerous academic and medical boards, including the NMHS Governing Council and as Chair of WA Clinical Senate, Department of Health. Dr Towler was also Executive Director of health policy at the Department of Health.

Professor Grant Waterer

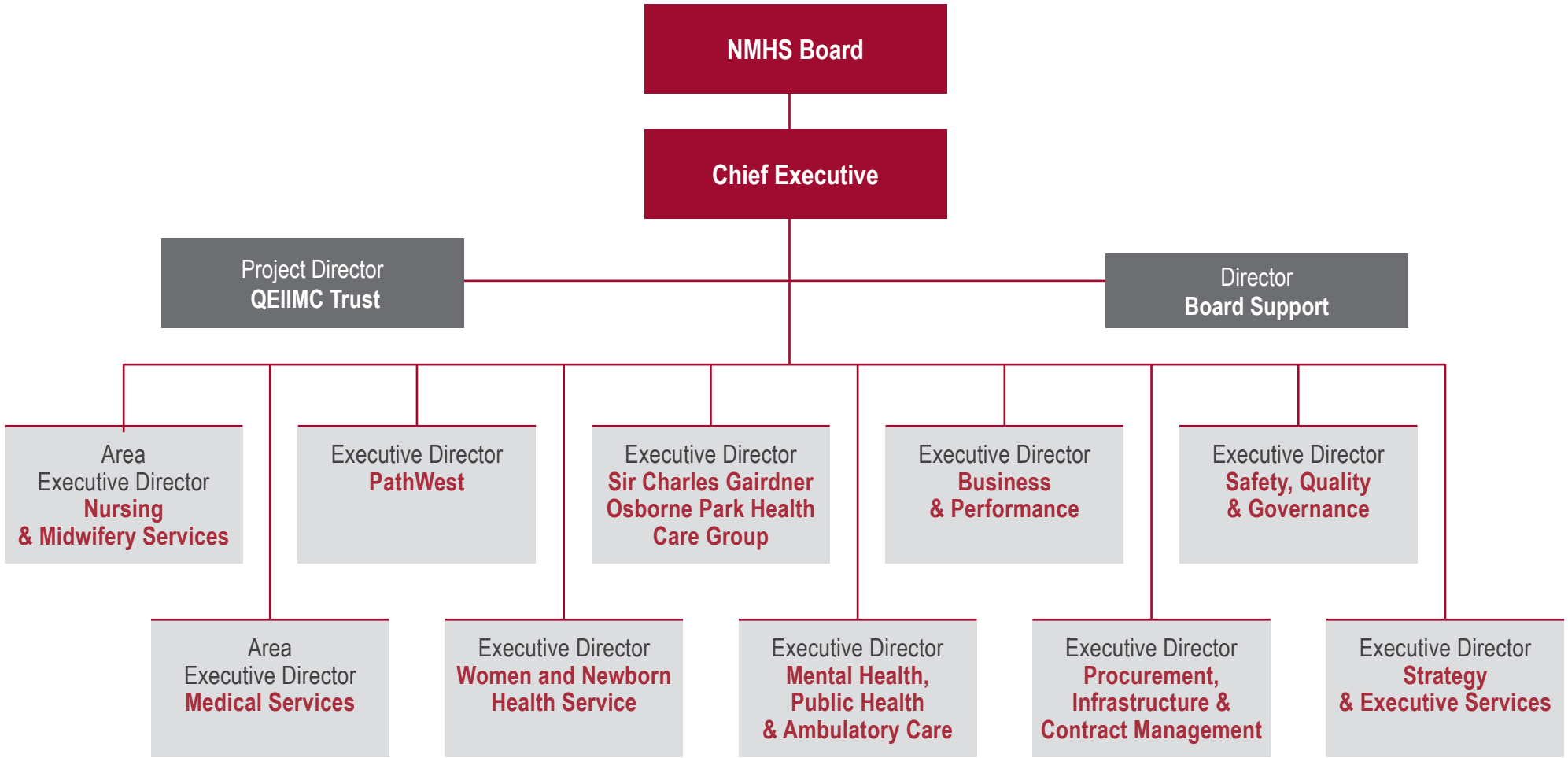
Board Member

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

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

Organisational Structure

NMHS structure displayed below was in place from July 2016 to June 2017.



Our leaders

North Metropolitan Health Service Executive:

Mr Wayne Salvage

Chief Executive, NMHS

Mr Wayne Salvage was appointed Chief Executive in May 2016 having acted in the role since July 2015.

Mr Salvage has worked in health service policy and management since 1990 and joined the WA Department of Health in 1998. Since then, he has played a leading role in budget strategy formulation and resource allocation, infrastructure planning and co-ordination, financial management, performance evaluation and engagement with the State and Commonwealth governments on public hospital financing arrangements and infrastructure development.

Mr Philip Aylward

Executive Director, Procurement, Infrastructure and Contract Management

A business graduate from Curtin University, with a Fellowship of the Australasian College of Health Service Managers, Mr Philip Aylward has worked extensively in senior management and leadership positions throughout Health and was appointed to NMHS in July 2015.

Mr Aylward is a Director of the Princess Margaret Hospital Foundation, an Adjunct Professor at Curtin University and is currently a State Branch Councillor of the Australasian College of Health Service Managers.

Mr Bill Bleakley

Acting Executive Director, Business & Performance

Bringing more than 30 years' WA Health sector experience to NMHS, Mr Bill Bleakley commenced as Acting Executive Director Business and Performance in July 2016.

Mr Bleakley's previous experience in WA Health includes executive roles in finance and information technology disciplines and finance and business services. His primary professional interests include change management processes and business improvement.

Dr Victor Cheng

Executive Director, SCGOPHCG

Dr Victor Cheng has held the role of Executive Director SCGOPHCG since June 2014.

Dr Cheng trained at The University of Western Australia and completed his internship at Sir Charles Gairdner Hospital before undertaking training as a Psychiatrist. After being awarded Fellowship to the Royal Australian and New Zealand College of Psychiatrists (RANZCP), Dr Cheng completed a Masters of Business Administration in 2007.

Mr Tony Dolan

Executive Director, Nursing and Midwifery Services

Mr Tony Dolan was appointed the Executive Director of Nursing and Midwifery Services, NMHS and SCGOPHCG in June 2010.

Mr Dolan is responsible for providing strategic and operational nursing leadership, and advice and direction on nursing related issues for SCGOPHCG and NMHS.

Mr Dolan holds a Master in Clinical Nursing and has an active interest in the promotion of clinical leadership and patient outcomes.

Ms Ros Elmes

Executive Director, Mental Health, Public Health and Ambulatory Care

Ms Ros Elmes was appointed the Executive Director of Public Health and Ambulatory Care, including Dental Health Service, in October 2008, and now also oversees Mental Health as part of her portfolio.

Ms Elmes has a Master of Business Administration, is a Graduate of Australian Institute of Company Directors, and a Fellow of both the Australasian College of Health Service Managers and Leadership WA. Ms Elmes is NMHS Executive Sponsor for engagement between the acute health sector and the primary health network.

Dr Amanda Frazer

Executive Director, Quality, Safety and Governance

Dr Amanda Frazer was appointed as the Executive Director of Quality, Safety and Governance in October 2016.

Dr Frazer is a qualified medical practitioner and holds a first class Honours degree in Law from The University of Western Australia and University of New South Wales. Dr Frazer is a member of the Australian Institute of Company Directors.

Ms Sylvia Meier

Acting Executive Director, Strategy and Executive Services

Ms Sylvia Meier was appointed Acting Executive Director Strategy and Executive Services in September 2016. She has more than 17 years' experience in various senior and executive roles in the public health sector, strategy, policy and ministerial areas.

Ms Meier completed psychology degrees in the late 1980s followed by a Master of Business Administration in 2001. Ms Meier is a graduate of the Australian Institute of Company Directors and is a member of the Australian College of Health Service Management. She holds a non-executive Director position with the Perth Children's Hospital Foundation (formerly Princess Margaret Hospital Foundation).

Mr Silvano Palladino

Executive Director, PathWest Laboratory Medicine

Associate Professor Silvano Palladino was appointed Executive Director of PathWest Laboratory Medicine WA in August 2009.

Since qualifying as a medical scientist from Curtin University, Mr Palladino has held senior laboratory management positions since 1990.

Mr Palladino was the inaugural Chair of the Australian Society for Microbiology Workforce Standing Committee and a Foundation Fellow of the Royal College of Pathologists of Australasia's Faculty of Science, as well as a member of the Faculty's Foundation Committee. He is a Graduate of the Australian Institute of Company Directors.

Dr Peter Wynn Owen

Executive Director, Women and Newborn Health Service

Dr Peter Wynn Owen was appointed Executive Director, WNHS in July 2015

Dr Wynn Owen studied medicine in the UK where he trained as a psychiatrist, and has since held senior administrative and executive roles in WA Health.

Dr Wynn Owen is a Fellow of the RANZCP and member of the RANZCP Faculty of Forensic Psychiatry; an Associate Fellow, of the Australian College of Health Service Management and a Graduate of the Australian Institute of Company Directors. He is also a qualified Gateway reviewer.

Dr Wynn Owen stepped down as Executive Director, WNHS in June 2017.

Performance Management Framework

Outcome-based Management Framework

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

NMHS contributes to the achievement of the outcomes through health services delivered either directly by the Health Service or indirectly through contracts with non-government organisations.

NMHS' outcomes and key performance indicators for 2016/17 are aligned to the State Government's goal of 'greater focus on achieving results in key service delivery areas for the benefit of all Western Australians'.

NMHS' outcomes for achievement in 2016/17 are as follows:

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

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

Activities related to Outcome 1 aim to provide:

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

Activities related to Outcome 2 aim to:

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

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

Outcome 1

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

Key effectiveness indicators contributing to Outcome 1

- Percentage of patients discharged to home after admitted hospital treatment
- Survival rates for sentinel conditions
- Proportion of elective wait list patients waiting over boundary for reportable procedures
- Unplanned hospital readmissions within 28 days for selected surgical procedures
- Rate of unplanned readmissions within 28 days to the same hospital for a mental health condition
- Percentage of liveborn term infants with an Apgar score of seven or less, five minutes post-delivery

Services delivered to achieve Outcome 1

- Public hospital admitted patients
- Home-based hospital programs
- Palliative Care
- Emergency Department
- Public hospital non-admitted patients

Key efficiency indicators contributing to Outcome 1

- Average cost per casemix adjusted separation for tertiary hospitals
- Average cost per casemix adjusted separation for non-tertiary hospitals
- Average cost per home-based hospital patient day
- Average cost per emergency department attendance
- Average cost per public patient non-admitted activity

Outcome 2

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

Key effectiveness indicators contributing to Outcome 2

- Rate of childhood dental screening
- Dental health status of target clientele
- Access to dental treatment services for eligible people
- Average waiting times for dental services
- Percentage of contacts with community-based public mental health non-admitted services within seven days prior to admission to a public mental health inpatient unit
- Percentage of contacts with community-based public mental health non-admitted services within seven days post discharge from public mental health inpatient units

Services delivered to achieve Outcome 2

- Prevention, promotion and protection
- Dental Health
- Contracted Mental Health

Key efficiency indicators contributing to Outcome 2

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

Changes to Outcome-based Management Framework

The Outcome-Based Management Framework in 2016/17 was updated to reflect the implementation of the *Health Services Act 2016 (WA)* and the nine legal entities that now comprise the WA Health System.

Shared responsibilities with other agencies

As part of the WA Health System, NMHS works with other agencies to provide and fund health services to achieve the stated desired health outcomes as per the Outcome-Based Management Framework.

Agency Performance

NMHS annual budget is contained within the approved Minister for Health *FMA 2006* Section 40 Estimates Annual Financial Statements, which were developed based on the initial (2016) Service Agreement.

In 2016/17, the total cost of providing State services and health services to the NMHS community was $2.4 billion. Results for 2016/17 against agreed financial targets (based on Budget Statements) are presented in Table 2.

Full details of the Health Service's financial performance during 2016/17 are provided in the Financial Statements.

Table 2: Actual results versus budget targets for NMHS

Financial Targets	2016/17 Target(1) $000	2016/17 Actual $000	Variance(2) $000
Total cost of services (expense limit) (sourced from Statement of Comprehensive Income)	2,328,946	2,405,248	76,302
Net cost of services (sourced from Statement of Comprehensive Income)	1,246,637	1,284,412	37,775
Total equity (sourced from Statement of Financial Position)	1,875,586	1,990,542	114,956
Net increase / (decrease) in cash held (sourced from Statement of Cash Flows)	-	15,247	15,247
Approved salary expense level	(1,367,293)	(1,356,459)	29,056

Data sources: Budget Strategy and Reporting, NMHS.

(1) As per the 2016/17 Section 40 Estimates Annual Financial Statements.

(2) Explanations of variances are contained in Note 56 'Explanatory Statement' to the Financial Statements.

Transition to NMHS Key Performance Indicators

The 2016/17 financial year heralded the beginning of a new stage for NMHS as the WA health system moved away from a centralised governance structure to a devolved structure. On 1 July 2016, the enactment of the *Health Services Act 2016 (WA)*, resulted in NMHS becoming its own statutory authority. Due to this governance change the following points should be noted:

- NMHS is only required to report the calendar year KPIs for the period July to December 2016.
- There are no comparison data for 2016/17 Annual Report.

Summary of Key Performance Indicators

Key performance indicators (KPI) assist NMHS to assess and monitor the extent to which Government outcomes are being achieved.

Effectiveness indicators provide information that aid with assessment of the extent to which outcomes have been achieved through the resourcing and delivery of services to the community. Efficiency indicators monitor the relationship between the service delivered and the resources used to produce the service. KPIs also provide a means to communicate to the community how NMHS is performing.

A summary of NMHS KPIs and variation from the 2016/17 targets is included in Table 3.

Note: Actual Results versus KPI Targets (Table 3) are to be read in conjunction with detailed information on each KPI found in the Disclosures and Legal Compliance section of this report.

Table 3: Actual Results versus KPI Targets

Key Performance Indicators	2016/17 Target	2016/17 Actual	Variation
Outcome 1: Restoration of patients' health, provision of maternity care to women and newborns, and support for patients and families during terminal illness.			
Key Effectiveness Indicators:			
Percentage of patients discharged to home after admitted hospital treatment			
0 to 39 years	98.4%	98.8%	0.4%
40 to 49 years	98.4%	98.3%	0.1%
50 to 59 years	98.4%	98.4%	0.0%
60 to 69 years	98.4%	98.6%	0.2%
70 to 79 years	98.4%	98.0%	0.4%
80+ years	98.4%	95.6%	2.8%
All ages	98.4%	98.2%	0.2%
Survival rates for sentinel conditions			
Stroke			
0 to 49 years	95.3%	87.7%	7.6%
50 to 59 years	92.8%	87.5%	5.3%
60 to 69 years	93.3%	92.4%	0.9%
70 to 79 years	90.8%	90.6%	0.2%
80+ years	83.3%	84.4%	1.1%

Key Performance Indicators	2016/17 Target	2016/17 Actual	Variation
Acute Myocardial Infarction			
0 to 49 years	99.5%	100.0%	0.5%
50 to 59 years	99.2%	99.2%	0.0%
60 to 69 years	98.4%	97.9%	0.5%
70 to 79 years	96.7%	93.3%	3.4%
80+ years	92.7%	90.1%	2.6%
Fractured Neck of Femur			
70 to 79 years	99.0%	93.8%	5.2%
80+ years	96.4%	97.4%	1.0%
Proportion of elective wait list patients waiting over boundary for reportable procedures:			
Category 1	0%	4.5%	4.5%
Category 2	0%	6.6%	6.6%
Category 3	0%	2.0%	2.0%
Unplanned readmissions within 28 days for selected surgical procedures (per 1,000):			
Knee replacement	22	21.9	0.1
Hip replacement	21	16.5	4.5
Tonsillectomy and Adenoidectomy	71	142.9	71.9
Hysterectomy	47	34.9	12.1
Prostatectomy	34	48.1	14.1
Cataract surgery	1	3.6	2.6
Appendectomy	39	28	11.0

Key Performance Indicators	2016/17 Target	2016/17 Actual	Variation
Rate of unplanned hospital readmissions within 28 days to the same hospital for a mental health condition (per 1,000)	66	48.7	17.3
Percentage of liveborn term infants with an Apgar score of less than seven, five minutes post-delivery	1.8%	1.6%	0.2%
Key Efficiency Indicators:			
Average cost per casemix adjusted separation for tertiary hospitals	$7,291	$7,842	$551
Average cost per casemix adjusted separation for non-tertiary hospitals	$6,812	$7,562	$750
Average cost per home-based hospital patient day	$480	$300	$180
Average cost per Emergency Department attendance	$700	$716	$16
Average cost per public patient non-admitted activity	$348	$357	$9

Key Performance Indicators	2016/17 Target	2016/17 Actual	Variation
Outcome 2: Enhanced health and wellbeing of Western Australians through health promotion, illness and injury prevention and appropriate continuing care.			
Key Effectiveness Indicators:			
Rate of childhood dental screening			
(a) Percentage of eligible school children who are enrolled in the School Dental Service program			
i) Pre-primary program	≥69%	70.0%	1%
ii) Primary program	≥69%	84.4%	15%
iii) Secondary program	≥69%	77.0%	8%
(b) Percentage of school children who are free of dental caries when initially examined and/or recalled for examination	≥65%	72.0%	7%
Dental health status of target clientele			
(a) Average number of decayed, missing or filled teeth for school children (age 12 years)	0.6–1.7	0.52	N/A
(b) Average number of decayed, missing or filled teeth for adults (35 to 44 years)	N/A	9.2	N/A
Access to dental treatment services for eligible people			
(a) Percentage of eligible people who accessed dental health services (adult)	≥15%	15%	0%
(b) Percentage of completed dental care			
i) Emergency dental treatment	≤50%	42%	8%
ii) Non-emergency dental treatment	≥50%	58%	8%
Average waiting times for dental services (months)	≤24	3	21
Percentage of contacts with community-based public mental health non-admitted services within seven days prior to admission to a public mental health inpatient unit	≥70%	61.2%	8.8%
Percentage of contacts with community-based public mental health non-admitted services within seven days post discharge from public mental health inpatient units	≥75%	52.9%	21.1%
Key Efficiency Indicators:			
Average cost per capita of Population Health Units	$77	$63	$14
Average cost per breast screening	$182	$210	$28
Average cost of service for School Dental Service	$134	$131	$3
Average cost of completed courses of adult dental care	$394	$388	$6
Average cost per day-bed in specialised mental health inpatient units	$1,567	$1,501	$66
Average cost per three-month period of care for community mental health	$2,105	$2,166	$61

Significant Issues Impacting the Agency

NMHS has embraced the changes and challenges that it faced throughout the year. The Board and DoH were aligned about areas of concern and the organisation responded by placing greater focus on key areas including:

- Achieving the Western Australian Emergency Access Target (WEAT). A systematic review was undertaken by SCGH and JHC, followed by action plans that are monitored on a monthly basis.
- Achieving the Western Australian Elective Surgery Target (WEST). There remains a continued focus across SCGH and OPH to ensure full utilisation of all theatres and facilities, and ensure that patients are discharged to appropriate care post-operatively.
- SCGH and OPH continue to experience a modest increase in activity, but a significant shift towards increasing complexity of emergency and elective demand. There has been significant work undertaken to increase the efficiency of SCGH theatres and transfer elective surgical and endoscopic activity to OPH. Theatre sessions at SCGH have been realigned to reflect the increasing need for all-day and extended hours theatre sessions for complex elective work, usually cancer and neurosurgical procedures.
- Demand pressures for inpatient beds in winter results in reduced capacity to undertake elective surgery. This is particularly challenging for services such as the State Cancer Centre and the State Neurosciences Centre at SCGH, which require regular access to inpatient beds for elective surgery.
- Demand for forensic mental health services continues to increase as court activity and prison occupancy grow. The Department of Corrective Services is also reviewing its provision of health services to offenders.
- Demand for specialist services, such as bariatric surgery, continues to exceed capacity. There is also an increasing demand for inpatient beds for patients who have complications following bariatric surgery at other services. These patients often have a prolonged length of stay and require treatment that is resource intensive.
- The recent Office of the Auditor General's (OAG) report in the system-wide Medical Equipment Replacement Program highlighted the challenges we face to ensure that medical equipment is replaced and maintained within the equipment lifecycle. NMHS will implement the recommendations of the OAG report and the Board will monitor this closely.

- Facilities Management service has been actively developing and commissioning facility management plans for the provision of facility, security, telecommunication, fleet and mail management services to the Perth Children's Hospital. These services are to be provided on a cost recovery basis to CAHS.
- A comprehensive Water Management Plan has been commissioned to ensure that, at a minimum, the quality of the water consistently meets the requirements of the Australian Drinking Water Quality Guidelines and Regulators. The Plan explains how the NMHS Facilities Management Department will undertake the management of site water quality at each of its accountable healthcare facilities.
- Work has commenced on a comprehensive Asset Condition Plan of all NMHS facilities. The purpose of the Plan is to identify and document the infrastructure risks and propose strategies to either mitigate or remedy the risks.
- A key challenge for NMHS is to deliver financially sustainable services. While the Health Service achieved a close to on-budget result in 2016/17, funding and cost pressures continue to increase. These include wage rises and allowances above funded levels, lower activity weightings (and therefore funding) for non-admitted episodes of care and additional costs relating to the provision of high specialty care, e.g. stroke and epilepsy services, liver transplants and sarcoma care. A number of strategies are being implemented to support the delivery of safe and high quality care within the allocated budget. These include a focus on budget ownership and accountability at all levels of the organisation, and improvements to business support systems to assist clinicians and managers, and new Patient Administration Billing systems.
- Governance, compliance and risk management for our workforce continues to be an area of focus. We must ensure that we are always fully compliant with policies and procedures concerning Working with Children, Visas, Professional Registration, and secondary employment.
- The culture of teams and the organisation will always be challenged during periods of change. With a number of services undergoing review, reform and amalgamation, it will be important to ensure that our employees remain engaged and maintain their focus on safety, quality and patient care.

While progress has been made to address these challenges, NMHS will continue to ensure that the services we provide are safe, sustainable and meet the needs of our community.

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 2017, 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.

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 2017 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 Responsibilities 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. 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.

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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 2017.

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 2017. 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 2017.

Matter of Significance
The Under Treasurer approved the removal of the following indicator as an audited key performance indicator (KPI):

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

The approval was conditional on its inclusion as an unaudited performance indicator in the Annual Report and that it be reinstated as an audited KPI following the implementation of a new Emergency Department data collection system. A new system had not been developed at 30 June 2017. Consequently, the KPI has not been included in the audited KPIs for the year ended 30 June 2017. 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.

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 2017 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.

COLIN MURPHY
AUDITOR GENERAL
FOR WESTERN AUSTRALIA
Perth, Western Australia
27 September 2017

Certification of Key Performance Indicators

For the year ended 30 June 2017.

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 performance and fairly represent the performance of the Health Service for the year ended 30 June 2017.

Graham McHarrie
Board Member
North Metropolitan Health Service

Date 26 September 2017

Professor Bryant Stokes AM
Board Chair
North Metropolitan Health Service

Date 26.9.2017

Detailed information in Support of Key Performance Indicators

Outcome 1
Percentage of patients discharged to home after admitted hospital treatment
Survival rates for sentinel conditions
Proportion of elective wait list patients waiting over boundary for reportable procedures
Unplanned hospital readmissions within 28 days for selected surgical procedures
Rate of unplanned readmissions within 28 days to the same hospital for a mental health condition
Percentage of liveborn term infants with an Apgar score of seven or less, five minutes post-delivery
Average cost per casemix adjusted separation for tertiary hospitals
Average cost per casemix adjusted separation for non-tertiary hospitals
Average cost per home-based hospital patient day
Average cost per emergency department attendance
Average cost per public patient non-admitted activity

Outcome 2
Rate of childhood dental screening
Dental health status of target clientele
Access to dental treatment services for eligible people
Average waiting times for dental services
Percentage of contacts with community-based public mental health non-admitted services within seven days prior to admission to a public mental health inpatient unit
Percentage of contacts with community-based public mental health non-admitted services within seven days post discharge from public mental health inpatient units
Average cost per capita of Population Health Units
Average cost per breast screening
Average cost of service for School Dental Service
Average cost of completed courses of adult dental care
Average cost per bed-day in specialised mental health inpatient units
Average cost per three-month period of care for community mental health

Percentage of patients discharged to home after admitted hospital treatment

Rationale

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

Measuring the number of patients discharged to home after hospital care allows for the monitoring of changes over time that can enable the identification of the priority areas for improvement. This in turn enables the determination of targeted interventions and health promotion strategies, aimed at ensuring optimal restoration of patients' health.

Target

The 2016 target is ≥98.4 per cent. Maintained performance is demonstrated by a result above, or equal to, the target.

Results

In 2016, 98.2 per cent of NMHS patients across all ages were discharged to home after receiving admitted hospital treatment (see Table 4). The overall performance was below target.

Table 4: Percentage of patients discharged to home after admitted hospital treatment, by age group, 2016

Age group (years)	2016 (%)
0 to 39	98.8
40 to 49	98.3
50 to 59	98.4
60 to 69	98.6
70 to 79	98.0
80+	95.6
All ages	**98.2**
Target (≥)	≥98.4

Note: As a result of the new, devolved governance structure being implemented 1 July 2016, as per the *Health Services Act 2016 (WA)*, this calendar year indicator has been reported for the period July to December 2016.

Data source: Hospital Morbidity Data System.

Survival rates for sentinel conditions

Rationale

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

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

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

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

Target

The 2016 target for each condition by age group:

Age group (years)	Sentinel Condition		
	Stroke (%)	Acute myocardial infarction (%)	Fractured neck of femur (%)
0 to 49	95.3	99.5	Not reported
50 to 59	92.8	99.2	Not reported
60 to 69	93.3	98.4	Not reported
70 to 79	90.8	96.7	99.0
80+	83.3	92.7	96.4

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

Results

In 2016, the survival rate for stroke met target for patients aged 80+ years (see Table 5); however, the survival rate was below target for patients in all other age groups. The number of cases reported for the 0 to 49 years age group was statistically smaller.

Table 5: Survival rate for stroke, by age group, 2016

Age group (years)	2016 (%)	Target (%)
0 to 49	87.7	95.3
50 to 59	87.5	92.8
60 to 69	92.4	93.3
70 to 79	90.6	90.8
80+	84.4	83.3

Note: As a result of the new, devolved governance structure being implemented 1 July 2016 as per the *Health Services Act 2016 (WA)*, this calendar year indicator has been reported for the period July to December 2016.

Data source: Hospital Morbidity Data System.

Survival rates for patients with an acute myocardial infarction met target for age groups 0 to 49 years and 50 to 59 years. Survival rate was below target for patients in age groups above 60 years old (see Table 6).

Table 6: Survival rate for acute myocardial infarction, by age group, 2016

Age group (years)	2016 (%)	Target (%)
0 to 49	100.0	99.5
50 to 59	99.2	99.2
60 to 69	97.9	98.4
70 to 79	93.3	96.7
80+	90.1	92.7

Note: As a result of the new, devolved governance structure being implemented 1 July 2016 as per the *Health Services Act 2016 (WA)*, this calendar year indicator has been reported for the period July to December 2016.

Data source: Hospital Morbidity Data System.

The survival rate for patients 80+ years with fractured neck of femur met target in 2016 (see Table 7); however, survival rate was below target for patients aged 70 to 79 years.

Table 7: Survival rate for fractured neck of femur, by age group, 2016

Age group (years)	2016 (%)	Target (%)
70 to 79	93.8	99.0
80+	97.4	96.4

Note: As a result of the new, devolved governance structure being implemented 1 July 2016 as per the *Health Services Act 2016 (WA)*, this calendar year indicator has been reported for the period July to December 2016.

Data source: Hospital Morbidity Data System.

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

Rationale

On 1 April 2016, WA Health introduced a new statewide performance target for the provision of elective services. The new target requires that no patients (0%) on the elective waiting lists wait longer than the clinically recommended time for their reportable 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 2016 target is 0%. Performance is demonstrated by a result equal to the target. The clinical review of patient urgency category is based on the acuity of patient condition.

The urgency categories and clinically desirable times were:

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

Results

In 2016/17, all urgency categories for elective surgery wait lists contained over boundary patients were above target (see Table 8). due to challenges associated with increased demand on service, access block and patient flow. To actively manage the proportion of elective wait list over boundary, initiatives under the Theatre Efficiency Reform Program, have been implemented to address challenges associated with access block and patient flow. These included strategies to improve data capture, availability of data, more efficient scheduling practices and allocation of wait list coordinators across more specialties to provide dedicated elective wait list oversight and management.

Table 8: Proportion of elective wait list patients waiting over boundary for reportable procedures

Urgency Category	2016 (%)	Target (%)
Category 1 over 30 days	4.5	0
Category 2 over 90 days	6.6	0
Category 3 over 365 days	2.0	0

Note: This is a new reportable indicator for 2016/17.

Data Source: Elective Services Wait List Data Collection.

Unplanned hospital readmissions within 28 days for selected surgical procedures

Rationale

Readmission rate is considered a global performance measure, as it potentially points to deficiencies in the functioning of the overall healthcare system. Good intervention, appropriate treatment together with good discharge planning will decrease the likelihood of unplanned hospital readmissions. A low unplanned readmission rate suggests that good clinical practice is in operation. These readmissions necessitate patients spending additional periods of time in hospital as well as utilising additional hospital resources.

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

Target

The 2016 target for unplanned readmissions within 28 days for selected surgical procedures:

Surgical Procedure	Target (per 1,000)
Knee replacement	22
Hip replacement	21
Tonsillectomy & adenoidectomy	71
Hysterectomy	47
Prostatectomy	34
Cataract surgery	1
Appendectomy	39

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

Results

In 2016, the rate of unplanned readmission within 28 days for Knee replacement, Hip replacement, Hysterectomy and Appendectomy met target (see Table 9). Cataract surgery, Prostatectomy, and Tonsillectomy and adenoidectomy rates for unplanned hospital readmissions within 28 days were above target. The number of readmission cases for various procedures was small and results should be interpreted with caution. For example, there were a total of 5 readmissions out of 1,402 Cataract surgery cases and 22 readmissions out of the 154 Tonsillectomy and adenoidectomy cases.

Table 9: Unplanned hospital readmissions within 28 days for selected surgical procedures (per 1,000), 2016

Surgical Procedure	2016 (per 1,000)	Target (per 1,000)
Knee replacement	21.9	22
Hip replacement	16.5	21
Tonsillectomy & adenoidectomy	142.9	71
Hysterectomy	34.9	47
Prostatectomy	48.1	34
Cataract surgery	3.6	1
Appendectomy	28.0	39

Note: As a result of the new, devolved governance structure being implemented 1 July 2016 as per the *Health Services Act 2016 (WA)*, this calendar year indicator has been reported for the period July to December 2016.

Data source: Hospital Morbidity Data Collection.

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

Rationale

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

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

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

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

Target

The 2016 target is 66 unplanned readmissions per 1,000 hospital separations for a mental health condition. Maintained performance is demonstrated by a result below, or equal to, the target.

Results

The rate of unplanned readmissions within 28 days to the same hospital for a mental health condition in 2016 is 48.7 cases per 1,000 hospital separations (see Table 10). The target was met due to a focus on discharge planning, development of targeted care pathways, service interventions.

Table 10: Rate of unplanned readmissions within 28 days to the same hospital for a mental health condition, 2016

	2016 (per 1,000)	Target (per 1,000)
Unplanned readmissions	48.7	66

Note: This indicator is based on a three-month period each year. For 2016, data were reported from 1 September to 30 November 2016.

Data source: Hospital Morbidity Data System.

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

Rationale

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

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.

Target

The 2016 target for liveborn term infants with an Apgar score of less than seven, five minutes post-delivery is 1.8%. Maintained performance is demonstrated by a result below, or equal to, the target.

Results

In 2016, the percentage of liveborn term infants with an Apgar score of less than seven, five minutes post-delivery is 1.6% (see Table 11). The target was met due to consistent evidence-based care across all sites, which has contributed to enhanced patient outcomes.

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

Live Births	2016 (%)	Target (%)
Apgar Score <7	1.6	1.8

Note: As a result of the new, devolved governance structure being implemented 1 July 2016 as per the *Health Services Act 2016 (WA)*, this calendar year indicator has been reported for the period July to December 2016.

Data source: Midwives Notification System.

Average cost per casemix adjusted separation for tertiary hospitals

Rationale

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

Target

The target for 2016/17 is $7,291 per casemix weighted separation from a tertiary hospital. Maintained performance is demonstrated by a result below, or equal, to target.

Results

In 2016/17, the average cost per casemix adjusted separation for tertiary hospitals was $7,842, which was above target (see Table 12).

Table 12: Average cost per casemix weighted separation for tertiary hospitals, 2016/17

	2016/17 ($)	Target ($)
Average cost	7,842	7,291

Data source: Hospital Morbidity Data System, Health Service Financial Systems.

Average cost per casemix adjusted separation for non-tertiary hospitals

Rationale

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

Non-tertiary hospitals provide crucial healthcare for Western Australians. As with tertiary hospitals, the role of non-tertiary hospitals is constantly evolving to meet the changing needs and characteristics of the population, yet still provide comprehensive specialist healthcare services.

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

Target

The target for 2016/17 is $6,812 per casemix weighted separation from a non-tertiary hospital. Maintained performance is demonstrated by a result below, or equal, to target.

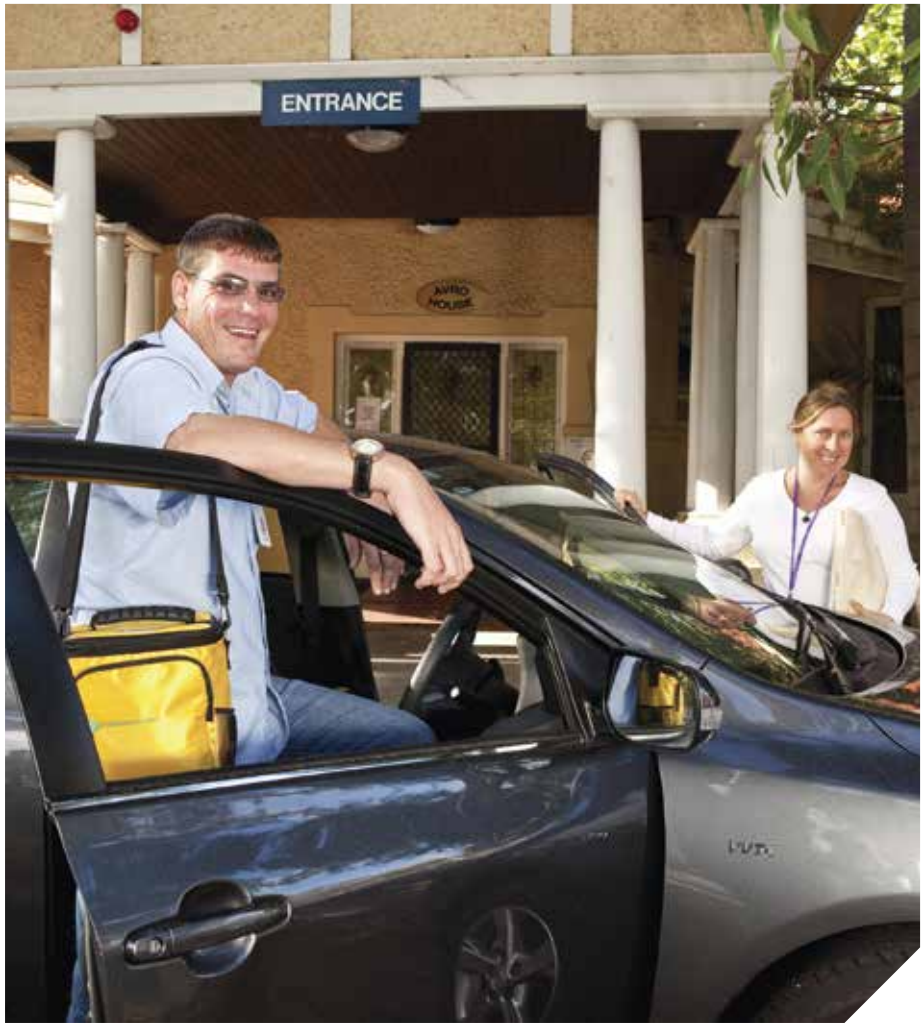
Results

In 2016/17, the average cost per casemix adjusted separation for non-tertiary hospitals for 2016/17 was $7,562, which was above target (Table 13).

Table 13: Average cost per casemix weighted separation for non-tertiary hospitals, 2016/17

	2016/17 ($)	Target ($)
Average cost	7,562	6,812

Data source: Hospital Morbidity Data System, Health Service Financial Systems.



Average cost per home-based hospital patient day

Rationale

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

Home-based hospital programs i.e. HITH, Rehabilitation in the Home (RITH) and Mental Health in the Home (MITH) have been implemented as a means of ensuring all Western Australians have timely access to effective healthcare. These home-based programs, provided by the public health system, aim to provide safe and effective medical care for suitable patients in their home. These patients would otherwise require admission to hospital.

Target

The target for 2016/17 is $480 per home-based hospital patient day. Maintained performance is demonstrated by a result below, or equal, to target.

The target is higher due to the inclusion of MITH patient days, which have been reported in a separate KPI for 2016/17.

Results

In 2016/17, the average cost per home-based hospital patient day was $300, which met target (see Table 14).

Table 14: Average cost per home based hospital patient day, 2016/17

	2016/17 ($)	Target ($)
Average cost	300	480

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

Average cost per Emergency Department attendance

Rationale

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

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

Target

The target for 2016/17 is $700 per Emergency Department attendance. Maintained performance is demonstrated by a result below, or equal, to target.

Results

In 2016/17, the average cost per Emergency Department attendance was $716, which was above target (see Table 15).

Table 15: Average cost per Emergency Department attendance, 2016/17

	2016/17 ($)	Target ($)
Average cost	716	700

Data source: Hospital Morbidity Data System, Health Service Financial Systems.

Average cost per public patient non-admitted activity

Rationale

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

Non-admitted care encompasses services provided to patients who do not undergo a formal admission process and do not occupy a hospital bed. These services provide consultations with a clinician or specialist to determine the most appropriate treatment of a patient's condition.

Target

The target for average cost per public patient non-admitted activity is $348. Maintained performance is demonstrated by a result below, or equal, to target.

Results

In 2016/17, the average cost per public patient non-admitted activity was $357, which was above target (see Table 16).

The higher cost of public patient non-admitted activity mainly reflects the inclusion of the Hepatitis C drug ($29 million), which was excluded from in the target and therefore does not include all costs.

Table 16: Average cost per public patient non-admitted activity, 2016/17

	2016/17 ($)	Target ($)
Average cost	357	348

Data sources: Non Admitted Patient Activity and Wait List Data Collection, Interim Collection of Aggregate Data, Health Service Financial Systems.

Rate of childhood dental screening

Rationale

Early detection and prevention of dental health problems, such as dental decay (also known as dental caries), in children can ensure better health outcomes and improved quality of life throughout the crucial childhood development years and into adult life.

While dental disease is common in children, it is largely preventable through population-based interventions and individual practices such as personal oral hygiene, better diet and regular preventive dental care.

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

By measuring the percentage of school children enrolled, 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 2016 targets are as follows:

(a) Percentage of eligible school children (pre-primary, primary and secondary) who are enrolled in the School Dental Service program.

	Target (%)
Pre-primary program	≥69
Primary program	≥69
Secondary program	≥69

(b) Percentage of school children (all ages) who are free of dental caries when initially examined and/or re-called for examination is ≥65 per cent.

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

Results

Children at all stages in the school system are enrolled in the school dental program at a rate that met target (see Table 17). Primary school children had the highest compliance rate of enrolment (84 per cent) to a school dental program.

Table 17: Percentage of pre-primary, primary and secondary school children enrolled in the school dental program, 2016

	2016 (%)	Target (%)
Pre-primary school children	70.0	≥69
Primary school children	84.4	≥69
Secondary school children	77.0	≥69

Notes: As a result of the new, devolved governance model being implemented 1 July 2016, as per the *Health Services Act 2016 (WA)*, this calendar year indicator has been reported for the period July to December 2016.

Data source: School Dental Health Clinics, Department of Education of WA.

In 2016, the rate of children free of dental caries when initially examined or recalled for examination met target (see Table 18).

Information packages regarding dental health services are provided to children at the commencement of the school year. Data collection for this indicator has improved due to implementation of an electronic data collection system.

Table 18: Percentage of children free of dental caries when initially examined and/or recalled for examination, 2016

	2016 (%)	Target (%)
Children free of dental caries	72.0	≥65

Notes: As a result of the new, devolved governance model being implemented 1 July 2016, as per the *Health Services Act 2016 (WA)*, this calendar year indicator has been reported for the period July to December 2016.

Data source: School Dental Health Clinics, Department of Education of WA.

Dental health status of target clientele

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.

Dental health is influenced by many factors including nutrition, water fluoridation, hygiene, access to dental treatment, income, lifestyle factors and trauma. Dental diseases place a considerable burden on individuals and communities. While dental disease is common, it is largely preventable through population-based interventions and individual practices such as personal oral hygiene and regular preventative dental care.

Costly treatment and high demand on public dental health services emphasises the need for a focus on prevention and health promotion. This indicator enables the monitoring of the dental health status of adults and children within specific age groups in order to assess the effectiveness of dental health practices, interventions and programs. Evidence-based accessible and affordable interventions that have a strong focus on dental health promotion, prevention and early identification of dental disease can then be implemented to improve the dental health of Western Australians.

Target

The 2016 target is 0.6–1.7 for children aged 12 years. Maintained performance is demonstrated by a result below, or equal to, the target.

No target has been set for the Average number of decayed, missing or filled teeth (DMFT) for adults aged 35 to 44 years.

Results

The average number of DMFT in 12 year olds in 2016 was 0.52 (see Table 19) and met target. A contributing factor to the outcome was the introduction of a decay prevention procedure, Fissure Sealant Program, across schools Statewide in 2013.

Table 19: Average number of decayed, missing or filled teeth for school children, 2016

Average number of DMFT for children by age (years)	2016	Target
12	0.52	0.6–1.7

Note: To ensure statistical validity of this KPI, the Dental Health Status of Target Clientele (school children) is based on the full 2016 calendar year.

Data source: Dental Health Clinics.

The average number of DMFT for adults in 2016/17 was 9.2 (see Table 20).

Table 20: Average number of decayed, missing or filled teeth for adults, 2016/17

Average number of DMFT for adults (years)	2016/17
35 to 44	9.2

Notes:

- The adult cohort for this KPI (aged 35 to 44 years) is Western Australians who have had access to the water fluoridation program, introduced in 1968. Fluoridated water is associated with a reduction in tooth decay, and on-going monitoring of DMFT among this cohort allows for evaluation of the success of the program.
- The average number of DMFT is based on a randomly selected sub-sample of the total number of patients from the National Adult Dental Health Service patient oral health survey. The average number of DMFT for adults aged 35 to 44 years at a confidence interval of 95% is 7.6–9.2.

Data source: Dental Health Clinics.

Access to dental treatment services for eligible people

Rationale

Oral health, including dental health, is fundamental to overall health, wellbeing and quality of life, with poor oral health likely to exist when general health is poor and vice versa. This makes access to timely dental treatment services critical in reducing the burden of dental disease on individuals and communities, as it can enable early detection and diagnosis with the use of preventative interventions avoiding the need for extensive restorative or emergency treatments.

To facilitate the equity of access to dental healthcare for all Western Australians, dental treatment services (including both emergency care and non-emergency care) are provided through subsidised dental programs to eligible Western Australians in need. This indicator measures the level of access to these subsidised dental health services by monitoring the proportion of all eligible people receiving the services.

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

Target

The 2016/17 targets are as follows:

(a) Eligible people who accessed dental health services: ≥15 per cent.

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

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

i. Emergency	≤50 per cent
ii. Non-Emergency	≥50 per cent

For completed emergency dental treatments, maintained performance is demonstrated by a result below, or equal to, the target

For completed non-emergency dental treatments, maintained performance is demonstrated by a result above, or equal to, the target.

Results

In 2016/17, the percentage of eligible adults who accessed public subsidised dental treatment services was 15 per cent, which met target (see Table 21).

Table 21: Percentage of eligible people who accessed dental treatment services, 2016/17

	2016/17 (%)	Target (%)
Eligible persons who accessed dental health services (adult)	15	≥15

Data source: Dental Health Clinics.

In 2016/17, 42 per cent of eligible people who accessed dental health services received emergency dental care below target and 58 per cent of eligible people who accessed dental health services received non-emergency dental care, which met target (see Table 22). Since 1 July 2013, the Dental Health Service has been Australia's leading provider servicing the WA community under the National Partnership Agreement with the Commonwealth Government to reduce wait lists. The reduction in emergency cases from wait lists, enables the Dental Health Service to treat a higher proportion of non-emergency dental patients.

Table 22: Percentage of completed dental care, 2016/17

Completed dental treatments	2016/17 (%)	Target (%)
Emergency	42	≤50
Non-emergency	58	≥50

Data source: Dental Health Clinics.

Average waiting times for dental services

Rationale

Oral health, including dental health, is fundamental to overall health, wellbeing and quality of life, with poor oral health likely to exist when general health is poor and vice versa. This makes access to timely dental services critical in reducing the burden of dental disease on individuals and communities as it can enable early detection and diagnosis with the use of preventative interventions rather than extensive restorative or emergency treatments.

Costly treatment and high demand on public dental health services emphasises the need for a focus on prevention and health promotion, which can be achieved through timely access to dental services.

Through monitoring waiting times for access to dental health services, targeted strategies can be implemented to ensure timely access to affordable dental care, which ultimately can lead to better health outcomes for Western Australians.

Target

The target for 2016/17 was ≤24 months. Maintained performance is demonstrated by a result below, or equal to, the target. This target is consistent with National standards as per the National Oral Health Plan 2015–2024.

Results

In 2016/17, patients waited an average of three months for public general dental treatment, which met target (see Table 23). Since 1 July 2013, the Dental Health Service has been the lead service provider for WA in the National Partnership Agreement with the Commonwealth Government to reduce wait lists. In 2016/17, the Dental Health Service offered oral healthcare to over 17,000 patients on wait lists, with approximately 14,500 patients accepting treatment. The Dental Health Service reduction in wait lists has enabled non-urgent dental care patients to access timely treatment.

Table 23: Average waiting times (months), per patient, 2016/17

	2016/17 (months)	Target (months)
Average waiting times for non-urgent dental care	3	≤24

Data source: Adult Dental Clinics.

Percentage of contacts with community-based public mental health non-admitted services within seven days prior to admission to a public mental health inpatient unit

Rationale

The impact of mental illness within the Australian population has become increasingly apparent with mental illness being one of the leading causes of non-fatal burden of disease in Australia. In 2014/15, there were 4.0 million Australians (17.5%) who reported having a mental or behavioral condition*, which is why it is crucial to ensure effective and appropriate care is provided not only in a hospital setting but also in the community care setting.

A large proportion of treatment of mental illness is carried out in a community care setting through ambulatory mental health services. The aim is to provide the best health outcomes for the individual through the provision of accessible and appropriate community mental healthcare, thereby alleviating the need for, or assisting with improving the management of, admissions to hospital-based inpatient care for mental illness.

Monitoring the level of accessibility to community mental health services pre-admission to hospital can be gauged in order to assist in the development of effective programs and interventions. This in turn can help to improve the health and wellbeing of Western Australian's with mental illness and ensure sustainability of the public health system.

Consideration at a national level regarding the robustness of this indicator is ongoing. A key limitation is that a number of key community based services are not considered.

Target

The target for 2016 was ≥70 per cent. Maintained performance is demonstrated by a result above, or equal to, the target.

Results

In 2016, 61.2 per cent of people who were admitted to a public mental health unit had been in contact with a community-based mental health service within seven days prior to admission (see Table 24). The result was below target due to the lack of availability of patient contact details. Strategies implemented to actively manage the percentage of contacts with community-based services prior to admission include setting up a performance review framework related to standardisation of community provisioning and ensuring contact frequency in line with established models of care.

The 2016 target is considered aspirational. The rate of pre-admission community care reported for the calendar year is similar, or higher, compared to those reported nationally by AIHW. The 2016 result is favourable relative to performance from other jurisdictions as per the recent recorded average reported by AIHW (2014/15).

Table 24: Percentage of contacts with a community-based mental health non-admitted service seven days prior to admission to a public mental health inpatient unit, 2016

	2016 (%)	Target (%)
Pre-admission community based contact	61.2	≥70

Source: *National Health Survey 2014/15.

Note: As a result of the new, devolved governance model being implemented 1 July 2016, as per the *Health Services Act 2016 (WA)*, this calendar year indicator has been reported for the period July to December 2016.

Data sources: Mental Health Information System, Hospital Morbidity Data System.

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

Rationale

In 2014/15, there were 4.0 million Australians (17.5%) who reported having a mental or behavioural condition*. 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 healthcare. 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 healthcare.

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 discharge 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

In 2016 the target was ≥75 per cent. Maintained performance is demonstrated by a result above, or equal to, the target.

Results

In 2016, 52.9 per cent of people who were admitted to a mental health unit were contacted by a community-based mental health service within seven days of discharge (see Table 25). This result was below target due to the lack of availability and data reliability of patient contact details.

During mid-2016/17, a range of strategies were implemented to actively manage contacts with community-based public mental health non-admitted services within seven days post discharge from a public mental health inpatient unit. These included a focus on staff training and education programs, and arranging correct data to be entered retrospectively, such as contact details for follow-up based on the patient's expected place of residence post discharge.

Table 25: Percentage of contacts with a community-based mental health non-admitted services within seven days post discharge from public mental health inpatient units, 2016

	2016 (%)	Target (%)
Post-admission community-based contact	52.9	≥75

Source: *National Health Survey 2014/15.

Note: As a result of the new, devolved governance model being implemented 1 July 2016, as per the *Health Services Act 2016 (WA)*, this calendar year indicator has been reported for the period July to December 2016.

Data sources: Mental Health Information System, Hospital Morbidity Data System.

Average cost per capita of Population Health Units

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 utilising the WA Health Promotion Strategic Framework 2012–2016 (the latest version is due for public at the end of this year). This is based on the growing understanding of the social, cultural and economic factors that contribute to a person's health status.

Target

The target for 2016/17 is $77 per capita of population health units. Maintained performance is demonstrated by a result below, or equal to, the target.

Results

In 2016/17, the average cost per capita of Population Health Unit was $63, which met target (see Table 26). The result reflects the actual cost per capita remaining stable, while the target is based on a forecast increase in the cost per capita.

Table 26: Average cost per capita of Metropolitan Population Health Units, to 2016/17

	2016/17 ($)	Target ($)
Average cost	63	77

Data source: Australian Bureau of Statistics, Health Service Financial Systems.

Average cost per breast screening

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 BSWA for women aged 40 years and over, as a preventative initiative.

Target

The target for 2016/17 is $182 per breast screening. Maintained performance is demonstrated by a result below, or equal to, the target.

Results

In 2016/17, the average cost per breast screening was $210, which was above target (see Table 27).

Costs have remained within expectation. The actual activity of 117,258 breast screens in 2016/17 is lower than the 121,939 breast screens factored into the target. This is mainly due to an increase in the number of “clients not arriving”.

Table 27: Average cost per breast screening, 2016/17

	2016/17 ($)	Target ($)
Average cost	210	182

Data source: Mammography Screening Registry, BSWA, Health Service Financial Systems.

Average cost of service for school dental Service

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.

Target

The target for 2016/17 is $134 for school dental care. Maintained performance is demonstrated by a result below, or equal to, the target.

Results

In 2016/17, the average cost to provide public general dental services to school-aged children was $131, which was below target (see Table 28).

Table 28: Average cost of service for school dental service, 2016/17

	2016/17 ($)	Target ($)
Average cost	131	134

Data source: School Dental Health Clinics - Dental Health Service

Average cost of completed courses of adult dental care

Rationale

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

Dental health is influenced by many factors, including nutrition, water fluoridation, hygiene, access to dental treatment, income, lifestyle factors, and trauma. Dental disease places a considerable burden on individuals and communities. While dental disease is common, they are largely preventable through population-based interventions, and individual practices such as personal oral hygiene and regular preventive dental care. Costly treatment and high demand on public dental health services emphasises the need for a focus on prevention and health promotion.

Target

The target for 2016/17 is $394 per completed course of adult dental care. Maintained performance is demonstrated by a result below, or equal to, the target.

Results

In 2016/17, the average cost of completed courses of adult dental care was $388, which met target (see Table 29).

Table 29: Average cost of completed courses of adult dental care, 2016/17

	2016/17 ($)	Target ($)
Average cost	388	394

Data sources: Adult dental clinics - Dental Health Service

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

Rationale

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

Target

The target for 2016/17 is $1,567 per bed-day in a specialised mental health unit. Maintained performance is demonstrated by a result below, or equal to, the target.

Results

In 2016/17, the average cost per bed-day in specialised mental health inpatient units was $1,501, which met target (see Table 30).

Table 30: Average cost per bed-day in specialised mental health inpatient units, 2016/17

	2016/17 ($)	Target ($)
Average cost	1,501	1,567

Data sources: Mental Health Information System, BedState, Health Service Financial Systems.

Average cost per three-month period of care for community mental health

Rationale

Mental illness is having an increasing impact on the Australian population and is one of the leading causes of disability burden in Australia. In 2014/15, there were four million Australians (17.5%) who reported having a mental or behavioral condition*. Therefore, it is important to ensure effective and appropriate care is provided to mental health clients not only in a hospital setting but also in the community through the provision of community mental health services.

Community mental health services consist of a range of community-based services such as emergency assessment and treatment, case management, day programs, rehabilitation, psychosocial, and residential services. The aim is to provide the best health outcomes for the individual through the provision of accessible and appropriate community mental healthcare.

Target

The target for 2016/17 is $2,105 per three-month period of care for a person receiving public community mental health services. Maintained performance is demonstrated by a result below, or equal to, the target.

Results

In 2016/17, the average cost per three-month period of care for a person receiving public community mental health services was $2,166, which was above target (see Table 31).

Table 31: Average cost per three-month period of care for a person receiving community mental health services, 2016/17

	2016/17 ($)	Target ($)
Average cost	2,166	2,105

Source: *National Health Survey 2014/15.

Data sources: Mental Health Information System, Health Service Financial Systems.

Additional Key Performance Indicator (un-audited)

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

Rationale

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

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

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

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

Target

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

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

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

Results

In 2016/17, 92.9 percent of all triage Category 5 patients were seen within the clinically recommended which met target (see Table 32).

In 2016/17, the Australasian College for Emergency Medicine targets for patients categorised as triage 1, 2, 3 and 4 were not met (see Table 32). Strategies to actively manage challenges associated with greater demand of services and access block issues included improvements to models of care, discharge planning and staff education and training.

Table 32 Percentage of emergency department patients seen within recommended times, by triage category, 2016/17

Triage Category	2016/17 (%)	Target (%)
1	99.80	100
2	76.90	≥ 80
3	40.20	≥ 75
4	57.30	≥ 70
5	92.90	≥ 70

Note: For 2016/17, this indicator is reported as an unaudited performance indicator.

Data source: Emergency Department Data Collection.

Ministerial Directives

Treasurer's Instructions (TI) 902 (12) require 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 (WA)*, NMHS has not received any ministerial directives related to this requirement.

Other Financial Disclosures

Pricing policy

The *National Health Reform Agreement 2011* sets the policy framework for the charging of public hospital fees and charges. Under the Agreement, an eligible person who receives public hospital services as a public patient in a public hospital or a publicly contracted bed in a private hospital is treated 'free of charge'. This arrangement is consistent with the Medicare principles, which are embedded in the *National Health Reform Agreement 2011*.

The majority of hospital fees and charges for public hospitals are set under Schedule 1 of the *Health Services (Fees and Charges) Order 2016* and are reviewed annually.

The following informs WA public hospital patient fees and charges for:

Nursing Home Type Patients

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

Compensable or ineligible patients

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

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

The following fees and charges also apply:

- The Pharmaceutical Benefits Scheme regulates and sets the price of pharmaceuticals supplied to outpatients, patients on discharge and for day admitted chemotherapy patients. Inpatient medications are supplied free of charge.
- The Dental Health Service charges to eligible patients for dental treatment are based on the Department of Veterans' Affairs Fee Schedule of dental services for dentists and dental specialists. Eligible patients are charged the following co-payment rates:
  - 50 per cent of the treatment fee if the patient holds a current Healthcare Card or Pensioner Concession Card
  - 25 per cent of the treatment fee if the patient is the current holder of one of the above cards and receives a near full pension or an allowance from Centrelink or the Department of Veterans Affairs.
- There are other categories of fees specified under Health Regulations through Determinations, which include the supply of surgically implanted prostheses, Magnetic Resonance Imaging services and pathology services. The pricing for these hospital services is determined according to their cost of service.

Capital works

NMHS has a substantial Asset Investment Program that facilitates re-modelling and development of health infrastructure. Program initiatives include the continuation of major projects to reconfigure and investment in metropolitan general and tertiary hospitals (see Table 33 and Table 34).

Table 33: Major Asset Investment Program works completed, 2016/17

Initiative	Estimated total cost in 2016/17 $000
Capital Works (including major redevelopments and equipment)	
Graylands Hospital - Redevelopment Planning	600
KEMH Holding	1,380
KEMH - Maternal Foetal Assessment Unit	5,500
SCGH - G Block lift upgrade	6,092
Statewide	
ICT Bunbury Breastscreening Clinic	500
Total	**14,072**

Table 34: Major capital works in progress, 2016/17

Initiative	Estimated total cost 2016/17 $000	Reported in 2015/16 $000	Variation $000	Expected completion date
Graylands Hospital - Development Stage[1]	92	92	-	N/A
Infection Prevention and Control System[2]	2,387	-	-	ongoing
SCGH - Catheter Laboratory 2 Upgrade[3]	832	835	3	Completed
SCGH - Redevelopment Stage 1[1,3]	26,539	48,028	21,489	Various
SCGH - Mental Health Unit 3	28,925	28,926	1	Completed
State Epilepsy Service relocation	1,383	-	-	Completed
OPH - Additional Parking Facility	3,330	3,330	-	Completed
SCGH and KEMH - Upgrade of PABX Infrastructure	3,000	3,000	-	Completed
PathWest - Laboratory Equipment and Asset Replacement/Maintenance	1,500	1,500	-	Completed
PathWest - Replacement of Laboratory Information Systems[3]	24,399	25,023	624	Jun-18
BSWA - Digital Mammography Technology[4]	-	12,666	-	Completed
Reconfiguring the Western Australian Spinal Cord Injury Service	500	-	-	Ongoing
JHC Development - Stage 1	215,152	215,152	-	Completed
JHC - Telethon Paediatric Ward[1]	12,118	14,718	2,600	Completed
Joondalup Mental Health Observation Area	7,064	-	7,064	May-18
QEIIMC - New Central Plant Facility	218,268	221,523	3,255	Completed

Notes:

1. The information above is based upon the:
   i) 2016/17 published budget papers.
   ii) 2015/16 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. The footnotes that apply to individual projects are:
   i) Transfer of funding between projects.
   ii) Impacted as part of Whole of Government Capital Audit.
   iii) 2016/17 Budget excludes amounts that will not be capitalised, therefore the estimated total cost may vary from that reported in the 2015/16 Budget.
   iv) Remaining budget is outside the forward estimates period, but was within the 2015/16 forward estimates period.

Employment profile

Government agencies are required to report a summary of the number of employees, by category. Table 35 shows the year-to-date (June 2017) number of NMHS full-time equivalent employees for 2016/17.

Table 35: NMHS total full-time equivalent employees by category, 2016/17

Category	Definition	2016/17
Administration and clerical	All clerical-based occupations together with patient-facing (ward) clerical support employees	1,700.6
Agency	Includes the following occupational categories: administration and clerical, medical support, hotel services, site services, medical salaried (excludes visiting medical practitioners) and medical sessional	168.4
Agency Nursing and Midwifery	Workers engaged on a 'contract for service' basis. Does not include workers employed by NurseWest	40.5
Assistants in Nursing	Support registered nurses and enrolled nurses in delivery of general patient care	36.6
Dental Clinic Assistants	Dental clinic assistants	297.8
Hotel Services	Includes catering, cleaning, stores/ supply laundry and transport occupations	760.4
Medical Salaried	All salary-based medical occupations including interns, registrars and specialist medical practitioners	1,249.7
Medical Sessional	Specialist medical practitioners that are engaged on a sessional basis	125.7
Medical Support	All allied health and scientific/ technical related occupations	2,619.7
Nursing and Midwifery	All nursing and midwifery occupations, excluding agency nurses and midwives	3,362.4
Site Services	Engineering, garden and security-based occupations	210.3
Other Occupations	Including, but not limited to, Aboriginal and Ethnic health employees	6.5
Total full-time equivalent employees		**10,578.6**

Notes:

1. Data Source: HR Data Warehouse;.data extracted on 12/07/2017.
2. Figures for 2015/16 cannot be provided because NMHS only became a separate legal entity as of 1 July 2016 (previously it was part of the MHS Board)
3. DoH employees employed under the Health Services Union award have been included in the above figures for NMHS. Paid FTE for these employees have been identified with a cost centre prefix of "011".
4. FTE is calculated as the monthly Average FTE and is the average hours worked during a period of time divided by the Award Full Time Hours for the same period. Hours include ordinary time; overtime; all leave categories; public holidays, Time Off in Lieu, Workers Compensation.
5. FTE figures provided are based on Actual (Paid) month to date FTE.

Industrial Relations

NMHS Industrial Relations Service provides advisory, representation and consultancy support in industrial relations. The Service also supports significant workforce management issues for NMHS, including PathWest and the Dental Health Service.

Major activities in 2016/17 included:

- Advocacy in matters before the Western Australian Industrial Relations Commission, Public Service Arbitrator, Public Service Appeal Board and Industrial Magistrates Court, as well as representation and management of disputes in the Western Australian Industrial Relations Commission.
- Advice to internal stakeholders in relation to industrial agreement interpretation and application as well as disciplinary, substandard performance and performance management matters.
- Negotiation of NMHS flexibility agreements.
- Coordination of responses to workplace industrial disputes.
- Liaison and negotiation with the relevant unions and associations as required.

Employee development

NMHS is committed to providing education and mandatory skills training for its employees to support the delivery of quality and safe healthcare services.

NMHS Learning and Development Department is an accredited, Registered Training Organisation and provides training to all new employees, including Accountable and Ethical Decision Making, Aboriginal Cultural Awareness, Activity Based Funding, and Management and Recordkeeping Awareness.

Each NMHS site delivers unique, specific role-related clinical and non-clinical training and education, either internal or external to the sites, and through online eLearning resources.

In 2016/17, NMHS provided a wide range of undergraduate, graduate, employee training and leadership development programs to employees.

Workers' compensation

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

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

In 2016/17, a total of 307 workers' compensation claims were made (see Table 36).

Table 36: Number of NMHS workers' compensation claims, 2016/17

Employee Category	Number
Nursing Services/Dental Clinic Assistants	154
Administration and Clerical	31
Medical Support	28
Hotel Services	66
Maintenance	21
Medical (salaried)	7
Total	**307**

Notes: For the purposes of the Annual Report, employee categories are defined as:

- Administration and clerical - administration employees and executives, ward clerks, receptionists and clerical employees
- Medical support - physiotherapists, speech pathologists, medical imaging technologists, pharmacists, occupational therapists, dietitians and social workers
- Hotel services - cleaners, caterers and patient service assistants.

For further details on the NMHS' occupational safety and health and injury management processes, please see the Occupational Safety, Health and Injury Management section of this report.

Governance Disclosures

Pecuniary Interests

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

NMHS Deputy Board Chair Rosanna Capolingua is a Board member SJGHC, which holds a contract with the State Government for the delivery of services at Midland Public Hospital via a PPP.

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

NMHS A/Executive Director Strategy and Executive Services Sylvia Meier and Executive Director Procurement, Infrastructure and Contract Management Philip Aylward are Directors of Perth Children's Hospital Foundation. The positions are voluntary, with no financial benefit.

Unauthorised use of credit cards

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

Purchasing Cards are provided to employees who require one as part of their role and are not for personal use. If a cardholder makes a personal purchase they must give written notice to the accountable authority within five working days and refund the total amount of expenditure.

Despite being made aware of obligations pertaining to the use of the cards, 31 NMHS cardholders recorded personal purchases on their Purchasing Card. The majority of these cardholders declared a personal expenditure, with $1,475.63 being refunded before the end of the reporting period, leaving an amount of $46.20 unpaid at the time of reporting (see Table 37).

Table 37: Personal use credit card expenditure by NMHS cardholders, 2016/17

Credit card personal use expenditure	Aggregated amount ($)
Personal use expenditure for the reporting period	1,522
Personal use expenditure settled by the due date (within 5 working days)	255
Personal use expenditure settled after the period (after 5 working days)	1,220
Personal use expenditure outstanding at balance date	46

Board and Committee remuneration

The total annual remuneration for each board or committee is listed as follows (see Table 38). For details of individual board or committee members please refer to Appendix C.

Table 38: Summary of State Government Boards and Committees within NMHS, 2016/17

Board / Committee Name	Total Remuneration ($)
NMHS Board	344,708
Graylands Hospital Management Team Meeting	330
KEMH Community Advisory Committee (renamed Women and Newborn Health Service Community Advisory Council)	7,830
Mirrabooka Consumer Advisory Group (ceased)	Nil
North Metropolitan Area Health Service Community Advisory Committee (ceased May 2017)	1,680
OPH Community Advisory Council	3,510
SCGH Mental Health Unity Project Working Group (ceased)	Nil
State Perinatal Mental Health Reference Group (ceased)	Nil

Other Legal Requirements

Advertising and sponsorship

In accordance with section 175Z of the *Electoral Act 1907*, NMHS incurred a total advertising expenditure of $250,675 in 2016/17 (see Table 39). A total of 75 per cent of all advertising expenditure was through the procurement of media advertising. There was no expenditure with polling and direct mail organisations.

Table 39: Summary of NMHS advertising expenditure by provider, 2016/17

Category	Provider	Amount ($)
Advertising agencies	Splash Promotion	1,750
	Lush Art	27,711
	Badge-a-mint	52
	Picton Press	29,903
	Sub-total	**59,876**
Market research organisations	Sensis	1,710
	Muka Matters	30
	Sub-total	**1,740**
Media advertising organisations	Telstra	27,249
	Adcorp	13,375
	Optimum Media Decisions (WA) Limited	144,243
	Australasian College of Physical Scientists and Engineers in Medicine	430
	Australasian Medical Publishing Co Proprietary Limited	3,762
	Sub-total	**189,059**
Total		**250,6745**

Disability Access and Inclusion Plan

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

In 2016, NMHS developed the NMHS Disability Access and Inclusion Plan (DAIP) 2017–2022. The DAIP includes overarching strategies to guide each of its hospital sites and services to ensure people with disability have the same opportunities as other people to fully access the range of health services and facilities, employment, consultation and information available in NMHS.

Access to Services

NMHS is committed to ensuring all people with disability have equitable access to all services. NMHS Intranet hub contains up-to-date event accessibility guidelines for employees to reference when planning events and/or services. Employees are guided on how to choose appropriate venues that are compliant in terms of access, parking, and transport to and from the building. Similarly, the guidelines may be referenced when planning new or existing services.

To enhance access to its services by people with disability, NMHS:

- hosted more than 65 disability services professionals and patients/carers at an International Day of People with a Disability event in November 2016
- developed a volunteer concierge service at KEMH to facilitate improved access to its services
- facilitated carers' corners throughout its hospital network, which is inclusive of people with disability
- reviewed patient forms in the KEMH Mother and Baby Unit to improve inclusion of people with disability.

Access to Facilities

NMHS is committed to improving disability access to buildings within its hospital and service network. Seventeen additional accessible parking bays were constructed at OPH, with SCGH seeing an increase of 57 new bays since the 2015/16 reporting period. The newly constructed Ralph and Patricia SNRI includes six accessible parking bays. A new accessible toilet and hand rail were installed in the Phlebotomy Service at KEMH.

Access to information

NMHS provides consumer information in alternative formats upon request. Examples include the NMHS DAIP 2017–2022 and the Public Health Ambulatory Care 'How we can help' document. The Dental Health Service provides information and resources in various formats for patients with literacy or vision difficulties upon request. All NMHS websites and intranet hubs are reviewed bi-annually to ensure content is accessible and contemporary, as well as being current.

Quality of Service

To ensure a consistent level of service is available, NMHS provides training about disability via employee orientation and in-service education. For example, as part of NMHS Disability Project, more than 800 frontline WNHS employees participated in a range of education and awareness sessions on the needs of people with disability aimed at improving their intake, admission and booking processes.

Opportunity to provide feedback

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

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

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

Participation in public consultation

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

Such participation opportunities included development of the NMHS DAIP 2017–2022, and implementation of the new DAIP eLearning package. People with disability are able to guide future activities and actions by becoming a member of the NMHS Disability Access and Inclusion Committee, various Health Service committees and Community Advisory Councils.

Opportunities to obtain and maintain employment

NMHS is committed to improving opportunities for people with disability to obtain and maintain employment. NMHS complies with the WA Health Recruitment, Selection and Appointment Policy and associated procedures to ensure recruitment and selection is undertaken in a consistent, inclusive and open and transparent manner.

Our Health Service demonstrates its commitment in this area by training and educating employees about disability, and encouraging and supporting the employment of people with disability. Employees who participate on recruitment and selection panels are offered education and training to ensure they are fully aware of relevant legislation, regulations and standards, including those that relate to the consideration of people with disability.

As part of our daily business, employees with disability are supported in the workplace through the following measures:

- Regular review of job descriptions to ensure they comply with relevant guidelines and templates, and do not unlawfully discriminate against people with disability.
  - Applying inclusive recruitment practices to ensure all employment opportunity advertisements include wording to encourage people with disability to apply, and that the advertising and recruitment processes are conducted in accordance with equal employment opportunity principles.

- Regular reviews of workplace accessibility and making necessary and timely adjustments to the work environment, as required.
- Embedding feedback obtained through the WA Health Employee Diversity survey into the workforce planning strategy.

Compliance with Public Sector Standards

All NMHS employees are required to comply with the Western Australian Public Sector Standards in Human Resource Management. 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 Recruitment Selection and Appointment Policy and Procedure
- WA Health Discipline Policy, Explanatory Notes and Template Letters
- WA Health Employee Grievance Resolution Policy
- WA Health Redeployment and Redundancy Policy
- WA Health Code of Conduct
- 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.

On-site human resource managers and consultants provide information and support to managers in the implementation of the Public Sector Standards.

Recruitment and Selection

In 2016/17, nine Breach of Standard claims were lodged regarding the recruitment, selection and appointment process, or the management process of an employee's performance. Two claims were finalised internally and seven were sent to the Public Sector Commission for review. There are no matters outstanding.

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

Grievance Resolution

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

Code of Conduct

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

NMHS informs and educates employees about their responsibilities through various online communications, eLearning and face-to-face training programs, and site-based induction programs. The Accountable and Ethical Decision Making training, as well as the Code of Conduct: Completion of the Preventing Workplace Bullying training is mandatory for all employees and is designed to communicate the expectations of workplace conduct and the process for managing breaches of conduct respectively.

Employee compliance with the Code of Conduct is monitored through our breaches of discipline internal reporting process. Under the WA Health Discipline Policy, NMHS is required to review, assess and investigate all complaints alleging non-compliance with the WA Health Code of Conduct. In 2016/17, a total of 157 matters were lodged and investigated internally.

Recordkeeping

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

NMHS Recordkeeping Plan was endorsed by the State Records Commission in 2015, and is due for review in 2020.

A review of the functional Retention and Disposal schedule for WA Health is underway. When complete, the schedule will form part of the legal authority for the disposal of NMHS records.

During 2016/17, NMHS selected HPE Records Manager as the preferred Electronic Document and Records Management System (EDRMS). Roll-out of EDRMS commenced in July 2016 following a review of existing systems and practices, with an eLearning package developed for employees.

NMHS Records Management Policy was endorsed by the Policy Co-ordination Committee in June 2017. In addition, numerous procedures and guidelines to support recordkeeping activities in all phases of the records lifecycle have been developed and these are accessible via the EDRMS, as well as the Intranet and via training sessions.

As the establishment of a formal corporate recordkeeping function is still in its early stages, a review is yet to be undertaken; however post-training feedback is incorporated into training and information dissemination.

Annual estimates

NMHS annual operational budget estimates for the following financial year are reported to the Minister for Health under Section 40 of the *FMA 2006*, and Treasurer's Instruction (TI) 953.

The annual estimates for 2017/18, as approved by the Minister for Health, are provided in Table 40.

Table 40: 2017/18 Budget Estimates for NMHS

Statement of Comprehensive Income	Note	2017/18 Estimate $000
COST OF SERVICES		
Expenses		
Employee benefits expense		1,289,481
Contracts for services		396,939
Patient support costs		296,184
Finance costs		184
Depreciation and amortisation expense		64,773
Repairs, maintenance and consumable equipment		63,546
Other supplies and services		72,244
Other expenses		74,285
Total cost of services		**2,257,635**
INCOME		
Revenue		
Patient charges		107,789
Other fees for services		59,477
Commonwealth grants and contributions		554,032
Other grants and contributions		244,291
Donation revenue		640
Interest revenue	1	-
Other revenue		72,210
Total revenue		**1,038,439**
Gains		
Loss/(Gain) on disposal of non-current assets	1	-
Gain on disposal of other assets	1	-
Total gains		**-**
Total income other than income from State Government		**1,038,439**
NET COST OF SERVICES		**1,219,196**
INCOME FROM STATE GOVERNMENT		
Services appropriation		1,155,632
Assets transferred	1	-
Services received free of charge		63,564
Royalties for Regions Fund	1	-
Total income from State Government		**1,219,196**
SURPLUS/(DEFICIT) FOR THE PERIOD		**-**
OTHER COMPREHENSIVE INCOME/(LOSS)		
Items not reclassified subsequently to profit or loss		
Changes in asset revaluation reserve	1	-
Total comprehensive loss for the period		**-**
TOTAL COMPREHENSIVE (LOSS)/INCOME FOR THE PERIOD		**-**

Statement of Financial Position	Note	2017/18 Estimate $000
ASSETS		
Current Assets		
Cash and cash equivalents		28,317
Restricted cash and cash equivalents		50,398
Inventories		6,658
Receivables		76,449
Other current assets		12,231
Total Current Assets		**17,053**
Non-current Assets		
Restricted cash and cash equivalents	2	10,600
Amounts receivable for services		760,267
Receivables		3,502
Property, plant and equipment		1,586,417
Intangible assets		4,184
Total Non-current Assets		**2,364,969**
Total Assets		**2,539,023**

Statement of Financial Position	Note	2017/18 Estimate $000
LIABILITIES		
Current Liabilities		
Payables		163,112
Provisions		263,573
Borrowings		678
Other current liabilities		910
Total Current Liabilities		**428,273**
Non-current liabilities		
Provisions		67,929
Borrowings		914
Total Non-current Liabilities		**68,843**
Total Liabilities		**497,116**
Net Assets		**2,041,907**
EQUITY		
Contributes equity		1,898,471
Reserves		143,436
Accumulated surplus	1	-
Total equity		**2,041,907**

Statement of Cash Flows	Note	2017/18 Estimate $000
CASH FLOWS FROM STATE GOVERNMENT		
Service appropriation		1,090,793
Capital appropriations		51,644
Net cash provided by State Government		**1,142,438**
Utilised as follows:		
CASH FLOWS FROM OPERATING ACTIVITIES		
Payments		
Employee benefits		(1,284,181)
Supplies and services		(839,633)
Finance costs		(118)
Receipts		
Receipts from customers		107,789
Commonwealth grants and contributions		554,032
Other grants and contributions		244,291
Interest received	1	-
Donations received		640
Other receipts		131,687
Net cash used in operating activities		**(1,085,493)**
CASH FLOWS FROM INVESTING ACTIVITIES		
Payments		
Payment for purchase of non-current physical and intangible assets		(49,072)
Receipts		
Proceeds from sale of non-current physical assets	1	-
Net cash used in investing activities		**(49,072)**

Statement of Cash Flows	Note	2017/18 Estimate $000
CASH FLOWS FROM FINANCING ACTIVITIES		
Repayment of finance lease liabilities		(2,572)
Repayment of borrowings	1	-
Repayment of other liabilities	1	-
Net cash using in financing activities		**(2,572)**
Net (decrease)/increase in cash and cash equivalents		**5,300**
Cash and cash equivalent at the beginning of the period		89,315
Cash transferred from Department of Health		-
Cash and cash equivalents transferred to other agencies	2	(5,300)
CASH AND CASH EQUIVALENTS AT THE END OF THE PERIOD		**89,315**

Notes:

1 No balance forecast at this point in time.

2 Funds held in a suspense account with the Department of Treasury for the purpose of meeting the 27th pay in a financial year that typically occurs every eleven years.

Government Policy

Substantive Equality

NMHS is committed to eliminating systemic forms of discrimination in diverse Western Australian communities, including Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse backgrounds, and other social minority groups.

NMHS embraces the principles of the WA Health Substantive Equality policy by adhering to them within its strategic, operational and associated plans. In 2016/17, NMHS contributed towards substantive equality for its employees and the population it serves through a range of initiatives, including:

- incorporating the Aboriginal Impact Statement and Declaration process in the development of new and revised policies, programs, strategies and practices
- Aboriginal Cultural awareness is mandatory training for all employees
- encouraging employees to develop Aboriginal cultural learning plans
- implementing targeted training and employment strategies for Aboriginal people to increase their representation in our workforce
- introducing scholarships and further learning opportunities to increase Aboriginal employment throughout the Health Service
- surveying its patients, stakeholders and employees to determine experience with service delivery
- actively seeking membership from people with disability, Aboriginal and Torres Strait Islander, culturally and linguistically diverse and Lesbian Gay Bisexual Transgender Queer representatives on the NMHS Partnering with Consumers Working Group, Community Advisory Council and Community Advisory Groups
- introducing an interpreter service for patients who present for specimen collection and pathology services, and providing printed instructions in multiple languages
- Continuing to participate in the National Heart Foundation of Australia's Lighthouse Hospital Project (in collaboration with the Australian Healthcare and Hospital Association). SCGH has entered Phase 3 (2017–2019), which involves implementation of a toolkit to enhance the integration of services and communication between the hospital, local community, Controlled Health Organisations, patients and communities, primary health networks and health professionals.

Government Building Contracts

NMHS is committed to complying with the Government Building Training Policy. In 2016/17, the Health Service included appropriate clauses in its tender documentation and commenced increased monitoring of compliance of in-scope building, construction or maintenance contractors for projects with a duration of greater than three months and a value of greater than $2 million.

As at 30 June 2017, no contracts subject to the Government Building Training Policy had been awarded.

Occupational Safety and Health, and Injury Management

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

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

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

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

OSH committees, comprising elected safety and health representatives and management representatives meet bi-monthly to review issues and data trends, discuss and resolve OSH-related matters. Issues may be referred to the site and NMHS Executive, if required. Local OSH groups consult with employees to facilitate early identification, discussion and resolution of issues.

An independent OSH audit of the whole of Health, commissioned by DoH Corporate Governance Directorate, was conducted by Ernst & Young in November 2014. The audit measured compliance with WA *OSH Act 1984* and the *Code of Practice: OSH in the WA Public Sector*. The report handed down in January 2015 made six recommendations, which have now been completed. The recommendations included improving access to and providing up-to-date OSH Information through the OSH intranet; review of the process for OSH training of medical practitioners; compliance by managers with positive performance OSH indicators; consideration of alternative methods for incident and hazard reporting; a review of the approach to managing aggression and violence; and changes to manual handling training following an extensive review by OSH in conjunction with Learning and Development Department.

In addition, OSH systems audits against AS/NZS 4801:2001 - OHS Management Systems and OHS AS18001:2007 - OHS Management were conducted by external auditors for each NMHS service in 2013/14. All recommendations from these audits have been assessed and implemented where reasonably practicable. An internal audit of injury management practices was conducted 2016/17, of which the recommendations will be reviewed and implemented at a local level, if deemed relevant.

Occupational safety and health assessment and performance indicators

The occupational safety and health assessment and performance indicators are summarised in Table 41.

Table 41: Occupational safety and health assessment and performance indicators, 2016/17

Indicator	Target	Actual	Comment
Number of fatalities	0	0	Target achieved
Lost time injury/disease (LTI/D) incidence rate (per 100)	0 or 10% reduction (2.47)	2.33	Target achieved
Lost time injury severity rate	0 or 10% reduction (28.19)	32.5	Target not achieved
Percentage of injured workers returned to work within 13 weeks	Greater than or equal to 80% return to work within 26 weeks	61%	Target not achieved
Percentage of injured workers returned to work within 26 weeks	Greater than or equal to 80% return to work within 26 weeks	78%	Target not achieved
Percentage of managers and supervisors trained in occupational safety, health and injury management responsibilities	Greater than or equal to 80%	85%	Target achieved

Certification of Financial Statements

Certification of Financial Statements for the year ended 30 June 2017.

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 represent fairly the financial transactions for the financial year ending 30 June 2017 and financial position as at 30 June 2017.

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.

Alain St. Flour
Chief Finance Officer
North Metropolitan Health Service

Date 26 September 2017

Wayne Salvage
Chief Executive Officer
North Metropolitan Health Service

Date 26 September 2017

Graham McHarrie
Board Member
North Metropolitan Health Service

Date 26 September 2017

Professor Bryant Stokes AM
Board Chair
North Metropolitan Health Service

Date 26 September 17

Statement of Comprehensive Income

For the year ended 30 June 2017

	Note	2017 $000
COST OF SERVICES		
Expenses		
Employee benefits expense	7	1,356,459
Contracts for services	8	429,812
Patient support costs	9	325,982
Finance costs	10	596
Depreciation and amortisation expense	11	61,869
Loss on disposal of non-current assets	12	393
Repairs, maintenance and consumable equipment	13	49,459
Other supplies and services	14	78,729
Other expenses	15	101,949
Total cost of services		**2,405,248**
INCOME		
Revenue		
Patient charges	16	113,784
Other fee for services	17	184,813
Commonwealth grants and contributions	18(i)	619,939
Other grants and contributions	18(ii)	179,495
Donation revenue		1,014
Interest revenue		587
Other revenue	19	21,204
Total revenue		1,120,836
Total income other than income from State Government		**1,120,836**
NET COST OF SERVICES*		**1,284,412**
INCOME FROM STATE GOVERNMENT		
Service appropriations	20	1,271,598
Assets (transferred)/assumed	21	(64)
Services received free of charge	22	65,617
Royalties for Regions Fund	23	139
Total income from State Government		**1,337,290**
SURPLUS FOR THE PERIOD		**52,878**
OTHER COMPREHENSIVE INCOME/(LOSS)		
Items not reclassified subsequently to profit or loss		
Changes in asset revaluation reserve	39	143,436
Total other comprehensive income / (loss)		143,436
TOTAL COMPREHENSIVE INCOME (LOSS) FOR THE PERIOD		**196,314**

Refer also to note 58 'Schedule of Income and Expenses by Service'.

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

Statement of Financial Position

As at 30 June 2017

	Note	2017 $000
ASSETS		
Current Assets		
Cash and cash equivalents	24	33,617
Restricted cash and cash equivalents	25	50,398
Receivables	26	63,964
Inventories	28	6,658
Other assets	29	12,231
Total Current Assets		**166,868**
Non-Current Assets		
Restricted cash and cash equivalents	25	5,300
Amounts receivable for services	27	695,494
Receivables	26	3,502
Property, plant and equipment	30	1,604,097
Intangible assets	32	6,222
Total Non-Current Assets		**2,314,615**
Total Assets		**2,481,483**

	Note	2017 $000
LIABILITIES		
Current Liabilities		
Payables	34	153,551
Borrowings	35	3,315
Provisions	36	263,573
Other current liabilities	37	980
Total Current Liabilities		421,419
Non-Current Liabilities		
Borrowings	35	1,593
Provisions	36	67,929
Total Non-Current Liabilities		69,522
Total Liabilities		**490,941**
NET ASSETS		**1,990,542**
EQUITY		
Contributed equity	38	1,794,228
Reserves	39	143,436
Accumulated Surplus	40	52,878
TOTAL EQUITY		**1,990,542**

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

Statement of Changes in Equity

For the year ended 30 June 2017

	Note	2017 $000
CONTRIBUTED EQUITY	38	
Balance at start of period		-
Transactions with owners in their capacity as owners:		
Capital appropriations		29,923
Other contributions by owners		1,787,465
Distributions to owners		(23,160)
Balance at end of period		1,794,228
RESERVES	39	
Asset Revaluation Reserve		
Balance at start of period		-
Other comprehensive income/loss for the period		143,436
Balance at end of period		143,436
ACCUMULATED SURPLUS	40	
Balance at start of period		-
Surplus for the period		52,878
Balance at end of period		52,878
TOTAL EQUITY		
Balance at start of period		-
Total comprehensive income/(loss) for the period		196,314
Transactions with owners in their capacity as owners		1,794,228
Balance at end of period		**1,990,542**

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

Statement of Cash Flows

For the year ended 30 June 2017

	Note	2017 $000 Inflows (Outflows)
CASH FLOWS FROM STATE GOVERNMENT		
Service appropriations		1,194,242
Capital appropriations		29,213
Royalties for Regions Fund		139
Net cash provided by State Government	41	**1,223,594**
Utilised as follows:		
CASH FLOWS FROM OPERATION ACTIVITIES		
Payments		
Employee benefits		(1,340,870)
Supplies and services		(933,650)
Finance costs		(511)
Receipts		
Receipts from customers		109,494
Commonwealth grants and contributions		619,939
Other grants and contributions		179,495
Donations received		976
Interest received		536
Other receipts		213,356
Net cash used in operating activities	41	**(1,151,235)**
CASH FLOWS FROM INVESTING ACTIVITIES		
Payments		
Payment for purchase of non-current physical and intangible assets		(52,761)
Receipts		
Proceeds from sale of non-current physical assets		162
Net cash used in investing activities		**(52,599)**
CASH FLOWS FROM FINANCING ACTIVITIES		
Payments		
Repayment of finance lease liabilities		(4,513)
Net cash used in financing activities		**(4,513)**
Net increase in cash and cash equivalents		15,247
Cash and cash equivalents transferred from abolished agency		74,068
CASH AND CASH EQUIVALENTS AT THE END OF PERIOD	41	**89,315**

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

Notes to the Financial Statements

For the year ended 30 June 2017

Note 1 Australian Accounting Standards

General

The Health Service's financial statements for the year ended 30 June 2017 have been prepared in accordance with Australian Accounting Standards. The term 'Australian Accounting Standards' includes Standards and Interpretations issued by the Australian Accounting Standards Board (AASB).

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

Early adoption of standards

The Health Service cannot early adopt an Australian Accounting Standard unless specifically permitted by TI's1101 '*Application of Australian Accounting Standards and Other Pronouncements*'. There has been no early adoption of any Australian Accounting Standards that have been issued or amended (but not operative) by the Health Service for the annual reporting period ended 30 June 2017.

Note 2 Summary of significant accounting policies

(a) General statement

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

The *FMA 2006* and the TI's impose legislative provisions that govern the preparation of financial statements and take precedence over the Australian Accounting Standards, the Framework, Statements of Accounting Concepts and other authoritative pronouncements of the AASB.

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.

Note 2 Summary of significant accounting policies (continued)

(b) Basis of preparation

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

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

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

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

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

(c) 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.

See also note 38 'Contributed equity'.

(d) Income

Revenue recognition

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

Sale of goods

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

Note 2 Summary of significant accounting policies (continued)

(d) Income (continued)

Provision of services

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

Interest

Revenue is recognised as the interest accrues.

Service Appropriations

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

See also note 20 ‘Service appropriations’ for further information.

Grants, donations, gifts and other non-reciprocal contributions

Revenue is recognised at fair value when the Health Service obtains control over the assets comprising the contributions, usually when cash is received.

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

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

Gains

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

(e) Borrowing costs

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

(f) Property, plant and equipment

Capitalisation/expensing of assets

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

Initial recognition and measurement

Property, plant and equipment are initially recognised at cost.

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

Note 2 Summary of significant accounting policies (continued)

(f) Property, plant and equipment (continued)

Subsequent measurement

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

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

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

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

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

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

See also note 30 'Property, plant and equipment and note 31 'Fair value measurement' for further information on revaluation'.

De-recognition

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

Asset revaluation reserve

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

Note 2 Summary of significant accounting policies (continued)

(f) Property, plant and equipment (continued)

Depreciation

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

In order to apply this policy, the following methods are utilised:

- Land - not depreciated
- Buildings - straight line
- Site infrastructure - straight line
- Plant and equipment - straight line

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

Buildings	50 years
Site infrastructure	50 years
Leasehold improvements	Term of the lease
Computer equipment	4 to 10 years
Furniture and fittings	5 to 20 years
Motor vehicles	4 to 7 years
Medical equipment	3 to 25 years
Other plant and equipment	3 to 50 years

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

(g) Intangible assets

Capitalisation/expensing of assets

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

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

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

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

Estimated useful life of an intangible asset is:

Computer software	5 years

Note 2 Summary of significant accounting policies (continued)

(g) Intangible assets (continued)

Computer software

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

(h) Impairment of assets

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

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

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

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

See also note 33 'Impairment of assets' for the outcome of impairment reviews and testing. Refer also to note 2(p) 'Receivables' and note 26 'Receivables' for impairment of receivables.

Note 2 Summary of significant accounting policies (continued)

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

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

(j) Leases

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

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

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

(k) Financial instruments

In addition to cash, the Health Service has two categories of financial instrument:

- Loans and receivables; and
- Financial liabilities measured at amortised cost.

Financial instruments have been disaggregated into the following classes

Financial assets:

- Cash and cash equivalents
- Restricted cash and cash equivalents
- Receivables
- Amounts receivable for services

Financial liabilities

- Payables
- Department of Treasury loans
- Finance lease liabilities

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

Note 2 Summary of significant accounting policies (continued)

(k) Financial instruments (continued)

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

(l) Cash and cash equivalents

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

(m) Accrued salaries

Accrued salaries (see note 34 'Payables') represent the amount due to employees but unpaid at the end of the financial year, as the pay date for the last pay period for that financial year does not coincide with the end of the financial year. Accrued salaries are settled within a fortnight of the financial year end. The Health Service considers the carrying amount of accrued salaries to be equivalent to its fair value.

(n) Amounts receivable for services (holding account)

The Health Service receives service appropriation funding from the State Government partly in cash and partly as an asset (holding account receivable). The holding account receivable balance is accessible on the emergence of the cash funding requirement to cover leave entitlements and asset replacement.

See also note 20 'Service appropriations' and note 27 'Amounts receivable for services'.

(o) Inventories

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

Inventories not held for resale are measured at cost unless they are no longer required, in which case they are measured at net realisable value (See note 28 ' Inventories').

(p) Receivables

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

See also note 2(k) ‘Financial Instruments’ and note 26 ‘Receivables’.

Note 2 Summary of significant accounting policies (continued)

(p) Receivables (continued)

Accounting procedure for Goods and Services Tax

Rights to collect amounts receivable from the Australian Taxation Office (ATO) and responsibilities to make payments for GST have been assigned to the DoH. This accounting procedure was a result of application of the grouping provisions of "*A New Tax System (Goods and Services Tax) Act 1999*" whereby the DoH became the Nominated Group Representative (NGR) for the GST Group. The entities in the GST group include DoH, Mental Health Commission, North Metropolitan Health Service, East Metropolitan Health Service, South Metropolitan Health Service, Child and Adolescent Health Service, Health Support Services, WA Country Health Service, QE II Medical Centre Trust, and Health and Disability Services Complaints Office.

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

(q) Payables

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

See also note 2(k) 'Financial instruments' and note 34 'Payables'.

(r) Borrowings

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

See also note 2(k) 'Financial instruments' and note 35 'Borrowings'.

(s) Provisions

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

See also note 36 'Provisions'.

Provisions - employee benefits

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

Annual leave and time off in lieu leave

Annual leave and time off in lieu leave are not expected to be settled wholly within 12 months after the end of the reporting period and is therefore considered to be 'other long-term

Note 2 Summary of significant accounting policies (continued)

(s) Provisions (continued)

employee benefits'. The annual leave liability and time off in lieu leave liability are recognised and measured at the present value of amounts expected to be paid when the liabilities are settled using the remuneration rate expected to apply at the time of settlement.

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

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

Long service leave

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

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

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

Sick leave

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

Note 2 Summary of significant accounting policies (continued)

(s) Provisions (continued)

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

Deferred salary scheme

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

Superannuation

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

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

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

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

Note 2 Summary of significant accounting policies (continued)

(s) Provisions (continued)

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

GESB makes all benefit payments in respect of the Pension Scheme and GSS transfer benefits, and recoups from the Treasurer the employer's share.

See also note 2(t) 'Superannuation expense'.

Employment on-costs

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

See also note 15 'Other expenses' and note 36 'Provisions'.

(t) Superannuation expense

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

(u) Services received free of charge or for nominal cost

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

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

(v) Assets transferred between government agencies

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

Note 2 Summary of significant accounting policies (continued)

(w) Comparative figures

No comparative figures, this is the first set of financial statements prepared by Health Service under the new *Health Services Act 2016 (WA)*.

(x) Trust accounts

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

Details of Trust Accounts are reported as a note to the financial statements (refer to note 54).

Note 3 Judgements made by management in applying accounting policies

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

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

Buildings

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

Note 4 Key sources of estimation uncertainty

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

Buildings

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

Employee benefits provision

In estimating the non-current long service leave liabilities, employees are assumed to leave the Health Service each year on account of resignation or retirement at 7.5% (turnover rate). Employees with leave benefits to which they are fully entitled are assumed to take all available leave uniformly over the following five years or to age 65 if earlier.

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

Note 5 Disclosure of changes in accounting policy and estimates

Initial application of an Australian Accounting Standard

The Health Service has applied the following Australian Accounting Standards effective for annual reporting periods beginning on or after 1 July 2016 that impacted on the Health Service.

AASB 1057	*Application of Australian Accounting Standards* This Standard lists the application paragraphs for each other Standard (and Interpretation), grouped where they are the same. There is no financial impact.
AASB 2014-4	*Amendments to Australian Accounting Standards - Clarification of Acceptable Methods of Depreciation and Amortisation* [AASB 116 & 138] The adoption of this Standard has no financial impact for the Health Service as depreciation and amortisation is not determined by reference to revenue generation, but by reference to consumption of future economic benefits.
AASB 2015-1	*Amendments to Australian Accounting Standards - Annual Improvements to Australian Accounting Standards 2012–2014 Cycle* (AASB 1, 2, 3, 5, 7, 11, 110, 119, 121, 133, 134, 137 & 140) These amendments arise from the issuance of International Financial Reporting Standard Annual Improvements to IFRSs 2012–2014 Cycle in September 2014, and editorial corrections. The Health Service has determined that the application of the Standard has no financial impact.

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

AASB 2015-2	*Amendments to Australian Accounting Standards - Disclosure Initiative: Amendments to AASB 101 (AASB 7, 101, 134 & 1049).* This Standard amends AASB 101 to provide clarification regarding the disclosure requirements in AASB 101. Specifically, the Standard proposes narrow-focus amendments to address some of the concerns expressed about existing presentation and disclosure requirements and to ensure entities are able to use judgement when applying a Standard in determining what information to disclose in their financial statements. There is no financial impact.
AASB 2015-6	*Amendments to Australian Accounting Standards - Extending Related Party Disclosures to Not-for-Profit Public Sector Entities (AASB 10, 124 & 1049).* The amendments extend the scope of AASB 124 to include application by not-for-profit public sector entities. Implementation guidance is included to assist application of the Standard by not-for-profit public sector entities. There is no financial impact
AASB 2015-7	*Amendments to Australian Accounting Standards - Fair value Disclosures of Not-for-Profit Public Sector Entities (AASB 13).* This Standard relieves not-for-profit public sector entities from the reporting burden associated with various disclosures required by AASB 13 for assets within the scope of AASB 116 that are held primarily for their current service potential rather than to generate future net cash inflows. It has no financial impact.

Future impact of Australian Accounting Standards not yet operative

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

Title		Operative for reporting periods beginning on/after
AASB 9	*Financial Instruments* This Standard supersedes AASB 139 *Financial Instruments: Recognition and Measurement*, introducing a number of changes to accounting treatments The mandatory application date of this Standard is currently 1 January 2018 after being amended by AASB 2012-6, AASB 2013-9 and AASB 2014-1 *Amendments to Australian Accounting Standards*. The Health Service has not yet determined the application or the potential impact of the Standard.	1 Jan 2018

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

AASB 15	*Revenue from Contracts with Customers* This Standard establishes the principles that the Health Service shall apply to report useful information to users of financial statements about the nature, amount, timing and uncertainty of revenue and cash flows arising from a contract with a customer. The Health Service's 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 and contribution revenues, the Health Service has not yet determined the potential impact of the Standard. In broad terms, it is anticipated that the terms and conditions attached to these revenues will defer revenue recognition until the Health Service has discharged its performance obligations.	1 Jan 2019
AASB 16	*Leases* This Standard introduces a single lessee accounting model and requires a lessee to recognise assets and liabilities for all leases with a term of more than 12 months, unless the underlying asset is of low value. The Health Service has not yet determined the application or the potential impact of the Standard. Whilst the impact of AASB 16 has not yet been quantified, the entity currently has operating lease commitments for $12.373 million. The worth of non-cancellable operating leases that the Health Service anticipates most of this amount will be brought onto the statement of financial position, excepting amounts pertinent to short-term or low value leases. Interest and amortisation expenses will increase and rental expense will decrease.	1 Jan 2019
AASB 1058	*Income for Not-for-Profit-Entities* This Standard clarifies and simplifies the income recognition requirements that apply to not-for-profit (NFP) entities, more closely reflecting the economic reality of NFP entity transactions that are not contracts with customers. Timing of income recognition is dependent on whether such a transaction gives rise to a liability, a performance obligation (a promise to transfer a good or service), or, an obligation to acquire an asset. The Health Service has not yet determined the application or the potential impact of the Standard.	1 Jan 2019
AASB 2010-7	*Amendments to Australian Accounting Standards arising from AASB 9 (December 2010) [AASB 1, 3, 4, 5, 7, 101, 102, 108, 112, 118, 120, 121, 127, 128, 131, 132,136, 137, 139, 1023 & 1038 and Int 2, 5, 10, 12, 19 & 127]* This Standard makes consequential amendments to other Australian Accounting Standards and Interpretations as a result of issuing AASB 9 in December 2010. The mandatory application date of this Standard has been amended by AASB 2012- 6 and AASB 2014-1 to 1 January 2018. The Health Service has not yet determined the application or the potential impact of the Standard.	1 Jan 2018

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

AASB 2014-1	*Amendments to Australian Accounting Standards.* Part E of this standard makes amendments to AASB 9 and consequential amendments to other Standards. It has not yet been assessed by the Health Service to determine the application or potential impact of the Standard.	1 Jan 2018
AASB 2014-5	*Amendments to Australian Accounting Standards arising from AASB 15.* This Standard gives effect to the consequential amendments to Australian Accounting Standards (including Interpretations) arising from the issuance of AASB 15. The Health Service has not yet determined the application or the potential impact of the Standard.	1 Jan 2018
AASB 2014-5	*Amendments to Australian Accounting Standards arising from AASB 9 (December 2014).* This Standard gives effect to the consequential amendments to Australian Accounting Standards (including Interpretations) arising from the issuance of AASB 9 (December 2014). The Health Service has not yet determined the application or the potential impact of the Standard.	1 Jan 2018
AASB 2015-8	*Amendments to Australian Accounting Standards - Effective Date of AASB 15.* This Standard amends the mandatory effective date (application date) of AASB 15 Revenue from Contracts with Customers so that AASB 15 is required to be applied for annual reporting periods beginning on or after 1 January 2018 instead of 1 January 2017. For Not-for-Profit entities, the mandatory effective date has subsequently been amended to 1 January 2019 by AASB 2016-7. The Health Service has not yet determined the application or the potential impact of AASB 15.	1 Jan 2019
AASB 2016-2	*Amendments to Australian Accounting Standards - Disclosure Initiative: Amendments to AASB 107.* This Standard amends AASB 107 S*tatement of Cash Flows* (August 2015) to require disclosures that enable users of financial statements to evaluate changes in liabilities arising from financing activities, including both changes arising from cash flows and non-cash changes. There is no financial impact.	1 Jan 2017
AASB 2016-3	*Amendments to Australian Accounting Standards - Clarifications to AASB 15.* This Standard clarifies identifying performance obligations, principal versus agent considerations, timing of recognising revenue from granting a licence, and, provides further transitional provisions to AASB 15. The Health Service has not yet determined the application or the potential impact.	1 Jan 2018

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

AASB 2016-4	*Amendments to Australian Accounting Standards - Recoverable Amount of Non-Cash-Generating Specialised Assets of Not-for-Profit Entities.* This Standard clarifies that the recoverable amount of primarily non-cash-generating assets of not-for-profit entities, which are typically specialised in nature and held for continuing use of their service capacity, is expected to be materially the same as fair value determined under AASB 13 *Fair Value Measurement*. The Health Service has not yet determined the application or the potential impact.	1 Jan 2017
AASB 2016-7	*Amendments to Australian Accounting Standards - Deferral of AASB 15 for Not-for-Profit Entities.* This Standard amends the mandatory effective date (application date) of AASB 15 and defers the consequential amendments that were originally set out in AASB 2014-5 Amendments to Australian Accounting Standards arising from AASB 15 for not-for-profit entities to annual reporting periods beginning on or after 1 January 2019, instead of 1 January 2018. There is no financial impact.	1 Jan 2017
AASB 2016-8	*Amendments to Australian Accounting Standards - Australian Implementation Guidance for Not-for-Profit Entities.* This Standard inserts Australian requirements and authoritative implementation guidance for not-for-profit entities into AASB 9 and AASB 15. This guidance assists not-for-profit entities in applying those Standards to particular transactions and other events. There is no financial impact.	1 Jan 2019

Note 6 Services of the Health Service

Information about the NMHS' services and the expenses and revenues which are reliably attributable to those services are set out in note 59. The key services of the Health Service are:

Public hospital admitted patient

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

Home-based hospital programs

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

Note 6 Services of the Health Service (continued)

Emergency Department

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

Public hospital non-admitted patients

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

Prevention, promotion and protection

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

Dental Health

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

Mental Health

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

Note 7 Employee benefits expense

	2017 $000
Salaries and wages (a)	1,241,650
Superannuation - defined contribution plans (b)	114,809
	1,356,459

(a) Includes the value of fringe benefits to employees plus the fringe benefits tax component and the value of superannuation contribution of leave entitlements.

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

Employment on-costs expenses (workers' compensation insurance) are included at note 15 'Other expenses'.

Note 8 Contracts for services

Public patients services (a)	377,480
MH	24,312
Other aged care services	14,616
Other contracts	13,404
	429,812

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

Note 9 Patient support costs

	2017 $000
Medical supplies and services	263,497
Domestic charges	18,307
Fees for visiting medical practitioners	13,880
Fuel, light and power	11,067
Food supplies	8,405
Patient transport costs	2,637
Research, development and other grants	8,189
	325,982

Note 10 Finance costs

Finance lease charges	511
Interest expense	85
	596

Note 11 Depreciation and amortisation expense

	2017 $000
Depreciation	
Buildings	36,056
Site Infrastructure	4,405
Leasehold improvements	579
Computer equipment	171
Furniture and fittings	665
Motor vehicles	60
Medical equipment	15,851
Other plant and equipment	3,936
	61,723
Amortisation	
Computer software	146
	61,869

Note 12 Loss/(Gain) on disposal of non-current assets

Carrying amount of non-current assets disposed	
Property, plant and equipment	555
Proceeds from disposal of non-current assets	
Property, plant and equipment	(162)
Net loss/(gain)	393

See note 30 ‘Property, plant and equipment’

Note 13 Repairs, maintenance and consumable equipment

	2017 $000
Repairs and maintenance	37,643
Consumable equipment	11,816
	49,459

Note 14 Other supplies and services

Sanitisation and waste removal services	2,516
Administration and management services	2,491
Interpreter services	1,977
Security services	749
Services provided by HSS	
Information, communication and technology (ICT) services	35,872
Supply chain services	10,766
Financial services	5,733
Human resource services	13,222
Other	5,403
	78,729

Note 15 Other expenses

	2017 $000
Communications	4,567
Computer services	3,395
Workers' Compensation insurance	20,030
Operating lease expenses	10,536
Other insurances	15,402
Consultancy fees	4,638
Other employee related expenses	8,410
Printing and stationery	5,453
Doubtful debts expense	5,168
Freight and cartage	3,571
Periodical subscription	2,928
Write-down of assets (a)	9,478
Motor vehicle expenses	1,549
Other	6,824
	101,949

(a) See note 30 'Property, plant and equipment' and note 32 'Intangible assets'.

Note 16 Patient charges

	2017 $000
Inpatient bed charges	45,060
Inpatient other charges	6,357
Outpatient charges	16,613
Pathology services to patients	45,754
	113,784

Note 17 Other fees for services

Recoveries from the Pharmaceutical Benefits Scheme (PBS)	72,108
Clinical services to other health organisations	8,581
Non-clinical services to other health organisations	7,547
Pathology provided to other health services and other government agencies (a)	96,337
Other	240
	184,813

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

Note 18 Grants and contributions

i) Commonwealth grants and contributions

	2017 $000
Capital Grants	
Project funded under the National Partnership Agreement	3,318
Other	78
Recurrent Grants	
National Health Reform Agreement (funding via DoH) (a)	506,121
National Health Reform Agreement (funding via Mental Health Commission) (a)	64,346
Other	46,076
	619,939

ii) Other grants and contributions

Mental Health Commission - service delivery agreement	168,952
Mental Health Commission - other	1,724
Disability Services Commission - community aids & equipment program	1,075
Other	7,744
	179,495

(a) Activity based funding and block grant funding is 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 DoH and Mental Health Commission

Note 19 Other revenue

	2017 $000
Use of hospital facilities	6,186
Rent from commercial properties	1,791
Rent from residential properties	728
Boarders' accommodation	1,198
RiskCover insurance premium rebate	2,579
Sale of radiopharmacies	1,311
Parking	2,613
Abatements	471
Other	4,327
	21,204

Note 20 Service appropriations

Appropriation revenue received during the period:	
Service appropriations (funding via the DoH)	1,271,598

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

Note 21 Assets (transferred)/assumed

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

	2017 $000
• Transfer of equipment to the DoH	(7)
• Transfer of medical equipment to WACHS	(33)
• Transfer of equipment to EMHS	(24)
• Transfer of medical equipment to CAHS	(14)
• Transfer of equipment from the QEII Medical Centre Trust	14
	(64)

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

Note 22 Services received free of charge

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

	2017 $000
Department of Finance - government-leased accommodation	24
Services received from HSS	
Information, communication and technology (ICT) services	35,872
Supply chain services	10,766
Financial services	5,733
Human resource services	13,222
	65,617

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

Note 23 Royalties for Regions Fund

Regional Community Services Account	139
	139

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

Note 24 Cash and cash equivalents

Current	33,617

Note 25 Restricted cash and cash equivalents

	2017 $000
Current	
Other capital grants from the Commonwealth Governments	3,554
Restricted cash assets held for other specific purposes (a)	46,720
Mental Health Commission Funding (b)	124
	50,398
Non-Current	
Accrued salaries suspense account (c)	5,300
	55,698

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

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

(b) See Note 55 'Special purpose accounts'.

(c) Funds held in the suspense account at the Department of Treasury will be used only for the purpose of meeting the 27th pay in a financial year that occurs every 11 years.

Note 26 Receivables

	2017 $000
Current	
Patient fee debtors	53,779
Other receivables	15,280
Less: Allowance for impairment of receivables	(27,511)
Accrued revenue	15,079
GST receivables	7,337
	63,964
Non-Current	
Other receivables	3,502
	3,502

Reconciliation of changes in the allowance for impairment of receivables:

Transfer from abolished agency	22,671
Doubtful debts expense (note 15)	5,168
Amounts written off during the period	(349)
Amount recovered during the period	21
Balance at end of period	27,511

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

See also note 2(p) 'Receivables' and note 57 'Financial instruments'.

Note 27 Amounts receivable for services (Holding Account)

	2017 $000
Non-Current	695,494

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

Amounts receivable for services associated with St John of God Midland Public Hospital ($8.920 million) were transferred to EMHS in 2016/17. See also Note 38 (e) 'Contributed equity' for further information on the transfer.

Note 28 Inventories

Current	
Pharmaceutical stores - at cost	5,926
Engineering stores - at cost	732
	6,658

See also note 2(o) 'Inventories'.

Note 29 Other assets

Current	
Pre-payments	2,793
Other	9,438
	12,231

Note 30 Property, plant and equipment

	2017 $000
Land (a) (b)	**267,966**
Buildings	
Clinical	
At fair value (a)(b)	1,021,159
Accumulated depreciation	-
	1,021,159
Site Infrastructure	
At cost	136,669
Accumulated depreciation	(4,405)
	132,264
Total land and buildings	1,421,389
Leasehold improvements	
At cost	2,265
Accumulated depreciation	(580)
	1,685
Computer equipment	
At cost	766
Accumulated depreciation	(171)
	595
Furniture and fittings	
At cost	7,020
Accumulated depreciation	(665)
	6,355
Motor vehicles	
At cost	199
Accumulated depreciation	(60)
	139

Note 30 Property, plant and equipment (continued)

	2017 $000
Medical equipment	
At cost	104,221
Accumulated depreciation	(15,851)
	88,370
Other plant and equipment	
At cost	74,460
Accumulated depreciation	(3,936)
	70,524
Works in progress	
Buildings under construction (at cost)	14,066
Other works in progress (at cost)	642
	14,708
Artworks	
At cost	332
Total property, plant and equipment	1,604,097

a) Land and buildings were revalued as at 1 July 2016 by the Western Australian Land Information Authority (Valuation Services). The valuations were performed during the year ended 30 June 2017 and recognised at 30 June 2017. In undertaking the revaluation, fair value was determined by reference to market values for land: $18.334 million and buildings: $0.819 million. For the remaining balance, fair value of buildings was determined on the basis of depreciated replacement cost and fair value of land was determined on the basis of comparison with market evidence for land with low level utility (high restricted use land). See also note 2(f) 'Property, plant and equipment'.

b) Information on fair value measurements is provided in Note 31 ‘Fair Value Measurements’.

Reconciliations

Reconciliations of the carrying amounts of property, plant and equipment at the beginning and end of the reporting period are set out as follows:

	2017 $000
Land	
Transfers from abolished agency	280,490
Transfers to other reporting entities	(13,200)
Revaluation increments/(decrements)	676
Carrying amount at end of period	267,966
Building	
Transfers from abolished agency	920,090
Additions	6,234
Transfers from works in progress	39,891
Revaluation increments/(decrements)	142,760
Depreciation	(36,056)
Transfers between asset classes	(51,760)
Carrying amount at end of period	1,021,159
Site infrastructure	
Transfers from abolished agency	76,509
Additions	7,113
Transfers from works in progress	1,287
Depreciation	(4,405)
Transfers between asset classes	51,760
Carrying amount at end of period	132,264
Leasehold improvements	
Transfers from abolished agency	1,664
Additions	601
Depreciation	(580)
Carrying amount at end of period	1,685
Computer equipment	
Transfers from abolished agency	678
Additions	183
Disposals	(6)
Depreciation	(171)

Note 30 Property, plant and equipment (continued)

	2017 $000
Write-down of assets	(89)
Carrying amount at end of period	595
Furniture and fittings	
Transfers from abolished agency	7,680
Additions	358
Depreciation	(665)
Write-down of assets	(1,018)
Carrying amount at end of period	6,355
Motor vehicles	
Transfers from abolished agency	34
Additions	168
Depreciation	(60)
Write-down of assets	(3)
Carrying amount at end of period	139
Medical equipment	
Transfers from abolished agency	86,510
Additions	23,898
Transfers from works in progress	512
Transfers from/(to) other reporting entities	(46)
Disposals	(549)
Depreciation	(15,851)
Write-down of assets	(6,104)
Carrying amount at end of period	88,370
Other plant and equipment	
Transfers from abolished agency	72,276
Additions	3,560
Transfers from works in progress	128
Transfers from/(to) other reporting entities	(178)
Depreciation	(3,936)
Transfers between asset classes	221
Write-down of assets	(1,547)
Carrying amount at end of period	70,524
Works in progress	
Transfers from abolished agency	53,931
Additions	6,650
Transfers between asset classes	18
Capitalised to asset classes	(41,817)
Write-down of assets	(4,074)
Carrying amount at end of period	14,708
Artworks	
Transfers from abolished agency	240
Additions	92
Carrying amount at end of period	332
Total property, plant and equipment	
Transfers from abolished agency (c)	1,500,102
Additions	48,858
Transfers between asset classes	239
Disposals	(555)
Transfers from/(to) other reporting entities	(13,424)
Revaluation increments/(decrements)	143.436
Depreciation	(61,723)
Write-down of assets (d)	(12,836)
Carrying amount at end of period	1,604,097

c) Information on transfers from abolished agency is provided under Note 38 'Contributed equity'.

d) The write-down of assets comprised $9.478 million recognised in other expense (Note 15) and $2.856 million adjustments to contributed equity (Note 38).

Note 31 Fair value measurements

a) Fair value hierarchy

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

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

The following table represents the Health Service's assets measured and recognised at fair value at 30 June 2017.

	Level 1 $000	Level 2 $000	Level 3 $000	Total $000
Land				
Residential	-	64		64
Specialised	-	18,270	249,632	267,902
Buildings				
Residential and commercial car park	-	59	9,818	9,877
Specialised	-	760	1,010,522	1,011,282
		19,153	1,269,972	1,289,125

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

The Health Service obtains independent valuations of land and buildings from the Western Australian Land Information Authority (Landgate Valuation Services) annually. Two principal valuation techniques are applied to the measurement of fair values:

Market approach (comparable sales)

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

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

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

Note 31 Fair value measurements (continued)

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

Cost approach

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

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

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

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

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

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

a) review and update of the 'as-constructed' drawing documentation;

b) categorisation of the drawings using the Building Utilisation Categories (BUCs) that designate the functional areas typically provided by the following types of clinical facilities. Each BUC has different cost rates which are calculated from the historical construction costs of similar clinical facilities and are adjusted for the year-to-year change in building costs using building cost index.

Note 31 Fair value measurements (continued)

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

- Nursing posts and medical centres
- Metropolitan secondary hospitals
- Tertiary hospital

c) measurement of the general floor areas;

d) application of the BUC cost rates per square metre of general floor areas;

e) application of the applicable regional cost indices, which are used throughout the construction industry to estimate the additional costs associated with building construction in locations outside of the Perth area.

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

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

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

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

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

The following table represents the changes in level 3 items for the period ended 30 June 2017:

2017	Land $000	Buildings $000
Fair value of balance transferred from abolished agency	249,632	919,170
Additions and transfers from work in progress	-	46,126
Revaluation increments/ (decrements)	-	142,842
Transfer from/(to) other asset class	-	(51,760)
Depreciation	-	(36,038)
Fair value at end of period	249,632	1,020,340

Note 31 Fair value measurements (continued)

d) Valuation processes

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

Note 32 Intangible assets

	2017 $000
Computer software	
At cost	355
Accumulated amortisation	(145)
Works in progress	210
Computer software under development (at cost)	6,012
Total intangible assets	6,222

Reconciliations

Reconciliations of the carrying amount of intangible assets at the beginning and end of the reporting period are set out as follows:

	2017 $000
Computer equipment	
Transfers from abolished agency	526
Additions	53
Write-down of assets	(2)
Amortisation expense	(146)
Transfers between asset classes	(221)
Carrying amount at end of period	210
Works in progress	
Transfers from abolished agency	-
Additions	6,030
Transfers between asset classes	(18)
Carrying amount at end of period	6,012
Total intangible assets	
Transfers from abolished agency (a)	526
Additions	6,083
Write-down of assets (b)	(2)
Amortisation expense	(146)
Transfers between asset classes	(239)
Carrying amount at end of period	6,222

a) Information on transfers from abolished agency is provided under Note 38 'Contributed equity'.

b) Works in progress capitalised in prior years but expensed in the current financial year. Refer to note 15 'Other expenses'.

Note 33 Impairment of assets

There were no indications of impairment to property, plant and equipment and intangible assets at 30 June 2017.

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

Note 34 Payables

	2017 $000
Current	
Trade creditors	22,149
Other creditors	11,170
Accrued expenses	103,357
Accrued salaries	16,869
Accrued interest	6
	153,551

See also note 2(q) 'Payables' and note 57 'Financial instruments'.

Note 35 Borrowings

Current	
Department of Treasury loans (a)	743
Finance lease liabilities - Joondalup Health Campus (b)	2,572
	3,315
Non-current	
Department of Treasury loans (a)	1,593
Total borrowings	4,908

a) This debt relates to funds advanced to the Health Service via the now defunct General Loan and Capital Works Fund. Funds advanced and related interest costs are repaid to the Department of Treasury by the DoH on behalf of the Health Service. Interest rates are linked to the State Government's debt servicing costs.

b) The finance lease contract is for the initial construction of the public hospital facility at JHC in 1996. Since September 2009, the public hospital facility has undergone significant redevelopment which is fully funded by the State Government. Consequently, the carrying amounts of the existing buildings for the public hospital facility are above the total amounts of the finance lease liabilities. Lease liabilities are effectively secured as the rights to the leased assets revert to the lessor in the event of default.

	2017 $000
The total carrying amounts of buildings (included in note 30) for the public hospital facility at JHC includes the amount pledged as security:	114,984

Note 36 Provisions

Current	
Employee benefits provision	
Annual leave (a)	128,729
Time off in lieu leave (a)	38,090
Long service leave (b)	94,841
Deferred salary scheme (c)	1,913
	263,573
Non-current	
Employee benefits provision	
Long service leave (b)	67,929
Total provisions	331,502

Note 36 Provisions (continued)

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

	2017 $000
Within 12 months of the end of the reporting period	116,773
More than 12 months after the end of the reporting period	50,046
	166,819

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

Within 12 months of the end of the reporting period	23,710
More than 12 months after the end of the reporting period	139,060
	162,770

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

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

Note 37 Other liabilities

	2017 $000
Current	
Refundable deposits	955
Paid parental leave scheme	16
Other	6
	980

Note 38 Contributed equity

The WA 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 39 'Reserves').

Balance at start of period	
Contributions by owners (c)	
Capital appropriation (b)	29,923
Transfers of net assets from abolished agency (a) (c)	1,789,941
Write down of net assets transferred from abolished agency (f)	(3,356)
Transfers from other agencies	880
	1,817,388
Distributions to owners (c) (d)	
Transfers of Amount Receivables for Services to EMHS (e)	(8,920)
Transfers of land for the Midland Public Hospital to EMHS	(13,200)
Transfers of other assets to other agencies	(1,040)
	(23,160)
Balance at end of period	1,794,228

Note 38 Contributed equity (continued)

(a) The *Health Services Act 2016 (WA)* has been enacted to replace the *Hospitals and Health Services Act 1927* as from 1 July 2016. The old MHS as a statutory authority was abolished and their assets and liabilities were transferred to five health service providers (CAHS, EMHS, NMHS, SMHS and HSS) that are separate statutory authorities. The assets and liabilities transferred to NMHS are outlined below.

Summary of assets and liabilities transferred from abolished agency is as follows:

	2017 $000
ASSETS	
Cash and cash equivalents	21,823
Restricted cash and cash equivalents	52,245
Receivables	75,246
Inventories	6,843
Amounts receivable for services	627,146
Property, plant and equipment	1,500,102
Intangible assets	526
Other assets	10,818
	2,294,749
LIABILITIES	
Payables	174,767
Borrowings	10,130
Provisions	318,750
Other liabilities	1,161
	504,808
Net contribution	**1,789,941**

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

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

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

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

e) The St John of God Midland Public Hospital (SJOG MPH) assets were transferred to the EMHS from the abolished MHS at the establishment of EMHS as a new statutory reporting entity at 1 July 2016. The Amount Receivables for Services (ARS), also known as Holding Accounts, for depreciation associated with SJOG MPH assets were however transferred to NMHS at the opening balance 1 July 2016. In May 2017, the ARS balance of $8.92 million, 131 associated with SJOG MPH assets was transferred from NMHS to EMHS. The transfer was accounted for under equity as it relates to the original restructure (abolishment of MHS and creation of new statutory reporting entities).

f) Some work in progress amounts included in the property, plant and equipment transferred from the abolished agency as explained under Note 38 (a) above were subsequently written down as new information became available after the initial transfers. The write-down was accounted for under equity as it relates to the original transfers.

Note 39 Reserves

	2017 $000
Asset revaluation reserve (a)	
Balance at start of period	-
Net revaluation increments/(decrements)	
Land	676
Buildings	142,760
Balance at end of period	143,436

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

Note 40 Accumulated surplus

Balance at start of period	-
Balance for the period	52,878
Balance at end of period	52,878

Note 41 Notes to the Statement of Cash Flows

Reconciliation of cash

Cash assets at the end of the financial year as shown in the Statement of Cash Flows are reconciled to the related items in the Statement of Financial Position as follows:

Cash and cash equivalents	33,617
Restricted cash and cash equivalents	55,698
	89,315

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

	2017 $000
Net cash used in operating activities (Statement of Cash Flows)	(1,151,235)
Increase/(decrease) in assets:	
GST receivable	615
Other current receivables	(3,555)
Inventories	(185)
Prepayments and other current assets	1,414
Decrease/(increase) in liabilities:	
Payables	23,351
Current provisions	(8,465)
Non-current provisions	(4,287)
Other current liabilities	180
Non-cash items:	
Doubtful debts expense (note 15)	(5,168)
Write-off receivables (note 26)	349
Receivables amount recovered during the period (note 26)	(21)
Depreciation and amortisation expense (note 11)	(61,869)
Net gain/(loss) from disposal of non-current assets (note 12)	(393)
Interest paid by DoH	(89)
Net donation of non-current assets	39
Services received free of charge (note 22)	(65,617)
Write down of assets (note 15)	(9,478)
Net cost of services (Statement of Comprehensive Income)	(1,284,412)

Note 41 Notes to the Statement of Cash Flows (continued)

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

	2017 $000
Notional cash flows	
Service appropriations as per Statement of Comprehensive Income	1,271,598
Capital contributions credited directly to Contributed equity (note 38)	29,923
Royalties for Regions Fund as per Statement of Comprehensive Income	139
	1,301,660
Less notional cash flows	
Items paid directly by the DoH for the Health Service and are therefore not included in the Statement of Cash Flows	
Interest paid to Department of Treasury	(89)
Repayment of interest-bearing liabilities to Department of Treasury	(709)
Accrual appropriations	(77,268)
	(78,066)
Cash Flows from State Government as per Statement of Cash Flows	1,223,594

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

Note 42 Revenue, public and other property written off

	2017 $000
a) Revenue and debts written off under the authority of the Accountable Authority	349
b) Public and other property written off under the authority of the Accountable Authority	-
c) Revenue and debts written off under the authority of the Minister	-
	349

Note 43 Losses of public moneys and other property

Losses of public moneys and public or other property through theft or default	150
Less amount recovered	(68)
	82

Note 44 Services provided free of charge

During the period the following services were provided to other agencies free of charge for functions outside the normal operations of the Health Service:

	2017 $000
Department of Corrective Services - dental treatment	1,413
Disability Services Commission - dental treatment	1,925
Aboriginal Community Controlled Health Services (ACCHS) - dental treatment	785
EMHS - pathology services (a)	22,056
SMHS - pathology services (a)	30,175
WACHS - pathology services (a)	29,491
CAHS - pathology services (a)	6,005
	91,850

a) Represents the cost of providing pathology services above the amounts billed to other Health Service providers.

Note 45 Compensation of key management personnel

The Health Service has determined that Key Management Personnel include Ministers, Board members and senior officers of the Health Service. However, the Health Service is not obligated to compensate Ministers and therefore disclosures in relation to Ministers' compensation may be found in the Annual Report on State Finances.

Compensation of Board Members	
$0	2
$40,001 - $50,000	7
$70,001 - $80,000	1
Total	10

	$000
Short-term employee benefits (a)	342
Post-employment benefits (b)	33
Total compensation of Board Members	375

Compensation 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 heads of service who report to the CEO. It also includes senior clinicians with a statewide role.

The number of senior officers other than senior officers reported as members of the Accountable Authority, whose total

Note 45 Compensation of key management personnel (continued)

Compensation of senior officers (continued)

fees, salaries, superannuation, non-monetary benefits and other benefits for the financial year, fall within the following bands are:

$120,001 – $130,000	1
$200,001 – $210,000	1
$240,001 – $250,000	3
$250,001 – $260,000	1
$280,001 – $290,000	1
$350,001 – $360,000	2
$400,001 – $410,000	1
$490,001 – $500,000	1
$560,001 – $570,000	1
$580,001 – $590,000	1
$600,001 – $610,000	1
$710,001 – $720,000	1
Total	15

	$000
Short-term employee benefits (a)	4,308
Post-employment benefits (b)	453
Other long-term benefits (c)	355
Termination benefits (d)	564
Total compensation of senior officers	5,680

The above information includes three senior officers that have since left the Health Service and have not been replaced.

(a) The short term employee benefits include salary, motor vehicle benefits, district and travel allowances incurred by the Health Service in respect of senior officers.

(b) The post-employment benefits represent the employer superannuation contribution.

(c) The other long-term benefits comprise annual and long-service leave accrued during the financial year.

(d) Termination benefits include severance payments, annual and long-service leaves paid on termination.

Note 46 Related Party Transactions

The Health Service is a wholly owned and controlled entity of the State of Western Australia. In conducting its activities, the Health Service is required to pay various taxes and levies based on the standard terms and conditions that apply to all tax and levy payers to the State and entities related to State.

Related parties of the Health Service include:

- all Ministers and their close family members, and their controlled or jointly controlled entities;
- all Board members and senior officers and their close family members, and their controlled or jointly controlled entities;
- other departments and statutory authorities, including their related bodies, that are included in the whole of government consolidated financial statements;
- associated and joint ventures, that are included in the whole of government consolidated financial statements; and
- GESB.

Note 46 Related Party Transactions (continued)

Material transactions with related parties

The Health Service had no material related party transactions with key management personnel and their related parties. Transactions with related parties that are considered Ordinary Citizen Transactions are not disclosed as they have immaterial implications to the financial position and performance of the Health Service.

Significant transactions with government related entities

The Health Service receives appropriation funding from Treasury via DoH to cover the net cost of service and project delivery.

The Health Service receives ICT, Financial, Human Resources and Supply Chain services provided free of charge from Health Support Services. The Health Service also leases accommodation free of charge from the Department of Finance.

The Health Service provides pathology services to other Health Service Providers, WA Police and the Department of the Attorney General.

The Health Service makes payments to:

- Insurance Commission and RiskCover for the provision of insurance;
- State Fleet for the provision of motor vehicle fleet management; and
- Auditor General as remuneration for the provision of audit service.

Significant transactions with other related parties

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

Note 47 Remuneration of auditor

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

	2017 $000
Auditing the accounts, financial statements and key performance indicators	165

Note 48 Commitments

The commitments below are inclusive of GST where relevant.

Capital expenditure commitments:

Capital expenditure commitments, being contracted capital expenditure additional to the amounts reported in the financial statements are payable as follows:

	2017 $000
Within 1 year	18,904

Operating lease commitments:

Commitments in relation to non-cancellable leases contracted at the end of the reporting period but not recognised as liabilities are payable as follows:

Within 1 year	4,313
Later than 1 year, and not later than 5 years	6,953
Later than 5 years	1,106
	12,372

Operating lease commitments predominantly consist of contractual agreements for office accommodation and residential accommodation. The basis of which contingent operating leases payments are determined is the value for each lease agreement under the contract terms and conditions at current values.

Finance lease commitments

Minimum lease payment commitments in relation to finance leases are payable as follows:

	2017 $000
Within 1 year	2,899
Minimum finance lease payments	2,899
Less future finance charges	(327)
Present value of finance lease liabilities (refer note 35)	2,572

The present value of finance leases payable is as follows:

Within 1 year	2,572
Present value of finance lease liabilities	2,572
Included in the financial statements as	2,572
Current (note 36)	2,572

Private sector contracts for the provision of health services

Expenditure commitments in relation to private sector organisations contracted for at the end of the reporting period but not recognised as liabilities, are payable as follows:

Within 1 year	492,173
Later than 1 year and not later than 5 years	2,073,142
Later than 5 years and not later than 10 years	2,918,447
Later than 10 years	622,347
	6,106,109

Note 48 Commitments (continued)

Other expenditure commitments

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

	2017 $000
Within 1 year	33,722
Later than 1 year and not later than 5 years	22,531
	56,253

Note 49 Contingent liabilities and contingent assets

Contingent liabilities

In addition to the liabilities included in the financial statements, the Health Service has the following contingent liabilities:

Litigation in progress	
Pending litigation that are not recoverable from RiskCover insurance and may affect the financial position of the Health Service	340
Number of claims	1

Contaminated sites

Under the *Contaminated Sites Act 2003* the Health Service is required to report known and suspected contaminated sites to the Department of Water and Environment 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.

Contingent assets

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

Note 50 Events occurring after the end of the reporting period

There were no events occurring after the reporting period which had significant financial effects on these financial statements.

Note 51 Related bodies

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

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

Note 52 Affiliated bodies

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

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

Note 53 Other statement of receipts and payments

Commonwealth Grant - Christmas and Cocos Island	2017 $000
Balance at start of period	-
Receipts	
Commonwealth grant	24
Payments	
Purchase of health services	(24)
Balance at the end of period	**-**

Note 54 Administered trust accounts

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

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

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

	2017 $000
Balance at start of period	156
Add Receipts	1,093
	1,249
Less Payments	(1,073)
Balance at end of period	176

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

RF Shaw Foundation	1,201
King Edward Memorial Clinical Staff Association	48
	1,249
Balance at start of period	1,221
Add Receipts	28
	1,249
Less Payments	-
Balance at end of period	1,249

Note 55 Special Purpose Account

Mental Health Commission Fund Account

The purpose of the special purpose account is to receive funds from the Mental Health Commission, to fund the provision of mental health services as jointly endorsed by DoH and the Mental Health Commission, in accordance with the annual Service Agreement and subsequent agreements.

	2017 $000
Balance at start of period	-
Add receipts	
Transfers from abolished agency	685
Service delivery agreement	
Commonwealth contributions	64,346
State contributions	168,952
Other	1,724
	235,022
Less Payments	(235,583)
Balance at end of period	124

The special purpose accounts are established under section 16(1d) of the *FMA 2006*.

Note 56 Explanatory statement

All variances between estimates (original budget) and actual results for 2017 are shown below. Narratives are provided for major variances, which are generally greater than 5% and $25 million.

Statement of Comprehensive income	Note	2017 Estimates $000	2017 Actual $000	Variance between estimate and actual $000
COST OF SERVICES				
Expenses				
Employee benefits expense		1,385,485	1,356,459	(29,026)
Contracts for services		424.661	429,812	5,151
Patient support costs		318,788	325,982	7,194
Finance costs		615	596	(19)
Depreciation and amortisation expense		54.609	61,869	7,260
Loss on disposal of non-current assets		-	393	393
Repairs, maintenance and consumable equipment		59,551	49,459	(10,092)
Other supplies and services	1	4,379	78,729	74,350
Other expenses		80,858	101,949	21,091
Total cost of services		**2,328,946**	**2,405,248**	**76,302**
INCOME				
Revenue				
Patient charges		112,765	113,784	1,019
Other fees for services	2	233,702	184,813	(48,889)

Note 56 Explanatory statement (continued)

Statement of Comprehensive income	Note	2017 Estimates $000	2017 Actual $000	Variance between estimate and actual $000
Commonwealth grants and contributions	3	574,862	619,939	45,077
Other grants and contributions	4	138,254	179,495	41,241
Donation revenue		2,855	1,014	(1,841)
Interest revenue		350	587	237
Other revenue		19,521	21,204	1,683
Total Revenue		**1,082,309**	**1,120,836**	**38,527**
Total income other than income from State Government		**1,082,309**	**1,120,836**	**38,527**
NET COST OF SERVICES		**1,246,637**	**1,284,412**	**37,775**
INCOME FROM STATE GOVERNMENT				
Service appropriations		1,241,178	1,271,598	30,420
Assets (transferred)/ assumed		-	(64)	(64)
Services received free of charge	1	-	65,617	65,617
Royalties for Regions Fund		-	139	139
Total income from State Government		**1,241,178**	**1,337,290**	**96,112**
SURPLUS/(DEFICIT) FOR THE PERIOD		**(5,459)**	**52,878**	**58,337**

Statement of Comprehensive income	Note	2017 Estimates $000	2017 Actual $000	Variance between estimate and actual $000
OTHER COMPREHENSIVE INCOME/(LOSS)				
Items not reclassified subsequently to profit or loss				
Changes in asset revaluation reserve		-	143,436	143,436
Total other comprehensive income/ (loss)		**-**	**143,436**	**143,436**
TOTAL COMPREHENSIVE INCOME/(LOSS) FOR THE PERIOD		**(5,459)**	**196,314**	**201,773**

Note 56 Explanatory statement (continued)

Statement of Financial Position	Note	2017 Estimates $000	2017 Actual $000	Variance between estimate and actual $000
ASSETS				
Current Assets				
Cash and cash equivalents		16,997	33,617	16,620
Restricted cash and cash equivalents		57,072	50,398	(6,674)
Receivables		68,524	63,964	(4,560)
Inventories		6,843	6,658	(185)
Other current assets		3,058	12,231	9,173
Total Current Assets		152,494	166,868	14,374
Non-current Assets				
Restricted cash and cash equivalents		-	5,300	5,300
Amounts receivable for services		696,170	695,494	(676)
Receivables		-	3,502	3,502
Property, plant and equipment	5	1,507,841	1,604,097	96,256
Intangible assets		653	6,222	5,569
Total Non-current Assets		2,204,664	2,314,615	109,951
Total Assets		**2,357,158**	**2,481,483**	**124,325**

Statement of Financial Position	Note	2017 Estimates $000	2017 Actual $000	Variance between estimate and actual $000
LIABILITIES				
Current Liabilities				
Payables		142,528	153,551	11,023
Borrowings		3,282	3,315	33
Provisions		269,382	263,573	(5,809)
Other current liabilities		1,112	980	(132)
Total Current Liabilities		416,304	421,419	5,115
Non-Current Liabilities				
Borrowings		1,626	1,593	(33)
Provisions		63,642	67,929	4,287
Total Non-Current Liabilities		65,268	69,522	4,254
Total Liabilities		**481,572**	**490,941**	**9,369**
NET ASSETS		**1,875,586**	**1,990,542**	**114,955**
EQUITY				
Contributed equity		1,881,044	1,794,228	(86,816)
Reserves		-	143,436	143,436
Accumulated surplus/ (deficit)		(5,458)	52,878	58,336
TOTAL EQUITY		**1,875,586**	**1,990,542**	**114,956**

Note 56 Explanatory statement (continued)

Statement of Cash Flows	Note	2017 Estimates $000	2017 Actual $000	Variance between estimate and actual $000
CASH FLOWS FROM STATE GOVERNMENT				
Service appropriations		1,172,050	1,194,242	22,192
Capital appropriations		68,667	29,213	(39,454)
Royalties for Regions Fund		-	139	139
Net cash provided by State Government		**1,240,717**	**1,223,594**	**(17,123)**
Utilised as follows:				
CASH FLOWS FROM OPERATING ACTIVITIES				
Payments				
Employee benefits		(1,367,293)	(1,340,870)	26,423
Supplies and services	7	(888,237)	(933,650)	(45,413)
Finance costs		(511)	(511)	-
Receipts				
Receipts from customers		112,765	109,494	(3,271)
Commonwealth grants and contributions	3	574,862	619,939	45,077
Other grants and contributions	4	138,254	179,495	41,241
Donations received		2,855	976	(1,879)
Interest received		350	536	186
Other receipts	2	253,226	213,356	(39,870)
Net cash used in operating activities		**(1,173,729)**	**(1,151,235)**	**22,494**

Statement of Cash Flows	Note	2017 Estimates $000	2017 Actual $000	Variance between estimate and actual $000
CASH FLOWS FROM INVESTING ACTIVITIES				
Payments				
Payment for purchase of non-current physical and intangible assets		(62,475)	(52,761)	9,714
Receipts				
Proceeds from sale of non-current physical assets		-	162	162
Net cash used in investing activities		**(62,475)**	**(52,599)**	**9,876**
CASH FLOWS FROM FINANCING ACTIVITIES				
Payments				
Repayment of finance lease liabilities		(4,513)	(4,513)	-
Receipts		-	-	-
Net cash used in financing activities		**(4,513)**	**(4,513)**	**-**
Net increase/(decrease) in cash and cash equivalents		-	15,247	15,247
Cash and cash equivalents transferred from abolished agency		74,069	74,068	(1)
CASH AND CASH EQUIVALENTS AT THE END OF PERIOD		**74,069**	**89,315**	**15,246**

Note 56 Explanatory statement (continued)

Significant variances between estimated and actual for 2017

1. Other supplies and services

The majority of the variance of $65.7 million represents services provided free of charge by HSS, not included in the Estimates.

2. Other fees for services

The variance in other fees for services is the result of different accounting treatment of Internal Services Revenue (ISR) and External Services Revenue (ESR). The estimate for other fees for services includes the ISR and ESR as part of revenue component, whereas the actuals offset them against their relevant expenses. As a result, the other fees for services revenue is lower than the estimate.

3. Commonwealth grants and contributions

The increase is due to an additional funding above budget of $16.9 million under the National Health Reform Agreement (NHRA). A further $14 million in increased NHRA funding relates to additional activity achieved during the 2016/17 financial year. There is also an additional $13 million in funding for Commonwealth programs related to aged care assessment, organ tissue donation and dental services.

4. Other grants and contributions

There has been an increase of $35 million in the State component of Mental Health Commission funding, which in previous years, was funded as part of Commonwealth grants and contributions.

5.Property, plant and equipment

The increased value in buildings as a result of revaluation has contributed to the significant increase in property, plant and equipment assets. The increment in revaluation is $143 million. This has been offset by a delay in the in the initiation and progress of various projects. See note 6 below for more information.

6. Capital Appropriations

The variance to estimate resulted from a delay in the initiation and progress of various capital projects. These include $10.3 million in replacement imaging equipment, $11 million in SCGH redevelopment, $7.7 million Intra-operative Magnetic Resonance Imaging and $2.9 million for JHC.

7. Supplies and services

The major variance is attributable to the payment of SJOG MPH of $19.5 million in the current financial year for invoices raised in the prior year (timing difference) and also Hepatitis C medicine for $29 million, not included in the estimate.

Note 57 Financial instruments

a) Financial risk management objectives and policies

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

Credit risk

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

The maximum exposure to credit risk at the end of the reporting period in relation to each class of recognised financial assets is the gross carrying amount of those assets inclusive of any allowance for impairment as shown in the table at Note 57(c) 'Financial instrument disclosures' and note 26 'Receivables'.

Credit risk associated with the Health Service's financial assets is generally confined to patient fee debtors (see note 26). The main receivable of the Health Service is the amounts receivable for services (holding account). For receivables other than government agencies and patient fee debtors, the Health Service trades only with recognised, creditworthy third parties. The Health Service has policies in place to ensure that sales of products and services are made to customers with an appropriate credit history. In addition, receivable balances are monitored on an ongoing basis with the result that the Health Service's exposure to bad debts is minimised. At the end of the reporting period, there were no significant concentrations of credit risk.

Allowance for impairment of financial assets is calculated based on historical evidence and trend analysis. For financial assets that are either past due or impaired, refer to Note 57 (c) 'Financial instrument disclosures'.

Liquidity risk

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

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

Market risk

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

Note 57 Financial Instruments (continued)

managed by DT through portfolio diversification and variation in maturity dates.

b) Categories of financial instruments

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

	2017 $000
Financial Assets	
Cash and cash equivalents	33,617
Restricted cash and cash equivalents	55,698
Loans and receivables (a)	755,623
Financial Liabilities	
Financial liabilities measured at amortised cost	158,458

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

Note 57 Financial Instruments (continued)

c) Financial instrument disclosures

Credit risk

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

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

Aged analysis of financial assets

	Carrying amount $000	Not past due and not impaired $000	Past due but not impaired 1–3 months $000	3–12 months $000	1–5 years $000	More than 5 years $000	Impaired financial assets $000
2017							
Cash and cash equivalents	33,617	33,617	-	-	-	-	-
Restricted cash and cash equivalents	55,698	55,698	-	-	-	-	-
Receivables (a)	60,129	30,660	13,822	8,716	6,931	-	-
Amounts receivable for services	695,494	695,494	-	-	-	-	-
	844,938	815,469	13,822	8,716	6,931	-	-

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

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.

Note 57 Financial Instruments (continued)

c) Financial instrument disclosures (continued)

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

	Weighted average effective interest rate %	Carrying amount $000	Interest Rate Exposure: Fixed interest rate $000	Interest Rate Exposure: Variable interest rate $000	Interest Rate Exposure: Non-interest bearing $000	Nominal amount $000	Maturity Dates: Up to 3 months $000	Maturity Dates: 3 months to 1 year $000	Maturity Dates: 1 to 5 years $000	Maturity Dates: More than 5 years $000
2017										
Financial Assets										
Cash and cash equivalents	1.98	33,617	-	6,190	27,427	33,617	33,617	-	-	-
Restricted cash and cash equivalents	-	55,698	-	-	55,698	55,698	50,398	-	-	5,300
Receivables - non-interest bearing (a)	-	56,627	-	-	56,627	56,627	56,627	-	-	-
Receivables - interest bearing	1.5	3,502	-	3,502	-	3,626	-	-	3,626	-
Amounts receivable for services	-	695,494	-	-	695,494	695,494	-	-	-	695,494
		844,938	-	9,692	835,246	845,062	140,642	-	3,626	700,794
Financial Liabilities										
Payables		153,551	-	-	153,551	153,551	153,551	-	-	-
Department of Treasury Loans	3.18	2,335	-	2,335	-	2,416	198	595	1,623	-
Finance lease Liabilities - Joondalup Health Campus	8.54	2,572	2,572	-	-	2,691	-	2,691	-	-
		158,458	2,572	2,335	153,551	158,658	153,749	3,286	1,623	-

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

Note 57 Financial Instruments (continued)

c) Financial instrument disclosures (continued)

Interest rate sensitivity analysis

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

	Amount Exposed to interest Rate Risk $000	-100 basis points		+100 basis points	
		Surplus $000	Equity $000	Surplus $000	Equity $000
2017					
Financial Assets					
Cash and cash equivalents	6,190	(62)	(62)	62	62
Receivables	3,502	(35)	(35)	35	35
Financial Liabilities					
Department of Treasury Loans	2,335	23	23	(23)	(23)
Total Increase/ (Decrease)		(12)	(12)	12	12

Fair values

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

Note 58 Schedule of Income and Expenses by service

	Public Hospital Admitted patient (a) 2017 $000	Home-based Hospital Programs 2017 $000	Emergency Department (a) 2017 $000	Public Hospital Non-admitted patients (a) 2017 $000
COST OF SERVICES				
Expenses				
Employee benefits expense	805,609	149	50,026	201,232
Contracts for services	323,572	1	72,190	10,464
Patient support costs	224,212	41	13,477	52,451
Finance costs	466	(1)	91	27
Depreciation and amortisation expense	41,240	6	3,378	8,876
Loss on disposal of non-current assets	273	-	16	74
Repairs, maintenance and consumable equipment	27,185	4	2,445	9,344
Other supplies and services	48,242	9	2,950	11,840
Other expenses	60,236	5	3,055	12,282
Total cost of services	1,531,035	214	146,628	306,590
Income				
Patient charges	82,414	-	6,245	19,640
Other fees for services	77,874	1	7,396	93,131
Commonwealth grants and contributions	391,585	1	56,246	91,207
Other grants and contributions	3,584	-	36	4,585
Donation revenue	845	-	2	164
Interest revenue	399	-	39	93
Other revenue	12,906	2	1,287	2,562
Total income other than income from State Government	569,607	4	71,251	211,382
NET COST OF SERVICES	**961,428**	**210**	**76,377**	**95,208**
INCOME FROM STATE GOVERNMENT				
Service appropriations	960,605	213	76,261	94,465
Assets (transferred)/assumed	(47)	-	(5)	(10)
Services received free of charge	39,415	5	3,846	8,608
Royalties for Regions Fund	139	-	-	-
Total income from State Government	1,000,112	218	80,102	103,063
SURPLUS/(DEFICIT) FOR THE PERIOD	**38,684**	**8**	**3,725**	**7,855**

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

(a) Includes pathology services provided by PathWest to agencies outside the NMHS.

Note 58 Schedule of Income and Expenses by service (continued)

	Prevention, Promotion & Protection 2017 $000	Dental Health 2017 $000	Continuing Care 2017 $000	Mental Health (b) 2017 $000	Total 2017 $000
COST OF SERVICES					
Expenses					
Employee benefits expense	47,744	65,935	4,049	184,715	1,356,459
Contracts for services	73	1,079	637	21,796	429,812
Patient support costs	5,462	14,664	1,350	14,325	325,982
Finance costs	10	-	1	2	596
Depreciation and amortisation expense	1,076	1,725	207	5,361	61,869
Loss on disposal of non-current assets	18	-	1	11	393
Repairs, maintenance and consumable equipment	1,233	4,088	199	4,961	49,459
Other supplies and services	2,597	2,637	279	10,175	78,729
Other expenses	5,935	6,984	211	13,241	101,949
Total cost of services	61,148	97,112	6,934	254,587	2,405,248
Income					
Patient charges	-	5,485	-	-	113,784
Other fees for services	1,958	3,545	15	893	184,813
Commonwealth grants and contributions	5,903	6,514	3,374	65,109	619,939
Other grants and contributions	265	329	20	170,676	179,495
Donation revenue	3	-	-	-	1,014
Interest revenue	9	-	1	46	587
Other revenue	597	910	72	2,868	21,204
Total income other than income from State Government	8,735	16,783	3,482	239,592	1,120,836
NET COST OF SERVICES	**52,413**	**80,329**	**3,452**	**14,995**	**1,284,412**
INCOME FROM STATE GOVERNMENT					
Service appropriations	52,577	78,653	3,463	5,361	1,271,598
Assets (transferred)/assumed	(2)	-	-	-	(64)
Services received free of charge	1,570	2,364	175	9,634	65,617
Royalties for Regions Fund	-	-	-	-	139
Total income from State Government	54,145	81,017	3,638	14,995	1,337,290
SURPLUS/(DEFICIT) FOR THE PERIOD	**1,732**	**688**	**186**	**-**	**52,878**

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

(b) Include services provided under agreement with the Mental Health Commission for specialised admitted patients and community mental health.

Appendices

Appendix A

Abbreviations and acronyms

AIHW	Australian Institute of Health and Welfare
AASB	Australian Accounting Standards Board
ACHS	Australian Council on Healthcare Standards
BSWA	BreastScreen WA
BUC	Building Utilisation Category
CAHS	Child and Adolescent Health Service
CF	Cystic Fibrosis
CRC	Clinical Research Centre
DoH	Department of Health, WA
DAIP	Disability Access and Inclusion Plan
DMFT	Decayed, Missing or Filled teeth
ECU	Edith Cowan University
EMHS	East Metropolitan Health Service
FMA	Financial Management Act
GESB	Government Employees Superannuation Board
GREaT	Get Real Experience and Try
GSS	Gold State Superannuation Scheme
HITH	Hospital in the Home
HSS	Health Support Services
JHC	Joondalup Health Campus
KEMH	King Edward Memorial Hospital
KPI	Key Performance Indicator
MCDC	Metropolitan Communicable Disease Control
MH	Mental Health
MHS	Metropolitan Health Services
MITH	Mental Health in the Home
NIISwa	Neurological Intervention & Imaging Service of WA
NFP	not-for-profit
NMHS	North Metropolitan Health Service
OAG	Office of the Auditor General
OPH	Osborne Park Hospital
OSH	Occupational Health and Safety
PPP	Public Private Partnership
QEII	Queen Elizabeth II
RITH	Rehabilitation in the Home
RANZCP	Royal Australian and New Zealand College of Psychiatrists
SAC	Severity Assessment Code
SCGH	Sir Charles Gairdner Hospital
SCGOPHCG	Sir Charles Gairdner Osborne Park Health Care Group
SJGHC	St John of God Healthcare
SNRI	Sarich Neuroscience Research Institute
SWMHGP	Statewide Mental Health Graduate Program
TI	Treasurer's Instruction
UND	University of Notre Dame
UWA	University of Western Australia
WA	Western Australia
WAAES	WA Adult Epilepsy Service
WACHS	WA Country Health Service
WEAT	West Australian Emergency Access Target
WEST	West Australian Surgical Target
WSS	West State Superannuation Scheme
WNHS	Women and Newborn Health Service

Appendix B

Contact information

NMHS

Street address: Queen Elizabeth II Medical Centre, 2 Verdun Street, NEDLANDS WA 6009
Postal address: Locked Bag 2012, NEDLANDS WA 6009
Telephone: (08) 6457 3496
Web: www.nmahs.health.wa.gov.au

Sir Charles Gairdner Hospital

Street address: Queen Elizabeth II Medical Centre, 2 Verdun Street, NEDLANDS WA 6009
Postal address: Locked Bag 2012, NEDLANDS WA 6009
Telephone: (08) 6457 3333
Fax: (08) 6457 3759
Web: www.scgh.health.wa.gov.au

NMHS Public Health and Ambulatory Care

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
Postal address: Private Bag 1, CLAREMONT WA 6910
Telephone: (08) 9346 8000
Fax: (08) 9346 8008
Web: www.oph.health.wa.gov.au

Women and Newborn Health Service

Street address: 374 Bagot Road, SUBIACO WA 6008
Postal address: PO Box 134, SUBIACO WA 6904
Telephone: (08) 6458 2222
Email: kemhcsu@health.wa.gov.au
Web: www.kemh.health.wa.gov.au

PathWest

Street address: J Block, Queen Elizabeth II Medical Centre, 2 Verdun Street, NEDLANDS WA 6009
Postal address: Locked Bag 2009, NEDLANDS WA 6909
Telephone: (08) 9346 3000
Fax: (08) 9381 7594
Email: pathwest@health.wa.gov.au
Web: pathwest.health.wa.gov.au

Dental Health Service

Street address: 43 Mount Henry Road, COMO WA 6152
Postal address: Locked Bag 15, BENTLEY DELIVERY CENTRE WA 6983
Telephone: (08) 9313 0555
Fax: (08) 9313 1302
Email: enquiries@dental.health.wa.gov.au
Web: www.dental.wa.gov.au

BreastScreen WA

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 Healthcare

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

Appendix C

Board and Committee remuneration, 2016/17

NMHS Board

Position	Name	Type of remuner-ation	Period of Member-ship (months)	Gross/ actual remuner-ation
Chair	Professor Bryant Stokes AM	Per annum	12	$66,290
Deputy Chair	Dr Rosanna Capolingua	Per annum	12	$39,774
Member	Dr Margaret Crowley	Per annum	12	$39,774
Member	Dr Felicity Jefferies	Per annum	12	$39,774
Member	Michele Kosky AM	Per annum	12	$39,774
Member	Geoff Mather	Per annum	12	$39,774
Member	Graham McHarrie	Per annum	12	$39,774
Member	Maria Saraceni	Per annum	12	$39,774
Member	Dr Simon Towler	Per annum	12	Nil
Member	Professor Grant Waterer	Per annum	12	Nil
Total				**$344,708**

Graylands Hospital Management Team Meeting

Position	Name	Type of remuner-ation	Period of Member-ship (months)	Gross/ actual remuner-ation
Chair	Dr Samir Heble	Per hour	3	Nil
Deputy Chair	Karen Elliott	Per hour	10	Nil
Member	Kevin Lau	Per hour	10	Nil
Member	Dannielle Orifici	Per hour	8	Nil
Member	Ann Brown	Per hour	4	Nil
Member	Tony Jonikis	Per hour	10	Nil
Member	Hazel McLean	Per hour	10	Nil
Member	Dr Sandy Tait	Per hour	10	Nil
Member	Sue Bascombe	Per hour	10	Nil
Member	Patricia Tran	Per hour	10	Nil
Member	Janie Ingram	Per hour	9	Nil
Member	Lisa Valentine	Per hour	10	Nil
Member	Barbara Ahmat	Per hour	10	Nil
Member	Patricia Fonceca	Per hour	8	Nil
Member	Rachel Dixon	Per hour	7	$210
Member	Alan Alford	Per hour	4	$120
Total				**$330**

KEMH Community Advisory Committee (name changed to Women's and Newborn's Health Service Community Advisory Council)

Position	Name	Type of remuner-ation	Period of Member-ship (months)	Gross/ actual remuner-ation
Chair	Jody Blake	Per meeting	12 months	$630
Vice Chair	Sonja Whimp	Per meeting	12 months	$1,260
Member	Amanda Hocking	Per meeting	12 months	$630
Member	Ann McRae	Per meeting	12 months	$660
Member	Briony McKenzie	Per meeting	12 months	$240
Member	Gail Yarran	Per meeting	12 months	$360
Member	Gemma Cadby	Per meeting	12 months	$540
Member	Jamie Yallup Farrant	Per meeting	12 months	$570
Member	Jane Jones	Per meeting	12 months	$480
Member	Maureen Helen	Per meeting	12 months	$240
Member	Nicole Woods	Per meeting	12 months	$600
Member	Sarah Sibson	Per meeting	12 months	$600
Member	Wendy Hunt	Per meeting	12 months	$450
Member	Maryam Aghamohammadi	Per meeting	12 months	$570
Total				**$7,830**

North Metropolitan Area Health Service Community Advisory Committee

Position	Name	Type of remuner-ation	Period of Member-ship (months)	Gross/ actual remuner-ation
Chair	Tim Benson	Per meeting	10 months	$300
Deputy Chair	Alan Alford	Per meeting	10 months	$300
Member	Joan Varian	Per meeting	10 months	$240
Member	Jacqueline Carter	Per meeting	10 months	Nil
Member	Theresa McCrae	Per meeting	10 months	$240
Member	Margaret Ryan	Per meeting	10 months	$300
Member	John Stafford	Per meeting	10 months	$180
Member	Ross Glossop	Per meeting	10 months	$120
Total				**$1,680**

OPH Community Advisory Council

Position	Name	Type of remuner-ation	Period of Member-ship (months)	Gross/ actual remuner-ation
Chair	Joan Varian	Per meeting	12	$450
Deputy Chair	Joey Cookman	Per meeting	12	$450
Member	Peter Merralls	Per meeting	12	$600
Member	Pam Van Ome	Per meeting	12	$450
Member	Tom Benson	Per meeting	12	$300
Member	Suresh Rajan	Per meeting	9	$360
Member	Lesley Shore	Per meeting	1	$60
Member	Ramah Raymond	Per meeting	1	$60
Member	Derek Tabarias	Per meeting	6	$240
Member	Dianne Glenster	Per meeting	6	$240
Member	Sue Haydon	Per meeting	6	$270
Member	Beverley Port-Louis	Per meeting	10	$30
Total				**$3,510**

Appendix D

NMHS Board member attendance at meetings, 2016/17

Board Member Name	Board		Audit and Risk Working Party		Safety and Quality Working Party		Finance Working Party	
	Held	Attended	Held	Attended	Held	Attended	Held	Attended
Professor Bryant Stokes AM (Chair)	11	11						
Dr Rosanna Capolingua (Deputy Chair)	11	10	9	2	14	11		
Dr Margaret Crowley	11	11	9	7	14	10		
Dr Felicity Jefferies	11	9					12	10
Michele Kosky AM	11	11	9	4	14	11		
Geoff Mather	11	9					12	9
Graham McHarrie	11	9	9	7			12	8
Maria Saraceni	11	9	9	8				
Dr Simon Towler	11	9			14	7	12	6
Professor Grant Waterer	11	10			14	2	12	9

Contacts

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