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

South Metropolitan Health Service

ANNUAL REPORT

2017–2018

"Fear, sleep deprivation and exhaustion had us on edge but the team helped us understand our options and showed genuine compassion." **Matthew**, **Lucy** and **Amelie**, cared for at Fiona Stanley Hospital

"Thank you for all you have done for me. I feel I am ready for the next step and to go out into the community." **Natalie**, cared for at Peel Community Mental Health

"I have never received such professional, courteous and friendly service." **Cathrynne**, cared for at Fremantle Hospital

"I was treated with respect and dignity and genuinely cared for. Thank you so much for making my procedure a quality experience." **Susan**, cared for at Fremantle Hospital

"There are not sufficient words for me to show my sincere appreciation to the entire team. Happy, cheerful and caring persons for whom I've only the highest regard." **David**, cared for at Fiona Stanley Hospital

"The hospital did a great job and made me feel looked after and safe in the knowledge that I was in good hands." **Patient**, cared for at Rockingham General Hospital

"The staff members in the Emergency Department are absolutely amazing. They became my heroes." **Andrea**, cared for at Peel Health Campus

"I could not have been more impressed with the level of care, attention to detail and professionalism that was displayed during my visit." **Patient**, cared for at Rockingham General Hospital

"Despite your busy schedules, there was no sense of pressure to hurry through our appointment, but to deal with each part of the assessment." **Lindsay**, cared for at Fremantle Hospital

"I just wanted to mention how absolutely wonderful the volunteers are in ED. You provide a truly exceptional service and keep us calm during hard times." **Nicholas**, cared for at Fiona Stanley Hospital

"This is the first hospital experience I've had and it has been extremely pleasing. It certainly gives me confidence in the public health system." **Ryan**, cared for at Fiona Stanley Hospital

"What your staff have done for me during their visits for the past months has deeply touched and moved me. They helped and supported me through my most difficult time." **Mei**, cared for by Rehabilitation-in-the-Home

Acknowledgement of Country and People

South Metropolitan Health Service respectfully acknowledges the Noongar people both past and present, the traditional owners of the land on which we work. We affirm our commitment to reconciliation through strengthening partnerships and continuing to work with Aboriginal peoples.

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HON MR ROGER COOK BA GradDipBus MBA MLA
MINISTER FOR HEALTH

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

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

Mr Rob McDonald
Chair
South Metropolitan
Health Service Board
21 September 2018

Mr David Rowe
Board Member
South Metropolitan
Health Service Board
21 September 2018

Executive summary

Board Chair overview

For South Metropolitan Health Service (SMHS) 2017–18 has been a year of consolidating delivery of high-quality and sustainable services to our community through an innovative approach. There has been continued maturing of our systems and processes, and the health service continues to be an active contributor to the wider WA Health system. This is all designed to ensure the organisation can provide the best care possible to our patients.

Following broad consultation with SMHS staff, including a staff survey and a series of workshops targeting both clinical and operational leaders, SMHS provided its submission to the WA Government's Sustainable Health Review (SHR). For sustainable quality health care for our growing and ageing population, SMHS proposed the need for Health Service Providers (HSP) such as SMHS to transition from a hospital-centric model to a model that focuses on building our populations' health and wellbeing.

SMHS has been faced with the challenge of ensuring timely access to services by the community, particularly in the areas of emergency care and elective surgery. Of particular concern to Board members was the unacceptable number of over-boundary elective surgery wait list cases the health service was managing. The implementation of the SMHS Elective Surgery Wait List Reduction Strategy significantly reduced over-boundary wait list cases, which is a noteworthy achievement as it has helped

MR ROB MCDONALD, BOARD CHAIR
SOUTH METROPOLITAN HEALTH SERVICE

improve the lives of many patients. This is the first of many steps for the health service to continually improve access to our services.

The cycle of continual review and improvement is not confined to SMHS and its hospitals and services, but it is also incumbent on the SMHS Board to ensure it provides strong leadership, operates effectively and adds value. During 2017–18 a formal and external evaluation of the SMHS Board was undertaken. The evaluation reviewed leadership and performance, and sought to ensure appropriate governance practices were in place. This was invaluable for the Board members as it identified strengths and opportunities.

Listening to the patient's perspective is one of the most crucial aspects of improving the care and services provided across SMHS, and there is a strong program in place for consumers to share their experiences, and have the opportunity for their voice to be heard. The latest addition to the suite of feedback mechanisms has been implementing Patient Opinion. Patient Opinion allows us to engage with our patients, their families and carers in a new and more accessible way and presents us with an opportunity to see the care we provide through the patient's eyes. This initiative is proving to be another valuable tool to putting the patient experience first and foremost in our decision making.

Additionally, to directly hear patient and staff views, the Board continued its Board to Ward visits. Members of the Board visit wards and workplaces to meet patients, families and staff to hear and discuss their experiences and at the same time, identify potential opportunities for improvement.

The SMHS Board continued its oversight on four key strategic areas through its committee structure:

- **Safety and Quality Committee's** attention is on the health service's ability to provide safe and quality care and preventing patient harm through monitoring and evaluating clinical incident reporting and management. This oversight provides the opportunity for continuous improvement in patient safety. The committee's sustained focus on incident reporting, clinical data and performance indicators along with regular internal and external audits ensures a high level of governance and oversight.
- **Culture and Engagement Committee** shapes the SMHS Board objective to foster a culture of transparent, appropriate and effective engagement with all stakeholders. To date, the committee has had oversight of the development and implementation of numerous new tools and strategies for engagement with clinicians, staff, patients, carers and the wider community. In addition, there has been progress in developing tools to effectively evaluate and measure engagement activity and the health service's culture.
- **Audit and Risk Committee** is key to maintaining effective and efficient audit functions, monitoring risk, controls and compliance frameworks, and provides advice and assurance to the Board on relevant legislation and instructions. Along with oversight of the health service's financial and non-financial risks, and working closely with the internal auditor, there has been greater focus on SMHS legal proceeding actions and outcomes with the aim of taking the analysis to a more sophisticated level.

- **Finance and Governance Committee** priority is overseeing the more complex and specialised financial and governance matters on behalf of the SMHS Board such as managing the Service Agreement and budgeting formulation process, and ensuring the health service's commercial and contractual obligations. The committee continues to concentrate on achieving a balanced budget, generating own-source revenue and reviewing key financial risks to ensure these are considered in future budget builds to ensure long term financial sustainability of the health service.

In the second half of 2018, the Board is looking forward to hosting its first public 'Meeting with the Board' event in conjunction with a hospital open day. It will be open to all stakeholders in line with the Board's engagement strategy and aimed at further increasing transparency of the health service.

Whilst organisational initiatives continue to be implemented to improve efficiency and effectiveness, the additional matters highlighted in last year's Annual Report continue to require significant attention by the Board:

- Increasing patient numbers with varying conditions along with the ever challenging pressures placed on SMHS, and with projections indicating this is not expected to reduce in the foreseeable future.
- The financial environment continues to be highly challenging, with significant work ongoing to ensure the organisation remains within budget.
- Contributing to and implementing the recommendations from the WA Government's Sustainable Health Review.

Developing a sustainable and innovative health service, and delivering accessible, quality and safe care does not come about without the support of others within the WA Health system. I acknowledge the ongoing assistance of the Director General Dr David Russell-Weisz and his senior officers at the Department of Health, and the counsel of my fellow HSP Board Chairs, which continues to be invaluable.

I take this opportunity to recognise the efforts of Paul Forden, Chief Executive SMHS, and the SMHS Executive team in delivering on the SMHS vision and creating tangible initiatives within the SMHS five strategic priorities areas. Likewise, the support provided by Adrienne Wehr and Jane Caldwell to ensure the effective operation of the Board has been excellent.

Importantly, I acknowledge the continued dedication and commitment of all SMHS staff in their resolve to deliver services according to our values of Care, Integrity, Respect, Excellence and Teamwork.

Finally, I thank my fellow SMHS Board members for their unwavering and resolute attention to their role and responsibilities, and delivering on the vision of **excellent health care, every time**.

On behalf of the Board, I am proud to present the SMHS Annual Report 2017–18.

Rob McDonald
Board Chair
South Metropolitan Health Service

Chief Executive summary

This has been my first full year as the SMHS Chief Executive, and I am delighted that during this year our staff have achieved so much and made many advances. There have been numerous opportunities to review and improve our practices, and to put the patient first in the care we provide while delivering a sustainable health service. Our staff continually step up and meet these challenges.

With the July 2017 release of Professor Hugo Mascie-Taylor's *Review of Safety and Quality in the WA health system: A strategy for continuous improvement*, it was evident there needed to be greater transparency and openness to our patients and public on our performance and outcomes. This is particularly important given the majority of our community do not have a choice of where their care is provided, and we know we must always strive to improve the care and treatment we give. As part of our commitment of moving towards a zero harm health care service, SMHS took the significant step of publically reporting our safety and quality indicators – a first for any WA HSP, and which are included in this Annual Report (refer page 38). This is one way we are helping our patients and consumers to make informed decisions about their care and to empower our health professionals and others to continue to drive improvement.

PAUL FORDEN, CHIEF EXECUTIVE
SOUTH METROPOLITAN HEALTH SERVICE

Our patients, particularly those who had waited longer than clinically recommended for their surgery, were also at the forefront of our drive to improve the elective surgery wait list. The community, rightly, has an expectation that if they require surgery it will be delivered in a timely manner. There has been considerable reporting of the extensive wait lists within the WA Health system and this is not likely to ease anytime soon, but to wait longer than recommended for surgery is not desirable for anyone. With more than 1,300 patients waiting longer than recommended for surgery at the commencement of the financial year, it was important for our health service to make a concerted effort to reduce this list (refer to page 60). I am pleased to say that by the end of the financial year, SMHS hospitals had reduced the number of patients on the over-boundary list by approximately 65 per cent, a significant achievement and one that SMHS will aim to reduce even further in the forthcoming year.

These achievements are just some of the many highlights for the health service during 2017–18. Other highlights include:

Innovation and research

- Development of the *SMHS Research Operational Plan 2018–2020* and establishment of a Research Advisory Committee to make research a central pillar upon which the health service can build its capability, innovation and reputation.
- Newborns at Fiona Stanley Hospital will make their mark on science, by having their faces photographed as part of a world-first study (BabyFace Project) to develop a tool for doctors to detect and diagnose rare diseases earlier.
- Researchers at Fiona Stanley Hospital and PathWest have discovered a simple blood test that can predict the risk of serious infection in rheumatoid arthritis patients. By doing so, doctors can tailor treatment accordingly which should help prevent some serious infections and lead to better overall health and wellbeing.

Enhanced services

- A rapid access neck lump clinic opened at Fiona Stanley Hospital this year, providing General Practitioners (GPs) a direct, fast-tracked referral process for patients with suspicious lumps to be seen within two weeks.
- In a first for Rockingham General Hospital, the endocrinology unit now provides a telehealth service, which enables regional patients who otherwise would have to travel for appointments, the ability to connect with their physician using digital technology.
- Fiona Stanley Hospital is one of five hospitals in WA involved in the Heart Foundation's Lighthouse project designed to improve coronary heart disease outcomes in Aboriginal and Torres Strait Islander communities.

Achievements

- Fiona Stanley Hospital's Pharmacy Department were named winners at the 2017 WA Health Excellence Awards. The pharmacy compounding service improvement project won the 'Managing resources effectively and efficiently' category. Two other SMHS projects were shortlisted including Fiona Stanley Hospital One-stop Urology Clinic and the Advanced Scope Physiotherapists in the Fiona Stanley Hospital Emergency Department.
- SMHS was proud to have two winners at the 2018 WA Nursing and Midwifery Excellence Awards. Fiona Stanley Hospital Oncology Department Clinical Nurse Consultant Barbara O'Callaghan won for Excellence in Registered Nursing and Rockingham General Hospital Advanced Skilled Enrolled Nurse in Mental Health Mandy Major in

the category of Excellence in Enrolled Nursing. SMHS Nurse Director of Informatics, Suki Loe, was a finalist for the category Excellence in Leadership.

Celebrations

- The statewide transplant service at Fiona Stanley Hospital accomplished their 100th kidney transplant since the hospital's opening.
- Rockingham Peel Group mental health service celebrated its 25th anniversary by receiving a WA Mental Health Award for its commitment to family-centred care. The service provides mental health care for around 1,100 people in the local catchment area with an inpatient unit and established network of community services.
- Fremantle Hospital celebrated 120 years of service to the community, with the onsite museum displaying the hospital's rich history and highlighting its significance in Fremantle since opening in 1897.

These accomplishments are underpinned by our robust approach to delivering a sustainable and financially sound health service. SMHS, in a time of financial restraint, has continued to deliver quality and safe care and treatment while being financially responsible. Considerable work and increased awareness and understanding by all SMHS staff of our responsibilities have helped ensure we deliver on our allocated budget. This will continue to be an area of focus for the health services in coming years as we work in a financial constrained environment with ever increasing expectations from our community.

As SMHS moves into the next financial year, there are many opportunities on the horizon. We will be the first public health service to have a da Vinci surgical system, to be located at Fiona Stanley Hospital, which will revolutionise prostate treatment in the public health system. With WA Government investing $5m in 2017–18 to purchase the robot, it will come into service in October 2018. This is a great step forward for SMHS and the WA Health system.

The first family birthing centre in the south metropolitan area will begin to take shape at Fiona Stanley Hospital. With $1.8 million in Government funding towards this election commitment, SMHS will establish the centre within the existing maternity ward area to include four birth and postnatal rooms along with a family room/kitchen area. An important aspect of developing the centre will be engaging with consumers with the assistance of the Health Consumers Council.

These remarkable achievements are made possible because of the SMHS staff and volunteers. It is through their dedication to providing **excellent health care, every time** and commitment to our values – Care, Integrity, Respect, Excellence, Teamwork – that SMHS delivers quality, safe and sustainable health services to its community.

Paul Forden
Chief Executive
South Metropolitan Health Service

Operational structure

Legislation

SMHS was established as a board-governed health service provider in the Health Services (Health Service Provider) Order 2016 made by the Minister for Health under section 32 of the *Health Services Act 2016*.

Responsible Minister

SMHS is responsible to the Deputy Premier, Minister for Health and Mental Health, the Honourable Roger Cook MLA.

Board of the Authority

SMHS Board is the governing authority. The SMHS Board met on 11 occasions in 2017–18.

Mr Rob McDonald

B.Bus CPA MAICD

Chair

Term: 3 years to 30 June 2019

Meetings attended: 11 out of 11

SMHS Board committee membership:

- Oversight of the Board's four committees

*"It is inspiring to see committed and passionate people – clinical and non-clinical – working within SMHS with dedication and integrity for our patients to give them the best possible outcomes – **excellent health care, every time**."*

In addition to his responsibilities as Board Chair, Mr McDonald also has an oversight role in the operations of the Board's four committees – Safety and Quality, Culture and Engagement, Finance and Governance and the Audit and Risk. He has more than 30 years' experience in the public service in finance, human resources, policy development and information technology.

Adjunct Associate Professor Robyn Collins

RN RM B.App Sc MAICD

Deputy Chair

Term: 2 years to 30 June 2018 (reappointed for a further 3 years)

Meetings attended: 11 out of 11

SMHS Board committee membership:

- Chair, Safety and Quality Committee

"I believe our values truly reflect that all team members are essential to achieving our vision. They are values that all staff can deliver every day."

Professor Collins chairs the Safety and Quality Committee tasked with providing strategic advice to improve reporting and analysis of patient care outcomes. She possesses considerable experience in senior healthcare management positions and is presently State Manager Western Australia for the Australian Health Practitioner Regulation Agency.

Dr Amanda Boudville

MBBS, FRACP

Term: 17 July 2017 to 30 June 2018 (reappointed for a further 2 years)

Meetings attended: 8 out of 11

SMHS Board committee membership:

- Safety and Quality Committee

"Placing the patient at the centre of all our discussions ensures focus on excellent care and why we are here."

Dr Boudville serves as a clinician representative on the Safety and Quality Committee. Her expertise provides a focus on ensuring the accurate and timely reporting of incidents and that review recommendations are well considered, of high quality and are followed through. She is an experienced geriatrician and stroke physician who has worked across various public and private health systems.

Clinical Adjunct Associate Professor Kim Gibson

B.App.Sci (Physio) MA

Public Sector Leadership FACHSM GAICD

Term: 3 years to 30 June 2019

Meetings attended: 10 out of 11

SMHS Board committee membership:

- Safety and Quality Committee
- Culture and Engagement Committee

"The Board to Ward visits are now embedded as an important way for Board members to connect with staff members, patients and their carers. These visits highlight the daily challenges of delivering ***excellent health care, every time*** *and have led to some significant changes at the local level."*

Professor Gibson is passionate about health service improvement through clinician and consumer engagement and serves on both the Safety and Quality and the Culture and Engagement committees. Her health career of 35 years spans clinical practice and education, health professional regulation, health reform, health service management and governance across public, private, community and hospital settings in Australia and overseas.

Mr Julian Henderson

B.Eng MBA

Term: 2 years to 30 June 2018 (reappointed for a further 3 years)

Meetings attended: 10 out of 11

SMHS Board committee membership:

- Finance and Governance Committee
- Audit and Risk Committee

*"The SMHS vision – **excellent health care, every time** – contains my wish for every person, their family and carers who receive a service from SMHS."*

Serving on both the Finance and Governance and the Audit and Risk committees, Mr Henderson has a keen interest in governance. With a breadth of experience in strategic planning, policy development, project management, operations and general administration, he is a highly qualified senior executive with wide-ranging experience within both the public and private sectors.

Professor Mark Khangure

AM, MB BS, MRCP (UK) FRCR FRANZCR

Term: 2 years to 30 June 2018 (reappointed for a further 1 year)

Meetings attended: 9 out of 11

SMHS Board committee membership:

- Culture and Engagement Committee

"I am passionate about our goal to see the SMHS workforce, both clinical and non-clinical, feeling fully engaged with patients, their immediate carers and the wider community."

Professor Khangure serves on the Culture and Engagement Committee. In addition to his considerable experience in health service delivery and management, Professor Khangure has made a significant contribution to clinical teaching and medical research throughout his career.

Ms Michelle Manook

BA, Post GdDip ADAS, GAICD

Term: 3 years to 30 June 2019

Meetings attended: 9 out of 11

SMHS Board committee membership:

- Audit and Risk Committee

"Supporting the professional development of our employees is important in ensuring that we have excellent people delivering excellent care."

Ms Manook is Board sponsor for innovation at SMHS, reflecting its commitment to embracing new ideas and opportunities to create a more efficient and sustainable health service. She also serves on the Audit and Risk Committee. Ms Manook has over 20 years' experience in strategic corporate, government affairs and investor relations, and began her career working within clinical mental health, alcohol and drug prevention and the aged care sector.

Ms Yvonne Parnell

PostGdDis, GAICD

Term: 3 years to 30 June 2019

Meetings attended: 10 out of 11

SMHS Board committee membership:

- Chair, Culture and Engagement Committee

"The voice of our patients, staff, community, and stakeholders is key and always considered when shaping and directing our health service."

Ms Parnell chairs the Culture and Engagement Committee that focuses on fostering a culture of transparent and effective engagement with SMHS stakeholders including clinicians, consumers, carers and the community to positively influence the patient experience. For the past decade Ms Parnell has held the role of Chief Executive Officer within the community sector assisting people with disabilities and their families overcome significant life challenges.

Mr David Rowe

BA (Soc Sc), Grad AASC, JP GAICD

Term: 3 years to 30 June 2019

Meetings attended: 11 out of 11

SMHS Board committee membership:

- Chair, Finance and Governance Committee
- Chair, Audit and Risk Committee

"One of the most rewarding experiences as a board member is working with enlightened clinicians and administrative staff who are focused on taking diagnosis and treatment to another level."

Mr Rowe chairs two committees on behalf of the SMHS Board. A key focus of the Finance and Governance Committee over the past year was oversight of the SMHS budget position and maintaining a performance overview of key statewide and SMHS service contracts. The Audit and Risk Committee focused on reviewing the Board's appetite for risk and re-shaping the SMHS risk register. With a keen interest in medical research, Mr Rowe is a past member of the SMHS Governing Council and focused on how to best deliver high quality health care at an affordable price.

Ms Fiona Stanton

B Juris, LLB

Term: Reappointed for further year to June 2018 (reappointed for a further 3 years)

Meetings attended: 10 out of 11

SMHS Board committee membership:

- Finance and Governance Committee
- Audit and Risk Committee

"My Board to Ward tour of mental health services operated in Rockingham gave me an opportunity to speak to some of our young patients suffering from severe mental illness, to understand how vital our services are for these patients and to appreciate the important work of our clinicians working in this area."

Ms Stanton's legal background encompasses medical negligence, health practitioner regulation and registration, insurance, employment and commercial litigation. Over the past year, the Finance and Governance and the Audit and Risk committees on which she serves have dealt with issues including financial performance and contract management.

Organisational structure

(as at 30 June 2018)

Minister for Health
Hon Roger Cook MLA

System Manager, Department of Health
Dr D J Russell-Weisz, Director General

South Metropolitan Health Service Board

Mr Rob McDonald
Chairperson

South Metropolitan Health Service

Mr Paul Forden
Chief Executive

Mark Cawthorne
Executive Director Finance and Corporate Services

Dr Maxine Wardrop
Executive Director Safety, Quality and Consumer Engagement

Kate Gatti
Executive Director Clinical Service Planning and Population Health

Rita Freijah
Executive Director Contract Management

Geraldine Carlton
Executive Director Organisational Development and Transformation

Janet Zagari
Executive Director Fiona Stanley Fremantle Hospitals Group

Kath Smith
Executive Director Rockingham Peel Group

Dr Paul Mark
Area Clinical Services Director Clinical Services
Fiona Stanley Fremantle Hospitals Group

Taylor Carter
Area Nursing and Midwifery Director Nursing and Midwifery
Fiona Stanley Fremantle Hospitals Group

Jodie Pudney
Manager, Corporate Communications

Director, Office of the Chief Executive: *Temporarily vacant*

Senior officers

Senior officers and their area of responsibility within the SMHS for the or the 2017–18 period.

The Minister and Director General, Department of Health (System Manager) have oversight of SMHS. The Minister for Health appoints the SMHS Board and has the authority to direct the Board. The System Manager is the employing authority of the SMHS Chief Executive.

Paul Forden **Chief Executive** **South Metropolitan Health Service** *Term contract*	
Mark Cawthorne **Executive Director** **Finance and Corporate Services** *Term contract*	Clinical coding Finance Audit and risk Site services: infrastructure, engineering, security, telecommunications Legal Soft facilities management Library
Dr Maxine Wardrop **Executive Director** **Safety, Quality and Consumer Engagement** *Term contract*	Clinical governance Patient safety and quality Consumer engagement Patient experience Policy Patient and staff survey
Ms Kate Gatti **Executive Director** **Clinical Service Planning and Population Health** *Term contract*	Health promotion Aboriginal health Community subacute services Clinical planning Mental health strategy Workforce planning
Rita Freijah **Executive Director** **Contract Management** *Acting | Postition holder: Leon McIvor*	Procurement Contract management Commercial property Public–private partnerships (PPP's) Major projects Information and communications technology

Geraldine Carlton **Executive Director** **Organisational Development and Transformation** *Term contract*	Innovation Organisational development Leadership and culture Human resources Medical workforce Industrial relations Occupational safety and health Research
Janet Zagari **Executive Director** **Fiona Stanley Fremantle Hospitals Group** *Acting | Postition holder: vacant*	Fiona Stanley Hospital Fremantle Hosptial Rottnest Island Nursing Post
Kathleen Smith **Executive Director** **Rockingham Peel Group** *Acting | Postition holder: Geraldine Carlton*	Rockingham General Hospital Murray District Hospital Peel Community Health
Dr Paul Mark **Area Clinical Services** **Director Clinical Services** **Fiona Stanley Fremantle Hospitals Group** *Substantive*	Clinical Advisors to Chief Executive and Executive Directors on strategic matters related to patient care; clinical priorities, workforce models; professional education and training and mental health.
Taylor Carter **Area Nursing and Midwifery** **Director Nursing and Midwifery** **Fiona Stanley Fremantle Hospitals Group** *Substantive*	
Temporarily vacant **Director** **Office of the Chief Executive** *Postition holder: Joel Gurr*	Ministerial and parliamentary liaison Executive support board Integrity and ethics Corporate communications Corporate record keeping management Travel coordination
Jodie Pudney **Manager, Corporate Communications** *Substantive*	Corporate communications Public relations Media management Marketing/advertising

Strategic focus

A snapshot of the SMHS community

SMHS' catchment has a population of more than **659,000** people. Of these:

1. Life expectancy is **81.8 years** of age for a male and **86.1 years** for a female.
2. **44%** of all potentially preventable hospitalisations were due to chronic conditions.
3. **206,075** people, including **7,142** Aboriginal people, were diagnosed with cancer in 2017–18.
4. More than **69%** of adults are overweight or obese.
5. **53.6%** of adults do not eat two serves of fruit and **90.5%** do not eat five serves of vegetables daily.
6. Close to **65%** of children do not undertake sufficient physical activity.
7. **18.8%*** of adults aged 25 years and over have high blood pressure or are taking medication for high blood pressure.
8. **17%** of adults aged 25 years and over have high cholesterol or are taking medication for high cholesterol.
9. **9.6%*** of adults smoke
10. **25.6%*** (aged 16 years and over) consume alcohol at levels deemed high-risk for long-term harm.

Note: The asterisk represents 2016 data.

A snap shot of health care provided

Our emergency departments treated in excess of **205,900** patients.

On its busiest day Fiona Stanley Hospital's emergency department cared for **354** patients.

More than **47,700** emergency patients were children aged between 0 and 15 years.

The baby-boom continues with close to **4,900** babies born during the year, with 45 multiple births.

Our surgical teams performed in excess of **30,400** elective and **13,900** emergency surgeries.

Our intensive care teams treated more than **3,100** patients.

129 patients had their lives changed by receiving a transplant:

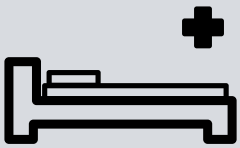
12 heart transplants

13 lung transplants

1 heart and lung transplant

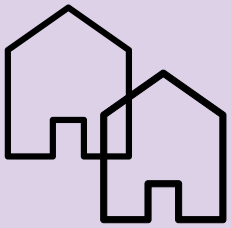
35 kidney transplants

68 bone marrow transplants

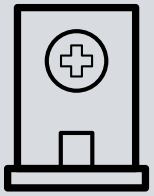


Our hospitals delivered inpatient care more than **158,600** times.

More than **139,800** patients attended in excess of **623,700** outpatient appointments.



Over **10,460** patients received more than **29,400** occasions of service in their homes from our community-based teams.



Close to **2,900** consumers were provided care by our hospital-based mental health teams.

Our community-based mental health teams assisted in excess of **10,800** consumers by delivering close to **162,000** occasions of service.

Our teams provided care via telehealth or telephone on more than **65,000** occasions.

Note: Comparison cannot be made to the snapshot data reported in the SMHS Annual Report 2016–17. The methodology used to provide 2017–18 snapshot data was refined and in some instances a different dataset was used to provide more precise statistics.

Vision and values

The SMHS vision is **excellent health care, every time**. In delivering on this vision SMHS will be a health service that:

- values a culture of safety and quality
- engages with all staff
- demonstrates high performance across all areas.

SMHS is unified across its hospitals and services by its values and behaviours that provide a strong expectation of conduct for all SMHS staff no matter where they work.

Integrity

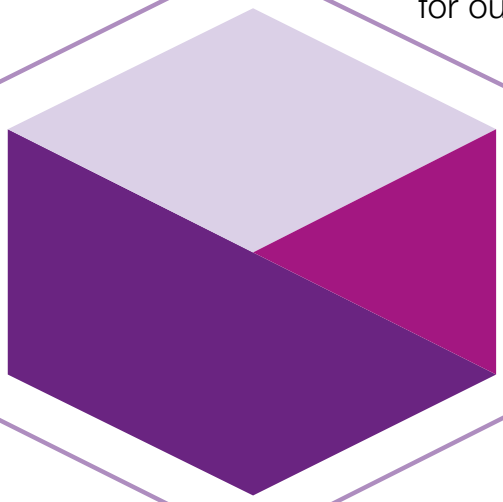
We are accountable for our actions and always act with professionalism.

Care

We provide compassionate care to the patient, their carer and family. Caring for patients starts with caring for our staff.

Respect

We welcome diversity and treat each other with dignity.



Excellence

We embrace opportunities to learn and continuously improve.

Teamwork

We recognise the importance of teams and together work collaboratively and in partnership.

Excellent health care, every time

Service delivery

SMHS delivers hospital and community-based services to nearly a quarter of the State's population within nine local government areas. In addition, SMHS provides services to WA Country Health Service (WACHS) patients from Great Southern, South West, Southern Wheatbelt and Goldfields as well as providing several statewide services.

SMHS comprises of:

- Fiona Stanley Hospital (including Rottnest Island Nursing Post)
- Rockingham General Hospital
- Fremantle Hospital
- Murray District Hospital
- Peel Health Campus (delivered as a public private partnership with Ramsay Health Care Limited).

A range of highly specialised multi-disciplinary services are provided:

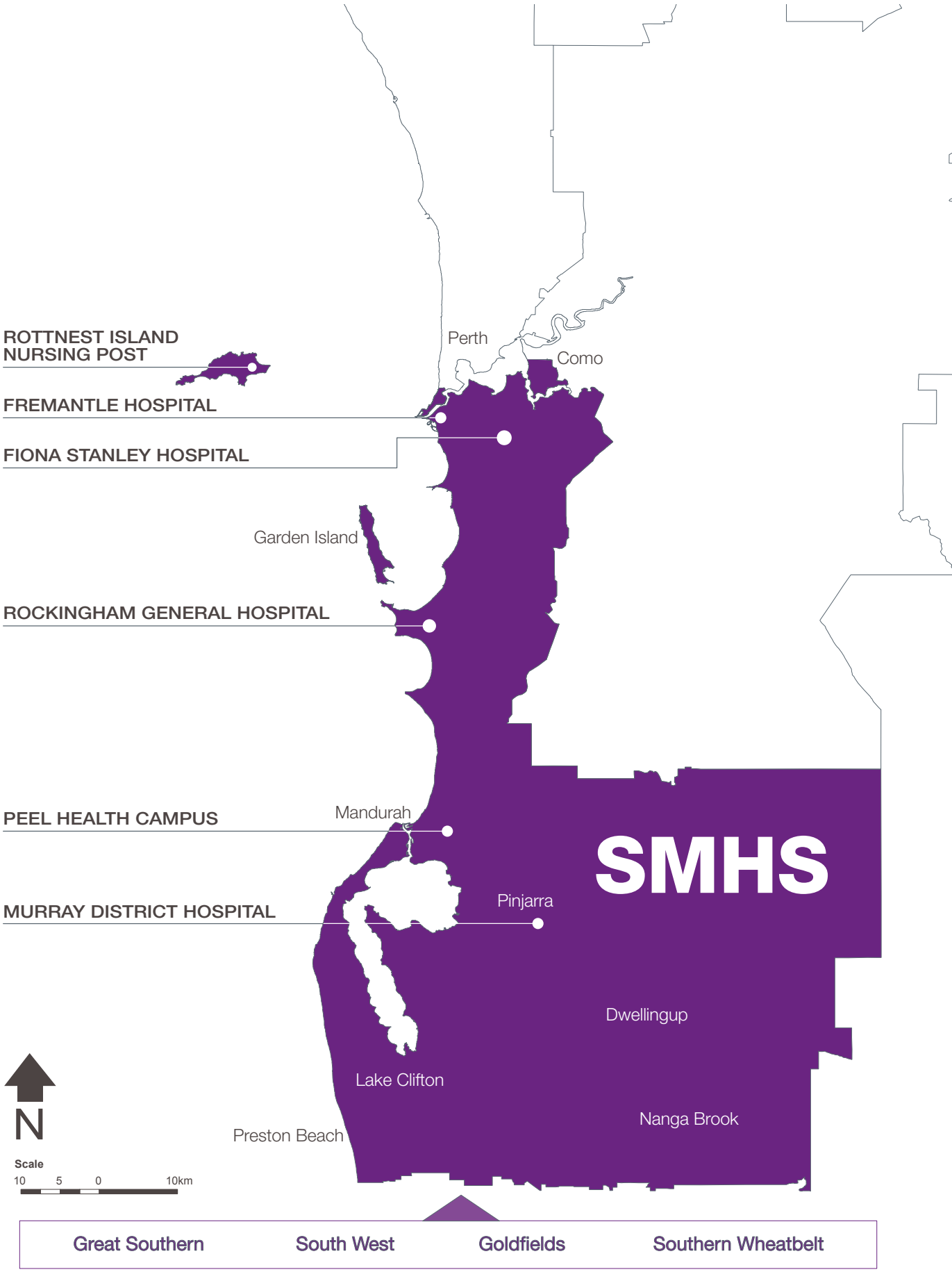
- medical
- surgical
- emergency
- rehabilitation and aged care
- coronary care
- cancer care
- intensive and high dependency care
- mental health
- paediatric
- obstetric and neonatal
- palliative care.

In addition, the health service provides statewide services:

- adult burns
- hyperbaric
- rehabilitation
- heart and lung transplant.

SMHS is also responsible for delivering local health promotion and community-based services:

- Health Promotion partners with community groups, workplaces, schools and local government within the SMHS catchment to reduce the prevalence of lifestyle-related chronic disease through public policy initiatives, advocacy and community-focused programs.
- Subacute service delivery programs help the facilitation of early discharge from hospital, support individuals in remaining independent, and prevent re-admissions. These services are provided metropolitan-wide by:
  - **Rehabilitation-in-the-Home (RITH)** provides short to medium-term, in-home multi-disciplinary rehabilitation post-discharge, or to prevent admission.
  - **Complex Needs Coordination Team (CoNeCT)** provides an assessment and care coordination service to patients in the community with complex health needs.
  - **Community Physiotherapy Service (CPS)** provides evidence-based, sub-acute physiotherapy rehabilitation at local community facilities.
- Western Australia Limb Service for Amputees (WALSA) provides funding for the purchase of essential prostheses for eligible amputees through an integrated client-focused service with three contracted community-based private prosthetic service providers.
- As part of its public health responsibilities, SMHS works in partnership with the WA Health Communicable Disease Control Directorate and other service providers to prevent and control the spread of communicable diseases.


ROTTNEST ISLAND NURSING POST
FREMANTLE HOSPITAL
FIONA STANLEY HOSPITAL
ROCKINGHAM GENERAL HOSPITAL
PEEL HEALTH CAMPUS
MURRAY DISTRICT HOSPITAL
Perth
Como
Garden Island
Mandurah
Pinjarra
SMHS
Dwellingup
Lake Clifton
Nanga Brook
Preston Beach
N
Scale
10 5 0 10km
Great Southern
South West
Goldfields
Southern Wheatbelt

FIONA STANLEY HOSPITAL

FREMANTLE HOSPITAL

ROTTNEST ISLAND NURSING POST

Snapshot of SMHS hospitals

Fiona Stanley Fremantle Hospitals Group

The single streamlined governance structure of Fiona Stanley Fremantle Hospitals Group (FSFHG) helps to ensure greater integration between the two hospitals with better access and flow for patients within and across specialty areas.

Fiona Stanley Hospital (FSH) is the major tertiary hospital in the south metropolitan area and offers comprehensive health care services. It has 783 beds and offers:

- general and specialist medical and surgical services
- subacute services including rehabilitation and aged care
- comprehensive cancer services
- State adult burns unit
- State rehabilitation service
- State heart and lung transplant service
- emergency and intensive care
- mental health
- maternity, paediatric and neonatal services.

As a 300-bed specialist hospital, Fremantle Hospital (FH) is important in supporting FSH, as the tertiary centre, and for the ongoing delivery of services to patients within the SMHS catchment.

FH offers a range of services including mental health, aged care, and elective surgical services in the following specialties:

- general surgery
- orthopaedics
- plastic surgery, specifically hands
- ear, nose and throat
- gynaecological
- dental and maxillo-facial
- endoscopy
- ophthalmology.

ROCKINGHAM GENERAL HOSPITAL

MURRAY DISTRICT HOSPITAL

PEEL HEALTH CAMPUS

Rockingham Peel Group

Services at Rockingham Peel Group (RkPG) comprise:

- Rockingham General Hospital (RGH) and Murray District Hospital (MDH) – a combined total of 242 beds
- Mandurah Community Health Centre
- Kwinana Community Health
- Rockingham Community Mental Health Service
- Peel Community Mental Health Service.

RGH is a general hospital with an emergency department (ED) and supports the following inpatient services:

- acute and general medicine
- geriatric medicine
- palliative care
- paediatrics
- obstetric and neonatal services
- surgical including ear, nose and throat, gastroenterology, general, gynaecology, orthopaedic, urology and paediatric (general)
- intensive care
- psychiatry (adult and older adult).

A range of day procedure and outpatient services are provided including chemotherapy.

MDH is located in Pinjarra and provides mainly aged care beds. Medical care is provided by medical staff from RGH and local GPs credentialed with admitting rights. Support services delivered at the hospital include medical imaging and allied health.

Peel Health Campus

Peel Health Campus (PHC) is a 193-bed public and private hospital of which 140 public beds are managed in partnership with private provider, Ramsay Health Care Australia Pty Ltd. PHC provides a full suite of general hospital services, including a 24-hour emergency department, medical and surgical services, maternity, aged care, rehabilitation, and oncology services.

Strategic priorities

In June 2017 the inaugural *2017–2020 SMHS Strategic Plan* was launched to provide a clear direction for the future and guide decisions at all levels of the health service.

Throughout 2017–18 considerable effort was directed to developing and prioritising tangible initiatives and projects under each of the five strategic priority areas with the aim of delivering real benefits for patients, staff and the community. In developing these initiatives SMHS was guided by the needs of patients, staff, and community; the allocation and availability of resources; and changes in internal and external environments.

The following initiatives, identified under the relevant SMHS strategic priority, highlight just some of what the health service, and its sites and services have implemented throughout the year.

Excellence in the delivery of safe, high quality clinical care

Champion health service for Choosing Wisely

SMHS became a champion health service for the global initiative Choosing Wisely. This program provides opportunities to increase clinician and patient awareness of treatments being provided to ensure only necessary tests, treatments and procedures are conducted. Under this umbrella, various service areas implemented changes that positively impacted patients. For example:

- The Intensive Care Unit (ICU) at FSH found many pathology blood tests were requested unnecessarily, partly due to the historical practice of a routine morning blood test round on most ICU patients. In line with Choosing Wisely, the ICU developed guidelines and began a unit-wide education campaign to reduce orders across a range of blood tests.
- A review was undertaken of the pathology order sets that define the protocols for requesting pathology and tests included within an order set or batch. It was identified that unnecessary testing was being undertaken with little evidence that the tests were clinically needed or appropriate. As a result, new order sets were developed with fewer tests per batch. The outcome was fewer invasive procedures for patients, which resulted in significant savings for SMHS.

Enhancing models of care

Numerous improvements to models of care were made across the health service, all aimed at improving a patient's health care journey. Highlights included:

- A new One-stop Rapid Access Neck Lump Clinic to diagnose head and neck tumours as early and as quickly as possible. Head and neck cancers progress rapidly and result in significant physical and psychosocial issues for

patients. Clinic patients were assessed by both FSH Ear, Nose and Throat (ENT) and Radiology teams on the same day, including the return of results, or within subsequent days for a small number of complex cases. Rapid access to further imaging was also available, if required. This initiative resulted in earlier diagnosis for patients, with some avoiding surgery through less invasive radiation oncology treatment.

- Implementation of a Rapid Assessment Clinic (RAC) at RGH delivered timely assessment and management of medical patients referred from the emergency department. Rather than admitting patients to a hospital ward for less than 24-hour care, appropriate patients were reviewed by the RAC for treatment. As a result, patients were discharged home safely and fast-tracked to appropriate outpatient appointments without a hospital admission.

Provide a great patient experience

SMHS Consumer and Carer Engagement Strategy

Healthcare providers are increasingly acknowledging the importance and effect of consistent consumer and carer engagement on the quality of the patient experience and their ability to meet the health care needs of the community. Whilst SMHS sites have always had consumer advisory councils and consumer-led activities in place, it was important to have an overarching strategic, organisational engagement approach. Following extensive consultation with internal and external stakeholders groups and with carers and consumers, the *SMHS Consumer and Carer Strategy* was developed and endorsed by the SMHS Board in 2017–18.

This strategy guides and embeds consumer and carer engagement activities at all levels of the health service to further improve the quality, accessibility and inclusiveness of services necessary to meet the health care needs of all the community, but particularly those patients from vulnerable groups. It provides a vehicle for patient groups to provide direct input regarding issues and potential solutions.

SMHS Consumer Feedback Strategy

Patient experience feedback and data is currently collected via a variety of sources across SMHS, including the use of Patient Opinion, patient surveys and compliments and complaints. As SMHS matures as a health service, it is important to collect patient experience data using various methods and link them to a more strategic, organisational approach. This includes greater sharing of results with staff for the implementation of quality initiatives to improve the patient experience.

The newly endorsed *SMHS Consumer Feedback Strategy* provides an organisational approach to implementing change as a result of patient and consumer feedback. The strategy provides direction on the suite of patient experience measurement methods SMHS is to implement to ensure feedback collected is representative of the diverse health care needs of consumers. It also establishes a clear, consistent process for the regular dissemination of feedback and results to all staff across the health service and consumers. This strategy was developed in consultation with consumers and numerous internal stakeholders.

Engage, develop and provide opportunities for our workforce

SMHS Institute of Healthcare Improvement Chapter

The SMHS Institute of Healthcare Improvement (IHI) Chapter provides opportunities for staff across the health service to access the IHI Open School. This further develops staff in areas including improvement capability, patient safety, leadership and person and family-centred care. More than 480 staff accessed these learning opportunities in 2017–18. After the initial IHI licences expired in April 2018, SMHS renewed its subscription and 300 new licenses were allocated for staff use in 2018 and 2019. Under this initiative, SMHS staff during 2017–18 earned:

- 137 Basic Certificates in Quality and Safety
- 8 Faculty Development Certificates
- 27 Patient Safety Certificates
- 46 Quality Improvement Certificates.

Staff wellness programs

Evidence shows staff who are physically and mentally healthy provide safer patient care. In 2017–18, SMHS continued to implement an evidence-based staff health and wellbeing program across its hospitals through staff wellness committees. Through the development of annual event calendars and linkages with relevant external providers these committees provided numerous opportunities for staff involvement in wellness initiatives.

In May 2018, the FSFHG Staff Wellness program was awarded silver status by the Healthier Workplace WA initiative recognising its leadership in workplace health and wellbeing. FSFHG is the first hospital group in WA to receive silver status in the Recognised Healthy Workplace (RHW) program. The Healthier Workplace WA initiative is provided by the Heart Foundation WA in conjunction with Cancer Council WA and in partnership with the State Government through the Department of Health.

Strengthen relationships with our community and partners

Partnering with Local Government Authorities

Local government authorities (LGAs) and SMHS play a significant role in creating healthy environments in which local communities can prosper. By engaging with the nine LGAs within its area, SMHS optimises the reach of its evidenced-based prevention programs, helps keep the community healthy, and ultimately reduces hospital admissions.

In particular, SMHS partnerships with LGAs during 2017–18 resulted in:

- the launch of the second edition of the *Pathway to a Healthy Community – A Guide for Councillors and Local Government*, a resource that supports local government public health planning

- the development of health and wellbeing profiles that outlined the prevalence of lifestyle risk factors and psychosocial behaviours within each LGA, enabling targeted strategies to be developed.

Improving referral pathways

From the outset, SMHS has collaborated with the WA Primary Health Alliance (WAPHA) on the HealthPathways project, an online tool for GPs to assess, diagnose, manage and refer patients. Given the excessive wait lists and wait times for outpatient ENT appointments, with many patients waiting years for care, a significant focus in 2017–18 was improving the referral process to ENT specialists.

Following a GP focus group session to inform the process, SMHS collaborated with Central Referral Service, East and North metropolitan health services and WAPHA's HealthPathways team to develop and implement metro-wide referral criteria for adults with common low acuity ENT conditions. The implementation of the referral criteria reduced low acuity referrals by 31 per cent at FSFHG.

Achieve a productive and innovative organisation which is financially sustainable

SMHS Telehealth Strategic Plan

Historically the biggest driver of telehealth has been individual clinician engagement and enthusiasm. This resulted in largely opportunistic growth in the use of telehealth in service delivery. A strategic approach to telehealth was critical to maximise its potential to improve service efficiencies and capabilities, develop new service models and extend patient interactions beyond traditional care settings.

The *SMHS Telehealth Strategic Plan 2018–2020* was approved in January 2018. The plan aims to improve patient access to high quality care by embedding telehealth into standard clinical practice, promoting new and innovative service delivery, and promoting an optimal patient experience by providing a choice that is flexible and responsive to patient needs.

Key achievements since implementation commenced include:

- All SMHS sites have the minimum technological resources required to conduct telehealth appointments.
- RGH developed and implemented an outpatient telehealth pilot project in endocrinology in May 2018.
- Telehealth processes and procedures at FH have been improved and the number of specialties using telehealth at FH has increased.

Towards Zero Harm

Counting what counts for patient safety

SMHS is dedicated to developing a culture and mindset of zero harm, of striving towards causing no harm to patients. This philosophy encourages an environment of openness, transparency and continual improvement of the safety, quality and effectiveness of care provided. It is underpinned by monitoring and measuring the safety and quality of the services provided to patients and the community. Measuring facilitates the identification of opportunities for improvement and enables SMHS to maintain a focus on '**counting what counts for patient safety**'.

Investigating clinical incidents

As a part of the towards zero harm approach, SMHS takes all clinical incidents seriously and to prevent recurrence, ensures systematic and in-depth investigation of incidents and implementation of learnings.

The clinical incident management process is undertaken in accordance with the *WA Clinical Incident Management Policy* and the *WA Open Disclosure Policy Statement*. The principles of open disclosure ensure SMHS communicates in an open, empathetic and timely manner as it supports patients, their family and carers, who have experienced harm during health care.

A severity assessment code (SAC) rating is applied to clinical incidents as an indicator of the actual or potential harm caused. SAC1 clinical incidents are identified as incidents where serious harm or death was, or could have been, caused by the health care provided, rather than the patient's underlying condition or illness.

There were 175 SAC1 clinical incidents notified within SMHS during 2017–18. At the time of reporting (9 July 2018) the investigation of 167 incidents had been completed and eight (8) were in progress. Of the **167 clinical incidents** investigated:

- 113 cases were confirmed as SAC1 clinical incidents
- 54 were declassified after investigations determined the health care provided did not contribute to the patient's outcome.

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

Of the **113 SAC1 clinical incidents** where health care was found to be a contributing factor:

- 10 were associated with a patient's death
- 44 with serious harm
- 38 with minor to moderate harm
- 21 with no harm.

Although 21 SAC1 clinical incidents resulted in no harm, these incidents were considered to have had the potential for serious harm and were investigated to prevent recurrence.

SMHS recognises serious clinical incidents may result in difficult times for patients, their families and our staff. As such, SMHS remains committed to learning from these incidents, and supporting families, carers and staff after the incident, and especially through the investigation and open disclosure process.

Measuring for patient safety

In building a zero harm culture it is important SMHS measures, in a reliable and regular manner, the occurrence and severity of healthcare-associated harm. Measuring ensures the identification of trends and issues, either in a hospital or across the health service, and allows action to be taken to address the issue(s).

Three common conditions monitored in hospitals are healthcare associated infections (HAI), pressure injuries, and falls. All are costly to patients, hospitals and the community as they can result in an extended hospital stay, slower recovery, and increased patient stress and anxiety. While these occur in any hospital setting, effective prevention and control can significantly reduce rates and therefore improve outcomes.

SMHS hospitals participate in a statewide surveillance program which assists them to closely monitor HAIs, pressure injuries and falls data, and to evaluate preventative strategies. Surveillance data is reported throughout all levels of the health service to support good decision-making.

Healthcare associated infections

The most common types of infection acquired in hospitals are urinary tract infections (UTI), pneumonia (lung infection), wound infections and bloodstream infections, i.e. *Staphylococcus aureus* bloodstream infections (SABSI). For an infection to qualify as healthcare-associated there must be no evidence it was present or developing at the time of hospital admission.

The nationally agreed benchmark set under the National Healthcare Agreement is currently no more than 2.0 cases of healthcare-associated SABSIs per 10,000 occupied bed-days. WA Health has adopted a lower benchmark of less than or equal to 1.0 healthcare-associated SABSIs per 10,000 occupied bed-days. Occupied bed-days are the number of beds in a hospital occupied by patients each day.

For the period July 2016 to March 2018 SMHS has remained below the national benchmark (refer to graph 1). These infection rates were related to a small number of cases.

When a SABSI occurs in a SMHS hospital, and when the HAI rate does not meet the agreed benchmark, a review is undertaken to identify the factors that contributed to both the individual case and the increased rate. Once these factors have been established, actions are developed to address the issue(s).

For example, the review of an infection in a patient's intravenous (IV) catheter determined there were a variety of dressings being used for this type of IV line across the hospital. As inconsistencies in treatment can increase the risk of infection, the dressings used for these IV lines were standardised and this was supported by an education program.

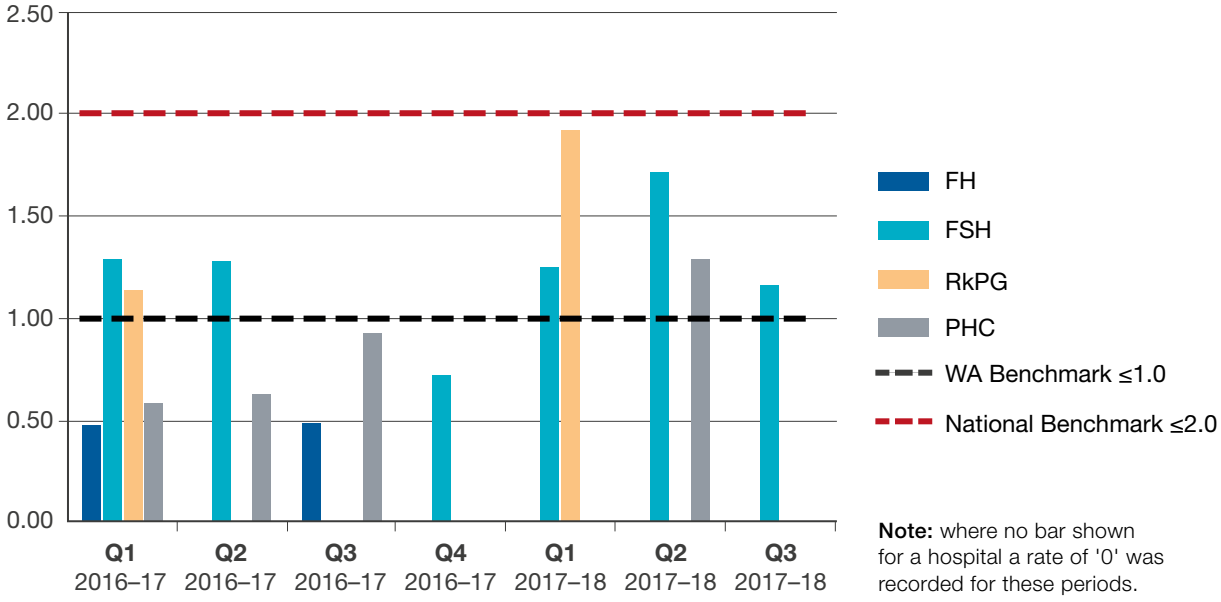
Pressure injuries

A pressure injury is a sore, break or blister of the skin caused by constant, unrelieved pressure on an area of the body over a long period. Pressure injury-related clinical incidents are reported for those pressure injuries that were not present on the patient's admission to hospital and for those injuries that have deteriorated since the patient was admitted.

SMHS patients are screened for pressure injuries on presentation to the emergency department and admission to hospital. Following admission, SMHS patients are risk assessed regularly to ensure pressure injury prevention strategies are in place as required. SMHS hospitals use a tool called the Braden scale to assist staff to predict a patient's risk for pressure injuries and then manage this risk in line with best practice guidelines.

As there is currently no national or state agreed inpatient pressure injury rate benchmark, SMHS sites and services use the Australian Council for Healthcare Standards (ACHS) annual peer rate as the benchmark. The most recently published ACHS annual peer rate is for 2015 and equates to less than or equal to 0.73 inpatient pressure injuries per 1,000 occupied bed-days.

Graph 1: Quarterly healthcare associated *Staphylococcus aureus* blood stream infections per 10,000 bed-days in SMHS hospitals, July 2016 to March 2018



Note: where no bar shown for a hospital a rate of '0' was recorded for these periods.

The total SMHS rate of inpatient pressure injuries averaged 0.37 from January 2017 to June 2018 and remains below the agreed benchmark (refer to graph 2). These rates relate to a small number of cases.

When a SMHS hospital's pressure injury rate does not meet the agreed benchmark a review is undertaken and an action plan is developed. For example, one SMHS hospital implemented a number of strategies following an increase in their pressure injury rate which included staff education on the functions built into pressure-relieving mattresses by the manufacturer.

Falls

Each year nearly one quarter of people over 60 years of age will experience a fall. Falls account for over 80 per cent of all injury-related hospital admissions for people aged 65 years and older.

To prevent falls, SMHS patients are assessed for the risk of a fall and the potential to be harmed from falls. A combination of falls prevention and harm minimisation strategies are used for those patients assessed as at risk of falling.

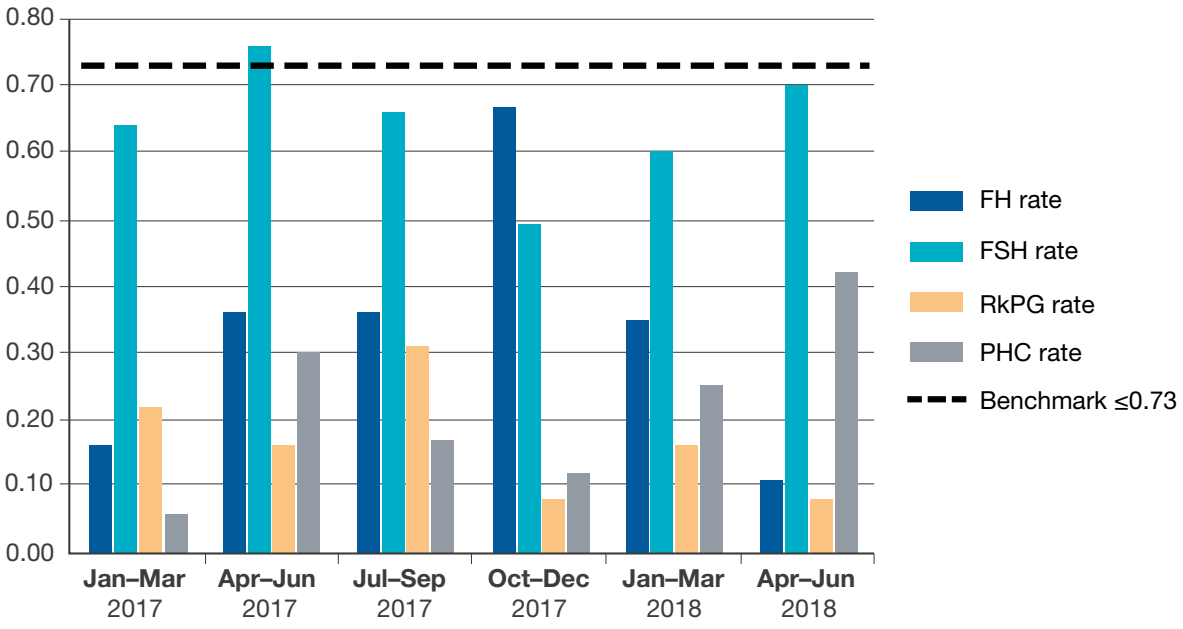
These strategies form a falls prevention plan for the patient, and this is monitored regularly to ensure its effectiveness and appropriateness. Patients and carers are also informed of the identified risks from falls and are encouraged to participate in the development of their falls prevention plan.

As there is currently no national or state agreed falls rate benchmark, SMHS sites and services use the ACHS annual peer rate as the benchmark. The most recently published ACHS annual peer rate is for 2015 and equates to ≤3.5 falls per 1,000 occupied bed-days.

The overall falls rate for SMHS is above the benchmark rate, which is reflective of the positive clinical incident reporting culture within SMHS (refer to graph 3). In addition, a review of the outcomes of patient falls shows the majority of falls had a patient outcome of no or minor harm. That is for 2017–18, 0.6 per cent of patient falls were associated with serious harm or death, 4.3 per cent moderated harm and 95.1 per cent with no or minor harm.

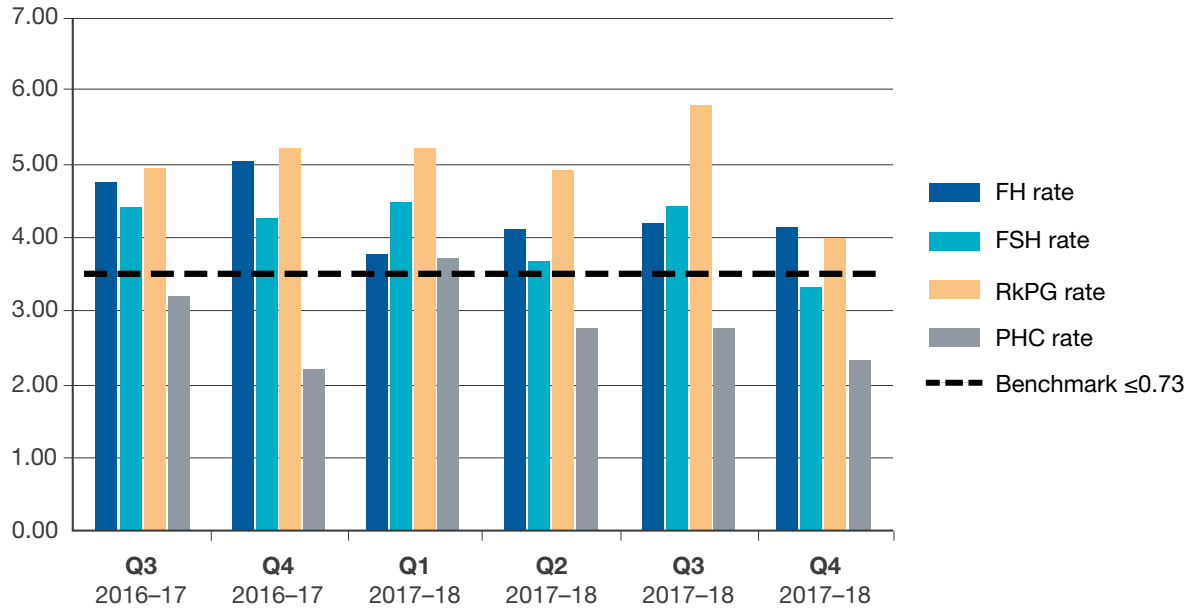
When a SMHS hospital's falls rate does not meet the agreed benchmark, or a fall occurs

Graph 2: Quarterly rate of pressure injuries stage ≥2 per 1,000 occupied bed-days by SMHS hospital, January 2017 to June 2018



which resulted in serious harm, a review is undertaken and falls prevention initiatives are implemented specific to the identified issues. For example, one SMHS hospital introduced a colour-coded falls risk card system that requires a coloured card to be placed in the front of each patient's file to ensure all staff are aware 'at a glance' of a patient's falls risk status.

Graph 3: Quarterly falls per 1,000 occupied bed-days by SMHS hospital, January 2016 to June 2018



Making patient feedback count

Obtaining feedback from patients, their families and carers allows SMHS to:

- gain an understanding of issues impacting on patient care
- identify gaps in service delivery
- celebrate staff and services that are providing positive experiences
- modify processes to improve the care provided.

SMHS collects patient feedback from a number of different sources including:

- continuous inpatient, mental health, emergency department and day surgery patient experience surveys, which help to monitor performance and assess quality
- complaints and compliments, which are managed in accordance with the *WA Health Complaints Management Policy 2015*
- Patient Opinion, a moderated online social media platform for the public to anonymously share their health care experience, positive or negative.

Data and information obtained from these feedback mechanisms is shared with relevant service areas and frontline staff, with improvement initiatives implemented as required. Active monitoring by various peak governance committees, including Board Safety and Quality, and Culture and Engagement Committees and SMHS

FSFHG and RkPG executive committees enables health service-wide trends to be identified and strategies developed to address areas of concern.

The issue of communication was commonly identified as an area for improvement across the health service. Specifically, patients, their families and carers wanted to ensure:

- instructions for ongoing care were always provided on discharge
- an inclusive approach to care with greater inclusion in decision making and better listening skills
- clear explanation of the reasons for treatment delays.

Examples of where services have been improved as a result of patient, carer and family feedback include:

- FSH State Rehabilitation Service (SRS) introduced fortnightly 'Welcome to SRS' induction and orientation for new patients and families. These ensured the routine discussion of care management plans with the patient and their significant others in preparation of discharge from the service.
- The Day Procedure Unit at RGH introduced the WHAMI mnemonic (wound, home transport, appointment, medications, important advice) to assist staff to cover all aspects of discharge information when communicating with patients, carers and family. WHAMI posters were installed at all bedsides and staff provided with WHAMI lanyard cards to serve as reminders.
- FH's mental health service introduced weekend recovery workshops, a consumer-led recovery group, after receiving patient feedback on the need for weekend activities within the service.
- PHC took on board feedback from the husband of a dementia patient cared for by the hospital, inviting him to a workshop to map the patient and carer journey through the healthcare system, which led to significant improvements. The gentleman is now on the hospital's Community Board of Advice, and delivers education at graduate and dementia/delirium study days.

Performance Management Framework

To comply with its legislative obligation as a Western Australian government agency, SMHS operates under the Outcome Based Management (OBM) Framework determined by the Western Australian Department of Health. This framework describes how outcomes, services and key performance indicators (KPIs) are used to measure agency performance towards achieving the relevant overarching whole-of-government goals.

This framework is underpinned by key principles of:

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

WA Health's 2017–18 KPIs measure the effectiveness and efficiency of SMHS in achieving the following health outcomes:

Outcome one: public hospital based services that enable effective treatment and restorative healthcare for Western Australians.

Outcome two: prevention, health promotion and aged continuing care services that help Western Australians to live healthy and safe lives.

The Figure 1 (page 46) aligns the SMHS KPIs to the WA Health outcomes and WA Government goals.

Performance against these activities and outcomes are summarised in the Summary of KPIs (page 51) and described in detail within the Disclosure and Compliance section (page 63) of this report.

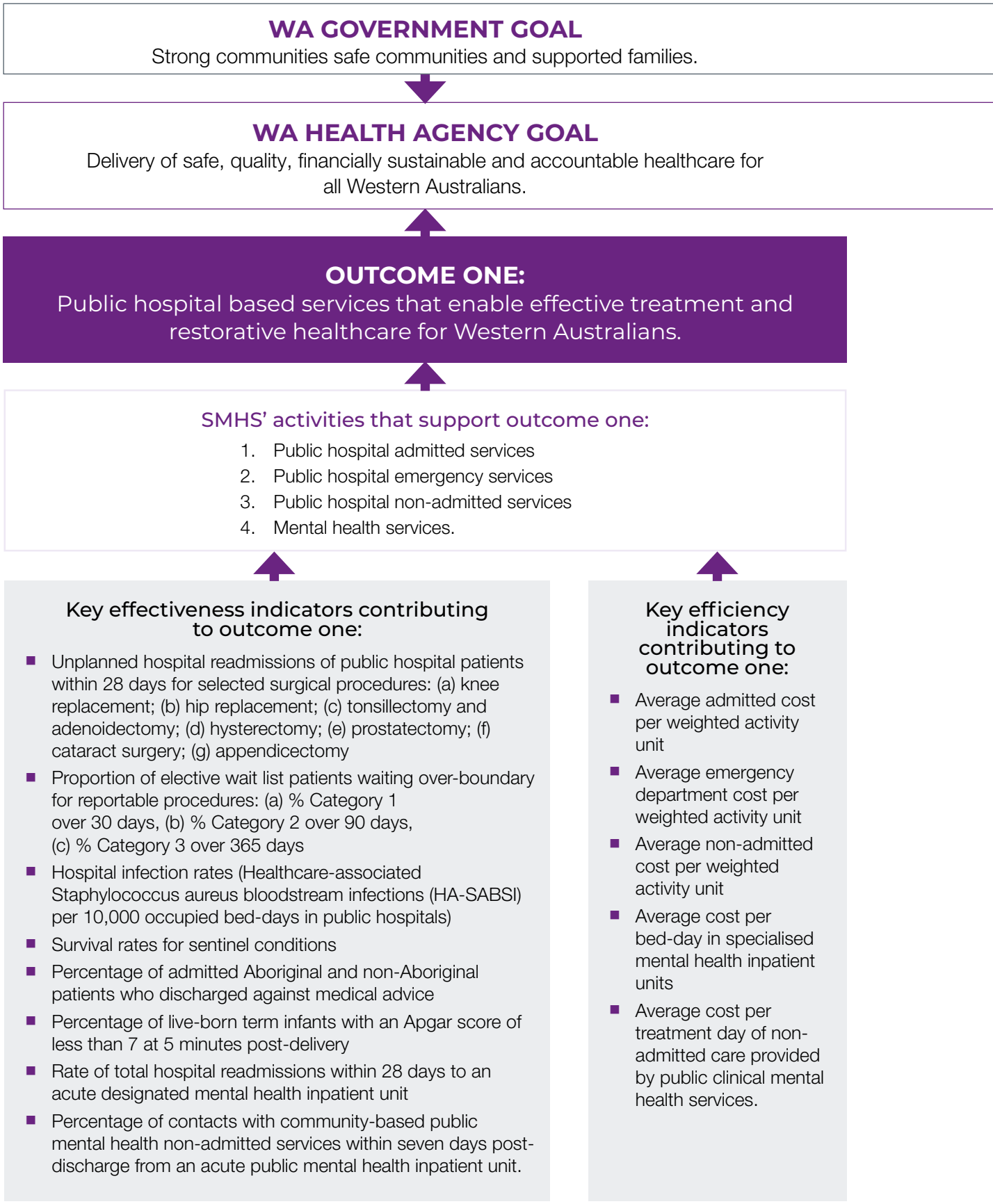
Changes to OBM Framework

WA Health introduced a new OBM Framework in 2017–18. Implementation of this new framework resulted in the re-alignment of costs and KPIs between hospitals and non-hospital services.

Shared responsibility with other agencies

Central to the success of SMHS in delivering health services is the ability to partner with others – government and non-government. In delivering care, SMHS works closely with the Department of Health, as System Manager, and other health service providers, plus various human service agencies, both State and Federal.

Figure 1: Services delivered by SMHS to achieve outcomes



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

SMHS' activities that support outcome two:

6. Public and community health services.

Key efficiency indicators contributing to outcome two:

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

Source: Extracted from 2017–18 Outcome Based Management KPI Data Definition Manual p11.

Agency performance

Financial targets

The total cost of SMHS providing health services in 2017–18 was $1.815 billion. Results for 2017–18 against agreed financial targets (based on Budget statements) are presented in Table 1 and indicate an overall minor deficit against financial targets.

Full details of SMHS' financial performance during 2017–18 are provided in the financial statements (refer page 69).

Table 1. Actual results vs budget targets for SMHS

	2017–18 Estimates $'000	2017–18 Actual $'000	Variation $ +/–
Total cost of services	1,747,952	1,815,020	67,068
Net cost of services	936,220	999,661	63,441
Total equity	2,625,947	2,451,477	(174,470)
Net increase/(decrease) in cash held	4,088	(19,925)	(24,013)
Approved salary expense level	919,686	955,545	35,859

Explanation

Overall financial outcome

Commencing the 2017–18 year SMHS was set the challenge to continue its program of delivering services in a safe and financially sustainable manner. Staff from all disciplines participated in developing and deploying innovative solutions and business improvements to assist this direction. These efforts were successful, with SMHS achieving a small 0.5 per cent deficit ($8.7 million) relative to the total cost of services of $1.8 billion.

Total cost of services variation

There were several issues contributing to the $67 million variation in cost of services. The main issues related to additional costs incurred in the uptake of PathWest shared service charges, increases in depreciation expenditure, higher dispensing of antiviral drugs and increases in delivery of services to patients. This was largely offset through the collection of additional revenue for services provided resulting in a small net operating deficit against budget of $4.7 million.

Net cost of services variation

The variance of $63 million dollars is due to the uptake of PathWest shared services charges, increases in depreciation costs and the extra services delivered to SMHS patients. Additional funding to offset was received from Government sources, which is accounted for separately to the 'Net cost of services'.

Total equity variation

In finalising the 2016–17 Annual Report late transactions occurred relating to asset revaluations. These late entries were not known at the time of preparing the 2017–18 estimates. Therefore, the large decrease in the total equity of $174 million was in the late recognition in 2016–17 of the prior year revaluation decrement associated with the FSH buildings.

Net increase/ (decrease) in cash held variation

The higher usage of cash reserves by $24 million is due to the additional services delivered above initial targeted levels. SMHS received restricted funds from the Commonwealth in 2016–17, which was confirmed as unrestricted during 2017–18 and available to support the increased costs incurred.

Approved salary expense level variation

As described in the 'Total cost of services variation' section, the variance in the salary expenses of $36 million, was largely due to the delivery of services greater than the initial targets provided, which lead to higher employment costs.

Summary of key performance indicators

A summary of SMHS key performance indicators and variations from the targets are given in Table 2. This is to be read in conjunction with the detailed information of each key performance indicator found in the Disclosure and Compliance section (page 63) of this report.

Key performance indicators assist SMHS to assess and monitor the extent to which WA 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 service delivery and the resources used to produce the service.

Table 2: 2017–18 KPI Summary

Key Performance Indicator (KPI)		Calendar year 2017 Target	2017 Actual	Variation
Outcome 1: Public hospital based services that enable effective treatment and restorative healthcare for Western Australians.				
Key Effectiveness Indicators				
Unplanned hospital readmissions of public hospital patients within 28 days for selected surgical procedures: (a) knee replacement; (b) hip replacement; (c) tonsillectomy and adenoidectomy; (d) hysterectomy; (e) prostatectomy; (f) cataract surgery; (g) appendicectomy (represented as per 1,000 separations)				
Knee replacement	≤	26.2	19.2	7.0
Hip replacement	≤	17.2	13.1	4.1
Tonsillectomy and adenoidectomy	≤	61.0	82.6	-21.6
Hysterectomy	≤	41.3	61.5	-20.2
Prostatectomy	≤	38.8	53.1	-14.3
Cataract surgery	≤	1.1	3.7	-2.6
Appendicectomy	≤	32.9	32.1	0.8
Hospital infection rates (Healthcare-associated Staphylococcus aureus bloodstream infections (HA-SABSI) per 10,000 occupied bed-days in public hospitals)	≤	1.0	0.9	0.1
Survival rates for sentinel conditions				
Survival rate for stroke, by age group				
0–49	≥	94.3%	96.8%	2.5%
50–59	≥	92.4%	95.2%	2.8%
60–69	≥	92.8%	97.4%	4.6%
70–79	≥	89.5%	92.9%	3.4%
80 and above	≥	80.9%	88.5%	7.6%
Survival rate for acute myocardial infarction, by age group				
0–49	≥	99.2%	99.4%	0.2%
50–59	≥	98.9%	98.8%	-0.1%
60–69	≥	98.1%	97.2%	-0.9%
70–79	≥	96.1%	97.6%	1.5%
80 and above	≥	91.7%	93.4%	1.7%
Survival rate for fractured neck of femur, by age group				
70–79	≥	98.9%	100.0%	1.1%
80 and above	≥	95.3%	98.1%	2.8%
Percentage of admitted Aboriginal and Non-Aboriginal patients who discharged against medical advice				
Aboriginal	≤	0.77%	2.89%	-2.12%
Non-Aboriginal	≤	0.77%	0.60%	0.17%
Percentage of live-born term infants with an Apgar score of less than 7 at 5 minutes post delivery	≤	1.8%	1.3%	0.5%
Rate of total hospital readmissions within 28 days to an acute designated mental health inpatient unit	≤	12%	19%	-7%
Percentage of contacts with community-based public mental health non-admitted services within seven days post discharge from an acute public mental health inpatient unit	≥	75%	80%	5%

Key Performance Indicator (KPI)	Financial year 2017–18 Target		2017–18 Actual	Variation
Outcome 1: Public hospital based services that enable effective treatment and restorative healthcare for Western Australians.				
Key Effectiveness Indicators				
Proportion of elective wait list patients waiting over-boundary for reportable procedures (a) % Category 1 over 30 days (b) % Category 2 over 90 days (c) % Category 3 over 365				
Urgency Category 1		0.0%	25.3%	-25.3%
Urgency Category 2		0.0%	20.6%	-20.6%
Urgency Category 3		0.0%	1.9%	-1.9%
Key Efficiency Indicators				
Average admitted cost per weighted activity unit	≤	$7,285 *	$7,273	$12
Average Emergency Department cost per weighted activity unit	≤	$7,043 *	$6,132	$911
Average non-admitted cost per weighted activity unit	≤	$7,160 *	$7,024	$136
Average cost per bed-day in specialised mental health inpatient units	≤	$1,534 *	$1,594	-$60
Average cost per treatment day of non-admitted care provided by public clinical mental health services	≤	$541 *	$584	-$43
Outcome 2: Prevention, health promotion and aged and continuing care services that help Western Australians to live healthy and safe lives.				
Key Efficiency Indicators				
Average cost per person of delivering population health programs by population health units	≤	$3	$17	-$14

*Targets were revised subsequent to published Government Budget Statements

This summary is to be read in conjunction with the detailed information of each key performance indicator found in the Disclosure and Compliance section (page 63) of this report.

Emergency department access performance

Emergency departments are specialist multidisciplinary units with expertise in providing health care to acutely unwell patients in their first few hours in hospital. With increasing demand, it is essential that the provision of emergency services 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 on how urgently treatment should be provided.

A patient is allocated a triage category between 1 (immediate) and 5 (least urgent) that indicates their treatment acuity. Treatment should commence within the recommended time of the triage category allocated (see Table 3). The aim of this process is to ensure treatment is given in the appropriate time and should prevent adverse conditions arising from deterioration in the patient's condition.

Table 3: Triage category, treatment acuity and WA performance targets

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

Note: The triage process and scores are recognised by the Australasian College for Emergency Medicine.

Table 4: Percentage of SMHS emergency department patients seen within recommended times, by triage category, 2017–18

		Percentage seen on time				
	Total ED Attendances	Triage 1	Triage 2	Triage 3	Triage 4	Triage 5
Fiona Stanley Hospital	107,755	99.9%	69.3%	25.4%	49.0%	84.1%
Rockingham General Hospital	55,714	100%	84.0%	54.6%	70.0%	91.2%
Peel Health Campus	42,483	100%	64.8%	38.6%	56.0%	90.3%
SMHS total	**205,952**	**99.9%**	**72.1%**	**36.2%**	**56.6%**	**86.9%**

Data source: Emergency department data collection

SMHS recognises this is a critical performance indicator in the delivery of safe, high quality care. The health service developed a methodical approach within each hospital with the view of delivering improvements (refer to Significant Issues section on page 57). However, it is recognised by all levels of the health service that further concentrated focus is required if SMHS hospitals are to meet the targets, and to ensure positive experience and outcomes for patients.

Significant issues

Significant issues

With a population of more than 659,000 people, the SMHS catchment represents 24 per cent of the State's population and by 2026 this is expected to increase by a further 21 per cent. The SMHS population is also ageing, with the older adult age group increasing by 76 per cent in the next ten years, compared to a 36 per cent increase for the under-65s.

The impact of this growth is likely to be significant for the health service, as rapidly growing populations tend, in general, to have a lower socioeconomic profile. Such population profiles (see page 25) often experience higher levels of chronic disease such as diabetes and cardiovascular disease, which in turn are strongly associated with lifestyle risk factors including smoking, lack of physical activity and high alcohol consumption. This growth in population challenges the health service's ability to provide timely access to emergency care and elective surgery.

Emergency access

Managing wait times in EDs at FSH, RGH and PHC is critical as it undeniably improves patient outcomes. Overall, SMHS performance remained well below the 90 per cent Western Australian emergency access target (WEAT).

Addressing emergency access performance requires active contribution from all departments and services within hospitals. Throughout 2017–18 processes across the entire patient journey, from the ED and wards through to hospital discharge, were examined, analysed and numerous initiatives implemented.

At FSH, the primary focus was removing the blockages that prevented patients moving quickly from the ED into an appropriate ward area. Initiatives included:

- providing additional weekend emergency theatre lists so patients did not wait for emergency surgery and therefore spent less time in hospital
- reconfiguring FH services and wards to enable increased general medicine and geriatric care, allowing suitable patients to move directly from the FSH Acute Medical Unit to FH
- increasing availability of the Rapid Access Team and Medical Assessment Triage within the ED to seven days per week, enabling patients requiring care to be triaged early and diagnostics procedures to be undertaken as soon as possible.

RGH developed several solutions to enhance patient flow, including:

- starting a Rapid Access Clinic for the timely assessment and management of medical and aged care patients
- coordinating diagnostics investigations after discharge to enable select patients to be discharged rather than wait for results to be returned
- earlier identification of palliative care patients for review by the palliative care team to reduce their time in the ED
- having a Rapid Assessment Team with a senior doctor available at triage to initiate earlier patient care and treatment.

PHC drove improvements through:

- enhancing its workforce with the appointment of a WEAT facilitator and expanding the role of the Rapid Assessment Team
- refining hospital practices and capacity, such as reconfiguring beds in the Short Stay Unit so patients could move quickly from the ED to a ward
- changing the ED layout to provide additional space for triage and ambulatory care areas
- introducing direct medical admissions processes to optimise transfer from the ED to ward areas.

SMHS acknowledges its EDs continue to underperform against WEAT, even with these initiatives and continued hard work of staff. With increasing patient demand, SMHS recognises this area will require improvement. SMHS is developing and implementing further initiatives to address the specific challenges of each emergency department. The health service remains fully committed to making sustained improvements in 2018–19.

Note: Refer to KPI on page 141 for performance information.

Elective surgery

Elective surgery is non-emergency surgery that is medically necessary, but can be delayed for at least 24 hours. A person requiring elective surgery is classified as either:

- **Category 1** – Urgent: procedures that are clinically indicated within 30 days
- **Category 2** – Semi-urgent: procedures that are clinically indicated within 90 days
- **Category 3** – Non-urgent: procedures that are clinically indicated within 365 days.

Any ready for care patient that waits longer than the clinically recommended time for the allocated urgency category is defined as over-boundary.

At the end of June 2017, a total of 9,174 ready for care cases were wait listed to receive an elective surgical procedure at a SMHS hospital. Of this total, 1,388 or 15 per cent were over-boundary. While the overall SMHS elective surgery wait list (ESWL) had decreased by 151 cases on the previous financial year, the number of over-boundary cases had increased from 1,334 to 1,413 cases. Further, at the end of June 2017, approximately 90 per cent of ready for care over-boundary cases were in five specialty areas (see table 5).

Table 5: Percentage of ready for care over-boundary cases at end June 2017 by specialty

Speciality	Percentage of cases
Gastroenterology	57.6%
Urology	13.6%
ENT	6.3%
General surgery	6.2%
Plastic surgery	6.2%
Total	89.9%

As a result, SMHS identified elective surgery as a key area for performance improvement, with the aim of reducing over-boundary wait lists in these five specialty areas to zero by the end of the financial year.

Due to this intensive focus the number of ready for care over-boundary cases reduced by 885 cases in total, or approximately 65 per cent. At the end of 2016–17, 15.1 per cent of SMHS' ESWL cases were over-boundary, compared with 6.4 per cent at the end of 2017–18 (see table 6).

Table 6: SMHS total ESWL on-list and over-boundary cases June 2017–June 2018

SMHS elective surgical wait list	30 June 2017	30 June 2018
Total cases on-list	9174	7813
Total cases over-boundary	1388	503
Percentage of cases over-boundary	15.1%	6.4%

Significant progress was made in the specialities of gastroenterology and ENT, with the number of:

- gastroenterology over-boundary cases reduced from 799 to 38
- ENT over-boundary cases reduced from 88 to 9.

The reduction in over-boundary cases is a significant achievement. However, continual management and attention to wait lists is needed including developing systems and processes to better align and manage demand from initial referral to surgery.


SIGN MIDAZOLAM 800

Disclosure and compliance

Auditor General

INDEPENDENT AUDITOR'S REPORT

To the Parliament of Western Australia

SOUTH METROPOLITAN HEALTH SERVICE

Report on the Financial Statements

Opinion

I have audited the financial statements of the South Metropolitan Health Service which comprise the Statement of Financial Position as at 30 June 2018, 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 South Metropolitan Health Service for the year ended 30 June 2018 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.

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

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 South 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 South 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 2018.

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 South Metropolitan Health Service for the year ended 30 June 2018. 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 South 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 2018.

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

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

The approval was conditional on its inclusion as an unaudited performance indicator in the Annual Report and that it be reinstated as an audited KPI following the implementation of a new Emergency Department data collection system. A new system had not been developed at 30 June 2018. Consequently, the KPI has not been included in the audited KPIs for the year ended 30 June 2018. 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 South Metropolitan Health Service for the year ended 30 June 2018 included on the Health Service's website. The Health Service's management is responsible for the integrity of the Health Service's website. This audit does not provide assurance on the integrity of the Health Service's website. The auditor's report refers only to the financial statements and key performance indicators described above. It does not provide an opinion on any other information which may have been hyperlinked to/from these financial statements or key performance indicators. If users of the financial statements and key performance indicators are concerned with the inherent risks arising from publication on a website, they are advised to refer to the hard copy of the audited financial statements and key performance indicators to confirm the information contained in this website version of the financial statements and key performance indicators.

CAROLINE SPENCER
AUDITOR GENERAL
FOR WESTERN AUSTRALIA
Perth, Western Australia
25 September 2018

Certification of financial statements

SOUTH METROPOLITAN HEALTH SERVICE

CERTIFICATION OF FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2018

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

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

pp Mr Rob McDonald
Chair
South Metropolitan
Health Service Board
21 September 2018

Mr David Rowe
Board Member
South Metropolitan
Health Service Board
21 September 2018

Mr Mark Cawthorne
Chief Finance Officer
South Metropolitan
Health Service
21 September 2018

South Metropolitan Health Service

Statement of Comprehensive Income

For the year ended 30 June 2018

	Note	2018 $000	2017 $000
COST OF SERVICES			
Expenses			
Employee benefits expense	3.1(a)	955,545	935,597
Fees for visiting medical practitioners		11,888	12,677
Contracts for services	3.3	140,411	134,140
Patient support costs	3.2	351,346	358,063
Finance costs	7.3	10,516	13,749
Depreciation and amortisation expense	5.1.1, 5.2.2	106,176	101,045
Asset revaluation decrement	9.9	2,990	2,870
Loss on disposal of non-current assets	4.6	240	20
Repairs, maintenance and consumable equipment	3.4	49,479	49,365
Other supplies and services	3.5	57,067	59,011
Other expenses	3.6	129,362	144,746
Total cost of services		**1,815,020**	**1,811,283**
INCOME			
Revenue			
Patient charges	4.2	93,073	87,264
Other fees for services	4.3	70,227	78,485
Commonwealth grants and contributions	4.4(i)	547,686	538,329
Other grants and contributions	4.4(ii)	91,657	90,388
Donation revenue	4.5	608	417
Interest revenue		9	9
Other revenue	4.5	12,099	12,576
Total revenue		**815,359**	**807,468**
Gains			
Gain on disposal of non-current assets	4.6	-	-
Total Gains		**-**	**-**
Total income other than income from State Government		**815,359**	**807,468**
NET COST OF SERVICES		**999,661**	**1,003,815**
INCOME FROM STATE GOVERNMENT			
Service appropriations	4.1	914,400	924,725
Assets (transferred)/assumed	4.1	33	(196)
Services received free of charge	4.1	76,557	94,545
Total income from State Government		**990,990**	**1,019,074**
SURPLUS/(DEFICIT) FOR THE PERIOD		**(8,671)**	**15,259**
OTHER COMPREHENSIVE INCOME			
Items not reclassified subsequently to profit or loss			
Changes in asset revaluation reserve	9.9	30,736	60,585
Total other comprehensive income		**30,736**	**60,585**
TOTAL COMPREHENSIVE INCOME FOR THE PERIOD		**22,065**	**75,844**

Refer also to note 2.2 'Schedule of Income and Expenses by Service'.
The Statement of Comprehensive Income should be read in conjunction with the accompanying notes.

South Metropolitan Health Service

Statement of Financial Position

As at 30 June 2018

	Note	2018 $000	2017 $000
ASSETS			
Current assets			
Cash and cash equivalents	7.4	19,353	23,856
Restricted cash and cash equivalents	7.4	9,688	28,610
Receivables	6.1	53,284	55,045
Inventories	6.3	5,208	5,277
Other current assets	6.4	4,949	1,732
Total Current Assets		**92,482**	**114,520**
Non-Current Assets			
Restricted cash and cash equivalents	7.4	7,148	3,648
Amounts receivable for services	6.2	723,685	610,791
Property, plant and equipment	5.1	2,093,730	2,166,154
Intangible assets	5.2	23,709	27,287
Total Non-Current Assets		**2,848,272**	**2,807,880**
Total Assets		**2,940,754**	**2,922,400**
LIABILITIES			
Current Liabilities			
Payables	6.5	92,996	93,031
Borrowings	7.1	52,894	60,187
Provisions	3.1 (b)	176,502	166,418
Other current liabilities	6.6	283	170
Total Current Liabilities		**322,675**	**319,806**
Non-Current Liabilities			
Borrowings	7.1	117,993	170,885
Provisions	3.1 (b)	48,609	47,225
Total Non-Current Liabilities		**166,602**	**218,110**
Total Liabilities		**489,277**	**537,916**
NET ASSETS		**2,451,477**	**2,384,484**
EQUITY			
Contributed equity	9.9	2,353,568	2,308,640
Reserves	9.9	91,321	60,585
Accumulated surplus	9.9	6,588	15,259
TOTAL EQUITY		**2,451,477**	**2,384,484**

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

South Metropolitan Health Service

Statement of Changes in Equity

For the year ended 30 June 2018

	Note	2018 $000	2017 $000
CONTRIBUTED EQUITY	9.9		
Balance at start of period		2,308,640	-
Transactions with owners in their capacity as owners:			
Transfer from Metropolitan Health Service (abolished)		-	2,241,747
Capital appropriations		65,628	69,795
Other contributions by owners		(27)	1,999
Distributions to owners		(20,673)	(4,901)
Balance at end of period		**2,353,568**	**2,308,640**
RESERVES	9.9		
Asset Revaluation Reserve			
Balance at start of period		60,585	-
Other Comprehensive income		30,736	60,585
Balance at end of period		**91,321**	**60,585**
ACCUMULATED SURPLUS	9.9		
Balance at start of period		15,259	-
Surplus/(deficit) for the period		(8,671)	15,259
Balance at end of period		**6,588**	**15,259**
TOTAL EQUITY			
Balance at start of period		2,384,484	-
Total comprehensive income for the period		22,065	75,844
Transactions with owners in their capacity as owners		44,928	2,308,640
Balance at end of period		**2,451,477**	**2,384,484**

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

South Metropolitan Health Service
Statement of Cash Flows
For the year ended 30 June 2018

	Note	2018 $000 Inflows (Outflows)	2017 $000 Inflows (Outflows)
CASH FLOWS FROM STATE GOVERNMENT			
Service appropriations		801,284	806,196
Capital appropriations		45,250	67,289
Cash transferred from Metropolitan Health Service (abolished)		-	36,762
Net cash provided by State Government	7.4.2	**846,534**	**910,247**
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Employee benefits		(940,689)	(931,842)
Supplies and services		(662,204)	(632,260)
Finance costs		-	(57)
GST payments on purchases		(1,150)	-
Receipts			
Receipts from customers		85,555	84,664
Commonwealth grants and contributions		547,686	538,329
Other grants and contributions		91,657	90,388
Donations received		275	417
Interest received		9	9
Other receipts		86,916	75,996
Net cash used in operating activities	7.4.2	**(791,945)**	**(774,356)**
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments			
Payment for purchase of non-current physical and intangible assets		(6,738)	(2,857)
Receipts			
Proceeds from sale of non-current physical assets		87	14
Net cash used in investing activities		**(6,651)**	**(2,843)**
CASH FLOWS FROM FINANCING ACTIVITIES			
Payments			
Repayment of finance lease liabilities		(67,863)	(76,934)
Net cash used in financing activities		**(67,863)**	**(76,934)**
Net increase / (decrease) in cash and cash equivalents		(19,925)	56,114
Cash and cash equivalents at the beginning of the period		56,114	-
CASH AND CASH EQUIVALENTS AT THE END OF PERIOD	7.4.1	**36,189**	**56,114**

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

South Metropolitan Health Service

Notes to the Financial Statements

For the year ended 30 June 2018

1. Basis of preparation

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

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

The annual financial statements were authorised for issue by the Accountable Authority of the Health Service on 21 September 2018.

Statement of compliance

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

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

The Financial Management Act 2006 and the Treasurer's Instructions take precedence over AAS. Several AAS are modified by the Instructions to vary application, disclosure format and wording. Where modification is required and has had a material or significant financial effect upon the reported results details of that modification and the resulting financial effect are disclosed in the notes to the financial statements.

Basis of preparation

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

Judgements and estimates

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

Contributed equity

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

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

2. Health Service outputs

This section includes information regarding the nature of funding the Health Service receives and how this funding is utilised to achieve the Health Service's objectives:

2.1 Health Service objectives

Services

To comply with its legislative obligation as a WA government agency, the Health Service operates under an Outcome Based Management framework (OBM). The OBM framework is determined by WA Health and replaces the former activity based costing framework for annual reporting from 2017–18 and beyond. This framework describes how outcomes, activities, services and key performance indicators (KPIs) are used to measure agency performance towards achieving the relevant overarching whole of government goal of strong communities, safe communities and supported families and the WA health system agency goal of delivery of safe, quality, financially sustainable and accountable healthcare for all Western Australians.

With the adoption of the OBM framework in the 2017–18 financial year, the key services and the methodology used to report the Health Service's income and expenses for each service have changed from the 2016–17 financial year. The five key services in the 2016–17 financial year were; public hospital admitted, public hospital emergency, public hospital non-admitted, mental health and prevention, promotion and protection. The six key services of the Health Service under the OBM framework are listed below.

Public Hospital Admitted Patient

The provision of health care services to patients in metropolitan and major rural hospitals that meet the criteria for admission and receive treatment and/or care for a period of time, including public patients treated in private facilities under contract to WA Health. Admission to hospital and the treatment provided may include access to acute and/or sub-acute inpatient services, as well as hospital in the home services. Public Hospital Admitted Services includes teaching, training and research activities provided by the public health service to facilitate development of skills and acquisition or advancement of knowledge related to admitted services. This service does not include any component of the Mental Health Services reported under 'Service 4 – Mental Health Services'.

Public Hospital Emergency Services

The provision of services for the treatment of patients in emergency departments of metropolitan and major rural hospitals, inclusive of public patients treated in private facilities under contract to WA Health. The services provided to patients are specifically designed to provide emergency care, including a range of pre-admission, post-acute and other specialist medical, allied health, nursing and ancillary services. Public Hospital Emergency Services includes teaching, training and research activities provided by the public health service to facilitate development of skills and acquisition or advancement of knowledge related to emergency services. This service does not include any component of the Mental Health Services reported under 'Service 4 – Mental Health Services'.

Public Hospital Non-Admitted Services

The provision of metropolitan and major rural hospital services to patients who do not undergo a formal admission process, inclusive of public patients treated by private facilities under contract to WA Health. This service includes services provided to patients in outpatient clinics, community-based clinics or in the home, procedures, medical consultation, allied health or treatment provided by clinical nurse specialists. Public Hospital Non-Admitted Services includes teaching, training and research activities provided by the public health service to facilitate development of skills and acquisition or advancement of knowledge related to non-admitted services. This service does not include any component of the Mental Health Services reported under 'Service 4 – Mental Health Services'.

2.1 Health Service objectives (continued)

Mental Health Services

The provision of inpatient services where an admitted patient occupies a bed in a designated mental health facility or a designated mental health unit in a hospital setting; and the provision of non-admitted services inclusive of community and ambulatory specialised mental health programs such as prevention and promotion, community support services, community treatment services, community bed-based services and forensic services. This service includes the provision of statewide mental health services such as perinatal mental health and eating disorder outreach programs as well as the provision of assessment, treatment, management, care or rehabilitation of persons experiencing alcohol or other drug use problems or co-occurring health issues. Mental Health Services includes teaching, training and research activities provided by the public health service to facilitate development of skills and acquisition or advancement of knowledge related to mental health or alcohol and drug services. This service includes public patients treated in private facilities under contract to WA Health.

Aged and Continuing Care Services

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

Public and Community Health Services

The provision of health care services and programs delivered to increase optimal health and wellbeing, encourage healthy lifestyles, reduce the onset of disease and disability, reduce the risk of long-term illness as well as detect, protect and monitor the incidence of disease in the population. Public and Community Health Services includes public health programs, Aboriginal health programs, disaster management, environmental health, the provision of grants to non-government organisations for public and community health purposes, emergency road and air ambulance services, services to assist rural-based patients travel to receive care, and statewide pathology services provided to external Western Australian agencies.

2.2 Schedule of income and expense by service – see over the page

2.2 Schedule of income and expense by service

	Public Hospital Admitted Patient		Public Hospital Emergency Services		Public Hospital Non-Admitted Services		Mental Health Services	
	2018 $000	2017 $000	2018 $000	2017 $000	2018 $000	2017 $000	2018 $000	2017 $000
COST OF SERVICES								
Expenses								
Employee benefits expense	607,544	618,392	83,939	79,678	129,394	123,281	113,002	108,206
Fees for visiting medical practitioners	8,379	9,320	1,158	1,201	1,784	1,858	269	207
Contracts for services	101,240	100,245	13,987	12,916	21,563	19,985	11	15
Patient support costs	247,917	263,536	34,258	33,956	53,288	52,538	7,571	5,444
Finance costs	7,563	10,213	1,045	1,316	1,611	2,036	27	84
Depreciation and amortisation expense	73,209	73,532	7,010	9,474	16,486	14,659	8,977	2,662
Asset revaluation decrement	2,156	2,145	298	276	459	428	-	-
Loss on disposal of non-current assets	173	15	24	2	37	3	-	-
Repairs, maintenance and consumable equipment	35,125	36,020	4,853	4,641	7,481	7,181	768	1,171
Other supplies and services	41,150	44,104	5,685	5,683	8,764	8,793	-	-
Other expenses	87,656	105,767	12,126	13,628	19,810	21,085	6,557	3,233
Total cost of services	1,212,112	1,263,289	164,383	162,771	260,677	251,847	137,182	121,022
Income								
Patient charges	67,113	65,221	9,272	8,404	14,294	13,002	-	-
Other fees for services	50,640	58,660	6,996	7,558	10,785	11,694	-	-
Commonwealth grants and contributions	371,768	381,164	51,364	49,112	79,179	75,988	32,118	28,342
Other grants and contributions	1,524	1,588	211	204	325	316	89,544	88,264
Donation revenue	438	312	61	40	93	62	-	-
Interest revenue	7	7	1	1	1	1	-	-
Other revenue	8,724	9,399	1,205	1,211	1,858	1,874	-	-
Gains								
Gain on disposal of non-current assets	-	-	-	-	-	-	-	-
Total income other than income from State Government	500,214	516,351	69,110	66,530	106,535	102,937	121,662	116,606
NET COST OF SERVICES	**711,898**	**746,938**	**95,273**	**96,241**	**154,142**	**148,910**	**15,520**	**4,416**
INCOME FROM STATE GOVERNMENT								
Service appropriations	652,886	689,139	90,203	88,793	139,051	137,385	8,977	2,662
Assets (transferred)/assumed	24	(147)	3	(19)	5	(29)	-	-
Services received free of charge	50,432	69,352	6,968	8,936	10,741	13,826	6,618	1,754
Total income from State Government	703,342	758,344	97,174	97,710	149,797	151,182	15,595	4,416
SURPLUS/(DEFICIT) FOR THE PERIOD	**(8,556)**	**11,406**	**1,901**	**1,469**	**(4,345)**	**2,272**	**75**	**-**

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

	Aged and Continuing Care Services		Public and Community Health Services		Patient Transport		Prevention, Promotion and Protection		Total	
	2018 $000	2017 $000	2018 $000	2017 $000	2018 $000	2017 $000	2018 $000	2017 $000	2018 $000	2017 $000
	7,856	-	13,810	-	-	-	-	6,040	955,545	935,597
	108	-	190	-	-	-	-	91	11,888	12,677
	1,309	-	2,301	-	-	-	-	979	140,411	134,140
	3,014	-	5,298	-	-	15	-	2,574	351,346	358,063
	98	-	172	-	-	-	-	100	10,516	13,749
	198	-	296	-	-	-	-	718	106,176	101,045
	28	-	49	-	-	-	-	21	2,990	2,870
	2	-	4	-	-	-	-	-	240	20
	454	-	798	-	-	-	-	352	49,479	49,365
	532	-	936	-	-	-	-	431	57,067	59,011
	1,249	-	1,964	-	-	-	-	1,033	129,362	144,746
	14,848	-	25,818	-	-	15	-	12,339	1,815,020	1,811,283
	868	-	1,526	-	-	-	-	637	93,073	87,264
	655	-	1,151	-	-	-	-	573	70,227	78,485
	4,807	-	8,450	-	-	-	-	3,723	547,686	538,329
	19	-	34	-	-	-	-	16	91,657	90,388
	6	-	10	-	-	-	-	3	608	417
	-	-	-	-	-	-	-	-	9	9
	113	-	199	-	-	-	-	92	12,099	12,576
	-	-	-	-	-	-	-	-	-	-
	6,468	-	11,370	-	-	-	-	5,044	815,359	807,468
	8,380	**-**	**14,448**	**-**	**-**	**15**	**-**	**7,295**	**999,661**	**1,003,815**
	8,443	-	14,840	-	-	15	-	6,731	914,400	924,725
	-	-	1	-	-	-	-	(1)	33	(196)
	652	-	1,146	-	-	-	-	677	76,557	94,545
	9,095	-	15,987	-	-	15	-	7,407	990,990	1,019,074
	715	**-**	**1,539**	**-**	**-**	**-**	**-**	**112**	**(8,671)**	**15,259**

3. Use of our funding

Expenses incurred in the delivery of services

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

	Notes	2018 $000	2017 $000
Employee benefits expenses	3.1 (a)	955,545	935,597
Employee benefits provisions	3.1 (b)	225,111	213,643
Patient support costs	3.2	351,346	358,063
Contracts for services	3.3	140,411	134,140
Repairs, maintenance and consumable equipment	3.4	49,479	49,365
Other supplies and services	3.5	57,067	59,011
Other expenses	3.6	129,362	144,746

3.1 (a) Employee benefits expenses

Salaries and wages (b)		873,049	853,961
Termination benefits		3,296	4,529
Superannuation – defined contribution plans (a) (b)		79,200	77,107
		955,545	**935,597**

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

(b) Includes recoveries of employee benefit expenses through Internal Service Recoup (ISR) accounts of $1,375,331 and External Service Recoup (ESR) accounts of $5,708,575.

Employment on-costs expenses (workers' compensation insurance) are included at note 3.6 Other expenses.

Salaries and Wages: Employee expenses include all costs related to employment including salaries and wages, fringe benefits tax (FBT), leave entitlements, termination payments and WorkCover premiums.

Termination benefits: Payable when employment is terminated before normal retirement date, or when and employee accepts an offer of benefits in exchange for the termination of employment. Termination benefits are recognised when the Health Service is demonstrably committed to terminating the employment of current employees according to a detailed formal plan without possibility of withdrawal or providing termination benefits as a result of an offer made to encourage voluntary redundancy. Benefits falling due more than 12 months after the end of the reporting period are discounted to present value.

Superannuation: Superannuation expense in the Statement of Comprehensive Income comprises employer contributions paid to the GSS (concurrent contributions), WSS, GESB, and other superannuation funds. The employer contribution paid to the GESB in respect of the GSS is paid back into the consolidated account by GESB.

GSS (concurrent contributions) is a defined benefit scheme for the purposes of employees and whole-of-government reporting. It is however, a defined contribution plan for 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.

3.1 (a) Employee benefits expenses (continued)

The Health Service does not recognise any defined benefit liabilities because it has no legal or constructive obligation to pay future benefits relating to its employees. The Liabilities for the unfunded Pension Scheme and the unfunded GSS transfer benefits attributable to members who transferred from the Pension Scheme, are assumed by the Treasurer. All other GSS obligations are funded by concurrent contributions made by the Health Service to GESB.

GESB and other fund providers administer public sector superannuation arrangements in Western Australia in accordance with legislative requirements. Eligibility criteria for membership in particular schemes for public sector employees vary according to commencement and implementation dates.

3.1 (b) Employee benefits provisions

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

	2018 $000	2017 $000
Current		
Employee benefits provision		
Annual leave (a)	81,668	78,575
Time off in lieu leave (a)	42,840	39,221
Long service leave (b)	50,955	47,450
Deferred salary scheme (c)	1,039	1,172
	176,502	166,418
Non-current		
Employee benefits provision		
Long service leave (b)	48,609	47,225
	48,609	47,225
Total provisions	**225,111**	**213,643**

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

Within 12 months of the end of the reporting period	83,742	80,798
More than 12 months after the end of the reporting period	40,766	36,998
	124,508	**117,796**

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

(b) Unconditional long service leave provision have been classified as current liabilities where there is no unconditional right to defer settlement 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 where there is an unconditional right to defer the settlement of the liability until the employee has completed the required years of service.

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

Within 12 months of the end of the reporting period	12,562	10,841
More than 12 months after the end of the reporting period	87,002	83,834
	99,564	**94,675**

3.1 (b) Employee benefits provisions (continued)

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

(c) Deferred salary scheme liabilities 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. Actual settlement of the liabilities is expected to occur as follows:

	2018 $000	2017 $000
Within 12 months of the end of the reporting period	352	297
More than 12 months after the end of the reporting period	687	875
	1,039	**1,172**

Key sources of estimation uncertainty – long service leave

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

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 per cent. This assumption was based on an analysis of the turnover rates exhibited by employees over a five year period. Employees with leave benefits to which they are fully entitled are assumed to take all available leave uniformly over the following five years or to age 65, if earlier.

Other estimations and assumptions used in calculating the Health Service's long service leave provision include expected future salary rates, discount rates, employee retention rates and expected future payments. Changes in these estimations and assumptions may impact on the carrying amount of the long service leave provision. Any gain or loss following revaluation of the present value of long service leave liabilities is recognised as employee benefits expense.

3.2 Patient support costs

Medical supplies and services	238,904	241,524
Domestic charges	53,065	50,963
Pathology services provided by PathWest (a) (b)	22,514	30,175
Fuel, light and power	13,237	12,448
Food supplies	15,693	15,399
Patient transport costs	7,882	7,363
Research, development and other grants	51	191
	351,346	**358,063**

(a) Pathology services provided by PathWest are in addition to the fee for services (FFS) charges already paid to PathWest, within medical supplies and services shown above.

(b) See note 4.1 Income from State Government.

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

	2018 $000	2017 $000

3.3 Contracts for services

Public patients services (a)	136,609	130,224
Home & Comm Care (HACC)	2,776	2,782
Child, community and primary health	767	689
Chronic Diseases	33	208
Patient Transport Service	220	172
Other contracts	6	65
	140,411	**134,140**

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

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

3.4 Repairs, maintenance and consumable equipment

Repairs and maintenance	7,561	7,396
Consumable equipment	41,918	41,969
	49,479	**49,365**

Repairs, maintenance and consumable equipment: Repairs and maintenance costs are recognised as expenses as incurred, except where they relate to the replacement of a significant component of an asset. In that case, the costs are capitalised and depreciated.

3.5 Other supplies and services

Sanitisation and waste removal services	2,750	1,958
Administration and management services	51,325	54,234
Interpreter services	1,932	2,128
Security services	281	190
Other	779	501
	57,067	**59,011**

Other supplies and services: Other supplies and services are recognised as an expense in the reporting period in which they are incurred.

	2018 $000	2017 $000

3.6 Other expenses

Communications	5,571	5,567
Computer services	21,330	20,034
Workers compensation insurance	18,040	15,195
Operating lease expenses	3,453	2,552
Other insurances	8,096	8,415
Consultancy fees	948	1,874
Other employee related expenses	1,110	1,749
Printing and stationery	2,850	2,908
Doubtful debts expense	5,930	2,526
Freight and cartage	384	388
Periodical subscription	2,572	2,563
Services provided by HSS	54,043	64,370
Write-down of non-current assets	-	12,105
Motor vehicle expenses	859	764
Audit fees	499	516
Other	3,677	3,220
	129,362	**144,746**

Employee on-cost include workers' compensation insurance only. Any on costs liability associated with the recognition of annual and long service leave liabilities are included in note 3.1 (b) Employee benefits provisions. Superannuation contributions accrued as part of the provision for leave are employee benefits and are not included in employment on-costs.

Operating lease expenses are recognised on a straight line basis over the lease term, except where another systematic basis is more representative of the time pattern of the benefits derived from the use of the leased asset.

Doubtful debts expense is recognised as the movement in the provision for doubtful debt. Please refer to note 6.1.1 Reconciliation of changes in the allowance for impairment of receivables.

Write down of non-current assets includes works in progress capitalised in prior years but expensed in the current financial year.

Services provided by Health Support Services (HSS) are services received free of charge or for nominal cost and are recognised as expenses at the fair value of those services that can be reliably measured and which would have been purchased if they were not donated.

Motor vehicle expenses include expenses associated with the operation, repair and maintenance and management of motor vehicles.

Audit fees include the final audit fee for the previous year's audit and any interim audit fees (if any) for the current year's audit and an accrual for the current year's final audit fee. A breakdown of which is shown below:

Internal audit fee – PricewaterhouseCoopers internal audit services	263
External audit fee – accrual 2017–18 SMHS OAG audit fee	236
	499

Other operating expenses generally represent the day-to-day running costs incurred in normal operations and are recognised as an expense in the period it is incurred.

4. Our funding sources

How we obtain our funding

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

	Notes	2018 $000	2017 $000
Income from State Government	4.1	990,990	1,019,074
Patient charges	4.2	93,073	87,264
Other fees for services	4.3	70,227	78,485
Commonwealth grants and contributions	4.4	639,343	628,717
Other revenue	4.5	12,707	12,992
Gains	4.6	(240)	(20)

4.1 Income from State Government

Appropriation received during the period:		
Service appropriation (funding via the Department of Health) (a)	914,400	924,725
	914,400	**924,725**
Assets transferred from/(to) other State government agencies during the period: (b)		
• Transfer of medical equipment from East Metropolitan Health Service	39	16
• Transfer of medical equipment from DG HSU	5	(44)
• Transfer of motor vehicles to North Metropolitan Health Service	(11)	(168)
Total assets (transferred) / assumed	**33**	**(196)**
Services received free of charge from other State Government agencies during the period: (c)		
Health Support Services (HSS)		
ICT services	40,488	48,549
Supply chain services	5,290	5,563
Financial services	1,976	3,495
Human resources services	6,289	6,763
PathWest – Pathology Services	22,514	30,175
Total services received	**76,557**	**94,545**
Total income from State Government	**990,990**	**1,019,074**

(a) **Service appropriations** are recognised as revenues at fair value in the period in which the Health Service gains control of the appropriated funds. Service appropriations fund the net cost of services delivered. The Health Service gains control of appropriated funds at the time those funds are deposited in the bank account or credited to the 'amounts receivable for services' (holding account) held at Department of Treasury.

4.1 Income from State Government (continued)

Service appropriations fund the net cost of services delivered (as set out in note 2.2 Schedule of income and expenses by service). Appropriation revenue comprises the following:

- cash component
- a receivable (asset).

The receivable (holding account – note 6.2 Amounts receivable for services (Holding Account)) comprises the following:

- the budgeted depreciation expense for the year
- any agreed increase in leave liabilities during the year.

(b) **Transfer of assets:** Discretionary transfers of net 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'. Other non-discretionary non-reciprocal transfers of assets and liabilities designated as contributions by owners under TI 955 are also recognised directly to equity.

(c) **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.

Pathology services provided by PathWest are in addition to the FFS charges already paid to PathWest included in note 3.2 Patient support costs.

	2018 $000	2017 $000

4.2 Patient charges

Inpatient bed charges	77,522	70,940
Inpatient other charges	7,151	7,316
Outpatient charges	8,400	9,008
	93,073	**87,264**

4.3 Other fees for services

Recoveries from the Pharmaceutical Benefits Scheme (PBS)	62,478	62,464
Clinical services to other health organisations	18	10
Non clinical services to other health organisations	7,731	5,592
Pathology services to other organisations	-	3
Statewide service RITH and CoNeCT	-	10,416
	70,227	**78,485**

4.4 Grants and contributions

i) Commonwealth grants and contributions		
Recurrent Grants:		
National Health Reform Agreement (funding via Department of Health) (a)	481,305	490,497
National Health Reform Agreement (funding via Mental Health Commission) (a)	32,118	28,342
Department of Veteran Affairs Program	24,000	15,500
Aged Care Assessment Team Program	2,589	2,421
Sub Acute Care Stroke Services Program	2,229	1,157
NHRA Substitued Funding	5,316	-
Other	129	412
	547,686	**538,329**
ii) Other grants and contributions		
Mental Health Commission – service delivery agreement	89,366	85,593
Mental Health Commission – other	178	2,672
Disability Services Commission – community aids and equipment program	1,214	1,379
Lotteries Commission	-	12
Other	899	732
	91,657	**90,388**
	639,343	**628,717**

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

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

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

	2018 $000	2017 $000

4.5 Other Revenue

Donation revenue		
General public contributions	608	417
	608	**417**
Other revenue		
Use of hospital facilities	204	410
Rent from commercial properties	2,838	2,867
Rent from residential properties	48	65
Boarders' accommodation	16	40
RiskCover insurance premium rebate	611	1,653
Parking	6,238	6,216
Research and clinical trial revenue	1,429	538
Course fees	135	247
Other	580	540
	12,099	**12,576**

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

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

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

Interest: Revenue is recognised as the interest accrues.

4.6 Gains

Net proceeds from disposal of non-current assets:		
Property, plant and equipment	36	15
Carrying amount of non-current assets disposed:		
Property, plant and equipment	(276)	(35)
Net gain/(loss)	**(240)**	**(20)**

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.

Gains and losses in the disposal of non-current assets are presented by deducting from the proceeds on disposal the carrying amount of the asset and related selling expenses. Gains and losses are recognised in profit or loss in the statement of comprehensive income (from the proceeds of sale).

5. Key assets

Assets the Health Service utilises for economic benefit or service potential.

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

	Notes	2018 $000	2017 $000
Property, plant and equipment	5.1	2,093,730	2,166,154
Intangibles	5.2	23,709	27,287
Total key assets		**2,117,439**	**2,193,441**

5.1 Property, plant and equipment

Land		74,605	79,645
At fair value		74,605	79,645
Buildings			
Clinical:			
At fair value		1,721,681	1,737,033
Accumulated depreciation		-	(166)
		1,721,681	1,736,867
Total land and buildings		**1,796,286**	**1,816,512**
Site infrastructure			
At cost		128,436	128,553
Accumulated depreciation		(6,128)	(3,073)
		122,308	**125,480**
Computer equipment			
At cost		117,822	117,773
Accumulated depreciation		(53,031)	(28,991)
		64,791	**88,782**
Furniture and fittings			
At cost		14,100	14,045
Accumulated depreciation		(4,269)	(2,528)
		9,831	**11,517**
Motor vehicles			
At cost		73	90
Accumulated depreciation		(27)	(19)
		46	**71**
Medical equipment			
At cost		120,167	118,366
Accumulated depreciation		(44,075)	(20,992)
		76,092	**97,374**
Other plant and equipment			
At cost		28,945	28,271
Accumulated depreciation		(5,096)	(2,634)
		23,849	**25,637**
Works in progress			
Buildings under construction (at cost)		294	548
Other works in progress (at cost)		6	6
		300	**554**
Artworks			
At cost		**227**	**227**
Total property, plant and equipment		**2,093,730**	**2,166,154**

5.1 Property, plant and equipment (continued)

Reconciliations

Reconciliations of the carrying amounts of property, plant and equipment at the beginning and end of the reporting period are set out below.

	2018 $000	2017 $000
Land		
Carrying amount at start of period	79,645	-
Additions	-	-
Transfer from Metropolitan Health Service (abolished)	-	86,410
Transfers from/(to) other reporting entities	(2,050)	(3,895)
Revaluation increments/(decrements)	(2,990)	(2,870)
Carrying amount at end of period	**74,605**	**79,645**
Buildings		
Carrying amount at start of period	1,736,867	-
Transfer from Metropolitan Health Service (abolished)	-	1,716,655
Additions	67	1,539
Transfers from works in progress	340	1,369
Transfers from/(to) other reporting entities	(911)	(261)
Disposals	(122)	-
Revaluation increments/(decrements)	30,886	60,585
Depreciation	(45,446)	(43,216)
Transfers between asset classes	-	196
Carrying amount at end of period	**1,721,681**	**1,736,867**
Site infrastructure		
Carrying amount at start of period	125,480	-
Transfer from Metropolitan Health Service (abolished)	-	128,553
Additions	-	-
Transfers from/(to) other reporting entities	(102)	-
Depreciation	(3,070)	(2,877)
Transfers between asset classes	-	(196)
Carrying amount at end of period	**122,308**	**125,480**
Computer equipment		
Carrying amount at start of period	88,782	-
Transfer from Metropolitan Health Service (abolished)	-	113,715
Additions	49	13,463
Transfers from works in progress	-	419
Depreciation	(24,040)	(28,260)
Transfers between asset classes	-	(10,552)
Write-down of assets	-	(3)
Carrying amount at end of period	**64,791**	**88,782**
Furniture and fittings		
Carrying amount at start of period	11,517	-
Transfer from Metropolitan Health Service (abolished)	-	15,170
Additions	56	155
Transfers from works in progress	-	517
Transfers from/(to) other reporting entities	-	17
Depreciation	(1,742)	(2,412)
Transfers between asset classes	-	(774)
Write-down of assets	-	(1,156)
Carrying amount at end of period	**9,831**	**11,517**
Motor vehicles		
Carrying amount at start of period	71	-
Transfer from Metropolitan Health Service (abolished)	-	91
Additions	-	-
Transfers from/(to) other reporting entities	(10)	
Depreciation	(15)	(19)
Write-down of assets	-	(1)
Carrying amount at end of period	**46**	**71**

5.1 Property, plant and equipment (continued)

	2018 $000	2017 $000
Medical equipment		
Carrying amount at start of period	97,374	-
Transfer from Metropolitan Health Service (abolished)	-	120,269
Additions	2,336	3,271
Transfers from works in progress		2,001
Transfers from/(to) other reporting entities	45	(476)
Disposals	(206)	(35)
Depreciation	(23,457)	(16,814)
Transfers between asset classes	-	(7,785)
Write-down of assets	-	(3,057)
Carrying amount at end of period	**76,092**	**97,374**
Other plant and equipment		
Carrying amount at start of period	25,637	-
Transfer from Metropolitan Health Service (abolished)	-	30,509
Additions	674	-
Transfers from works in progress	-	(12)
Transfers from/(to) other reporting entities	-	(209)
Depreciation	(2,462)	(2,174)
Transfers between asset classes	-	(1,595)
Write-down of assets	-	(882)
Carrying amount at end of period	**23,849**	**25,637**
Works in progress		
Carrying amount at start of period	554	-
Transfer from Metropolitan Health Service (abolished)	-	1,386
Additions	87	-
Transfers from works in progress	(341)	-
Transfers between asset classes	-	10,709
Capitalised to asset classes	-	(4,535)
Write-down of assets (a)	-	(7,006)
Carrying amount at end of period	**300**	**554**
Artworks		
Carrying amount at start of period	227	-
Transfer from Metropolitan Health Service (abolished)	-	221
Additions	-	6
Carrying amount at end of period	227	227
Total property, plant and equipment		
Carrying amount at start of period	2,166,154	-
Transfer from Metropolitan Health Service (abolished)	-	2,212,979
Additions	3,269	18,434
Transfers from works in progress	(1)	4,294
Disposals	(328)	(35)
Transfers from/(to) other reporting entities	(3,028)	(4,824)
Revaluation increments/(decrements)	27,896	57,715
Depreciation	(100,232)	(95,772)
Transfers between asset classes	-	(9,997)
Capitalised to asset classes	-	(4,535)
Write-down of assets (a)	-	(12,105)
Carrying amount at end of period (b)	**2,093,730**	**2,166,154**

(a) Works in progress capitalised in prior years but expensed in the current financial year. Refer to note 3.6 Other expenses.

(b) At 30 June 2018, the net carrying amount includes leased medical, computer and other plant and equipment of $146.472 million. Refer details at note 7.1 Borrowings.

5.1 Property, plant and equipment (continued)

Initial recognition

Items of property, plant and equipment, costing $5,000 or more are measured initially at cost. Where an asset is acquired for no or nominal cost, the cost is valued at its fair value at the date of acquisition. Items of property, plant and equipment costing less than $5,000 are immediately expensed direct to the Statement of Comprehensive Income (other than where they form part of a group of similar items which are significant in total).

Assets transferred as part of a machinery of government change are transferred at their fair value.

The initial cost for a non-financial physical asset under a finance lease is measured at amounts equal to the fair value of the leased asset or, if lower, the present value of the minimum lease payments, each determined at the inception of the lease.

Subsequent measurement

Subsequent to initial recognition of an asset, the revaluation model is used for the measurement of:

- land
- buildings.

Land is carried at fair value. Buildings are carried at fair value less accumulated depreciation and accumulated impairment losses. All other items of property, plant and equipment are stated at historical cost less accumulated depreciation and accumulated impairment losses.

Land and buildings are independently valued annually by the Western Australian Land Information Authority (Landgate 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.

Land and buildings were revalued as at 1 July 2017 by the Western Australian Land Information Authority (Valuation Services). The valuations were performed during the year ended 30 June 2018 and recognised at 30 June 2018. In undertaking the revaluation, fair value was determined by reference to market values for land: $2.811 million (2017: $2.901 million) and buildings: $1.519 million (2017: $0.97 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).

Revaluation Model:

1. Fair value 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. When buildings are revalued by reference to recent market transactions, the accumulated depreciation is eliminated against the gross carrying amount of the asset and the net amount restated to the revalued amount.

2. Fair value in the absence of market-based evidence

   Where buildings are specialised or where land is restricted, the fair value of land and buildings (clinical sites) is determined on the basis of existing use.

   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. Where the fair value of buildings is determined on the depreciated replacement costs basis, the accumulated depreciation is eliminated against the gross carrying amount of the asset and the net amount restated to the revalued amount.

   The 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).

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

5.1.1 Depreciation and impairment

	2018 $000	2017 $000
Charge for the period		
Depreciation		
Buildings	45,446	43,216
Site infrastructure	3,070	2,877
Leasehold improvements	-	-
Computer equipment	24,040	28,260
Furniture and fittings	1,742	2,412
Motor vehicles	15	19
Medical equipment	23,457	16,814
Other plant and equipment	2,462	2,174
	100,232	**95,772**

As at 30 June 2018 there were no indications of impairment to property, plant and equipment.

All surplus assets at 30 June 2018 have either been classified as assets held for sale or have been written-off.

Please refer to note 5.2 Intangible assets for guidance in relation to the impairment assessment that has been preformed.

Finite useful lives

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

Depreciation is calculated on a straight line basis, at rates that allocate the asset's value, less any estimated residual value, over its estimated useful life.

Estimated useful lives for the different asset classes for current and prior years are included in the table below.

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

The estimated useful lives, residual values and depreciation method are reviewed at the end of each annual reporting year, and any adjustments are made where appropriate.

Land and artworks, which are considered to have an indefinite life, are not depreciated. Depreciation is not recognised in respect of these assets because their service potential had not, in any material sense, been consumed during the reporting period.

5.1.1 Depreciation and impairment (continued)

Impairment

Non-financial assets, including items of property, plant and equipment, are tested for impairment whenever there is an indication that the asset may be impaired and 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 and an impairment loss is recognised.

Where an asset measured at cost is written down to its recoverable amount, an impairment loss is recognised through profit and loss 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.

If there is an indication that there has been a reversal in impairment, the carrying amount shall be increased to its recoverable amount. However, this reversal should not increase the asset's carrying amount above what would have been determined, net of depreciation or amortisation, if no impairment loss had been recognised in prior years.

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

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.

5.2 Intangible assets

	2018 $000	2017 $000
Computer software		
At cost	34,306	29,091
Accumulated amortisation	(11,324)	(5,380)
	22,982	**23,711**
Works in progress		
Computer software under development (at cost)	727	3,576
Total intangible assets	**23,709**	**27,287**

Reconciliations

Reconciliations of the carrying amount of intangible assets at the beginning and end of the reporting period are set out below.

Computer software		
Carrying amount at start of period	23,711	-
Transfer from Metropolitan Health Service (abolished)	-	27,284
Additions	1,675	2,388
Transfers from works in progress	3,540	403
Transfer from/(to) other reporting entities	-	(183)
Amortisation expense	(5,944)	(5,273)
Transfers between asset classes	-	(908)
Carrying amount at end of period	**22,982**	**23,711**
Works in progress		
Carrying amount at start of period	3,576	-
Transfer from Metropolitan Health Service (abolished)	-	3,279
Additions	690	-
Capitalised to computer software	(3,539)	(611)
Transfers between asset classes	-	908
Carrying amount at end of period	**727**	**3,576**
Total intangible assets		
Carrying amount at start of period	27,287	-
Transfer from Metropolitan Health Service (abolished)	-	30,563
Additions	2,365	2,388
Transfers from Work in Progress	1	(208)
Transfers from/(to) other reporting entities	-	(183)
Amortisation expense	(5,944)	(5,273)
Carrying amount at end of period (a)	**23,709**	**27,287**

(a) At 30 June 2018, the net carrying amount of leased computer software was $9.078 million. See also note 7.1 Borrowings.

5.2 Intangible assets (continued)

Initial recognition

Acquisitions of intangible assets costing $5,000 or more and internally generated intangible assets costing $5,000 or more are capitalised.

Costs incurred below these thresholds are immediately expensed directly to the Statement of comprehensive income.

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

Subsequent measurement

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

5.2.2 Amortisation and impairment

	2018 $000	2017 $000
Charge for the period		
Amortisation		
Computer software	5,944	5,273
	5,944	**5,273**

As at 30 June 2018 there were no indications of impairment to intangible assets.

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

Amortisation of finite life intangible assets is calculated on a straight line basis at rates that allocate the asset's value over its estimated useful life. All intangible assets controlled by the Health Service have a finite useful life and zero residual value.

Estimated useful life of intangible assets is:	Computer software – 5 to 15 years

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

Impairment of intangible assets

Intangible assets with finite useful lives are tested for impairment annually or when an indication of impairment is identified.

The policy in connection with testing for impairment is outlined in note 5.1.1 Depreciation and impairment.

6. Other assets and liabilities

This section sets out those assets and liabilities that arose from the Health Services controlled operations and includes other assets utilised for economic benefits and liabilities incurred during normal operations.

	Notes	2018 $000	2017 $000
Receivables	6.1	53,284	55,045
Amounts receivable for services	6.2	723,685	610,791
Inventories	6.3	5,208	5,277
Other current assets	6.4	4,949	10,667
Payables	6.5	92,996	93,031
Other liabilities	6.6	283	170

6.1 Receivables

Current		
Patient fee debtors (a)	31,678	43,776
Other receivables	2,097	2,632
Less: Allowance for impairment of receivables	(6,871)	(20,573)
Accrued revenue	22,656	26,635
GST Receivables	3,724	2,575
	53,284	**55,045**

(a) Under the Private Patient Scheme approved by the State Government, the Department of Health provides ex-gratia payments towards private patient fees not paid in full by health insurance funds. The total amounts of ex-gratia payments is $8.94 million for 2017–18 ($12.35 million for 2016–17).

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

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

Accounting procedure for Goods and Services Tax

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

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

6.1.1 Reconciliation of changes in the allowance for impairment of receivables:

	Notes	2018 $000	2017 $000
Balance at start of period		20,573	-
Transfer from Metropolitan Health Service (abolished)			18,918
Doubtful debts expense	3.6	5,930	2,526
Amounts written off during the period		(19,653)	(1,106)
Adjustment commensurate with Government restructure		-	235
Amounts recovered during the period		21	-
Balance at end of period		**6,871**	**20,573**

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.

6.2 Amounts receivable for services (Holding Account)

Non-current	723,685	610,791
	723,685	**610,791**

Amounts receivable for services 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.

The Health Service receives funding on an accrual basis. The appropriations are paid partly in cash and partly as an asset (holding account receivable). The accrued amount receivable is accessible on the emergence of the cash funding requirement to cover leave entitlements and asset replacement.

6.3 Inventories

Current		
Pharmaceutical stores – at cost	5,122	5,196
Engineering stores – at cost	86	81
	5,208	**5,277**

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.

	2018 $000	2017 $000

6.4 Other assets

Current		
Prepayments	4,794	1,648
Other	155	84
Total current	**4,949**	**1,732**

Other non-financial assets include prepayments which represent payments in advance of receipt of goods or services or that part of expenditure made in one accounting period covering a term extending beyond that period.

6.5 Payables

Current		
Trade creditors	14,653	10,764
Other creditors (a)	7,232	7,010
Accrued expenses	55,240	62,802
Accrued salaries	15,856	12,431
Accrued interest	15	24
	92,996	**93,031**

(a) Includes $7.2 million PAYG (Pay As You Go) tax due to the ATO for the last pay in 2017–18 and $0.1 million Fringe Benefits Tax due to the ATO for 2017–18 Fringe Benefits Tax liability.

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

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

6.6 Other liabilities

Current		
Income received in advance	108	5
Refundable deposits	48	56
Paid parental leave scheme	93	99
Other	34	10
	283	**170**

7. Financing

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

	Notes
Borrowings	7.1
Finance Lease	7.2
Finance costs	7.3
Cash and cash equivalents	7.4
Reconciliation of cash	7.4.1
Reconciliation of operating activities	7.4.2
Commitments	7.5
Non-cancellable operating lease commitments	7.5.1
Capital commitments	7.5.2
Private sector contracts	7.5.3
Other expenditure commitments	7.5.4

7.1 Borrowings

	2018 $000	2017 $000
Current		
Department of Treasury loans (a)	2,747	2,626
Finance lease liabilities – Fiona Stanley Hospital (b)	50,147	57,561
	52,894	60,187
Non-current		
Department of Treasury loans (a)	2,881	5,627
Finance lease liabilities – Fiona Stanley Hospital (b)	115,112	165,258
	117,993	170,885
Total borrowings	**170,887**	**231,072**

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

(b) Equipment and intangible assets for the FSH are procured by a private sector provider through a leasing facility with a bank. Although the arrangement, that is under a Tripartite Agreement between the Minister for Health, the private sector provider and the bank, is not in the legal form of a lease, it is accounted for as such based on its terms and conditions. The first finance lease payment (including the finance lease charges) was made on 1 May 2014.

During the year, no leased assets were acquired (2017: $4.40 million) and there were no procurement, bank and legal fees expensed to the statement of comprehensive income (2017: $1.14 million).

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

Leased computer software	9,078	11,864
Leased computer equipment	64,733	88,773
Leased medical equipment	66,255	82,312
Leased other plant and equipment	15,484	17,873
	155,550	**200,822**

7.2 Finance Leases

	Notes	2018 $000	2017 $000
Finance lease commitments:			
Minimum lease payment commitments in relation to finance leases are payable as follows:			
Within 1 year		57,691	67,863
Later than 1 year, and not later than 5 years		111,038	153,921
Later than 5 years		18,144	32,952
Minimum finance lease payments		186,873	254,736
Less future finance charges		(21,614)	(31,917)
Present value of finance lease liabilities	7.1	**165,259**	**222,819**
The present value of finance leases payable is as follows:			
Within 1 year		50,147	57,562
Later than 1 year, and not later than 5 years		98,694	135,399
Later than 5 years		16,418	29,858
Present value of finance lease liabilities		**165,259**	**222,819**
Included in the financial statements as:			
Current	7.1	50,147	57,562
Non-current	7.1	115,112	165,257
		165,259	**222,819**

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.

The Health Service has the option to purchase leased assets at their agreed fair value on expiry of the lease. These leasing arrangements do not have escalation clauses, other than in the event of payment default. There are no restrictions imposed by these leasing arrangements on other financing transactions. Certain finance leases have a contingent rental obligation; however, these are not material when compared to the total lease payments made.

Finance lease rights and obligations are initially recognised, at the commencement of the lease term, as assets and liabilities equal in amount to the fair value of the leased item or, if lower, the present value of the minimum lease payments determined at the inception of the lease. 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.

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

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

7.2 Finance Leases (continued)

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

	2018 $000	2017 $000

7.3 Finance costs

Finance lease charges	10,303	13,442
Interest expense	213	307
	10,516	**13,749**

Finance costs expensed

Finance Costs' includes interest costs associated with the FSH Finance Lease Payments and WA Treasury Loan.

7.4 Cash and cash equivalents

Cash and cash equivalents

Current	19,353	23,856

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

Restricted cash and cash equivalents

Current		
Restricted cash assets held for other specific purposes (a)	9,151	9,289
Capital appropriation from the Fiona Stanley Hospital Construction Account (b)	-	18,867
Fiona Stanley Hospital – Upgrade Works Account (c)	462	454
Mental Health Commission Funding (d)	75	-
	9,688	**28,610**
Non Current		
Accrued salaries suspense account (e)	7,148	3,648
	16,836	**32,258**

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 staff benevolent funds.

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

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

(d) See note 9.7 Special purpose accounts.

(e) 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. In a normal year there are 26 payroll periods where cash is outlaid. Every 11 years, however, there is an additional fortnightly payroll to the standard 26. This additional pay period is termed the 27th pay and the next occurrence is in the year 2027–28. To ensure sufficient cash resources are available, it is prudent to reserve a portion of cash funds towards this event each year. For 2016–17, the Department of Health made a one off contribution into the Treasury suspense account on behalf of the Health Service; the value reserved represents an estimated payroll amount for one day.

7.4 Cash and cash equivalents (continued)

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.

	Notes	2018 $000	2017 $000
7.4.1 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		19,353	23,856
Restricted cash and cash equivalents		16,836	32,258
		36,189	**56,114**
7.4.2 Reconciliation of net cost of services to net cash flows used in operating activities			
Net cash used in operating activities (statement of cash flows)		(791,945)	(774,356)
Increase/(decrease) in assets:			
GST receivable		1,150	(1,279)
Other current receivables		(16,612)	6,197
Inventories		(69)	(1,458)
Prepayments and other current assets		3,217	132
Decrease/(increase) in liabilities:			
Payables		(1,367)	2,155
Current provisions		(10,084)	(5,609)
Non-current provisions		(1,384)	(2,387)
Other current liabilities		(113)	(128)
Other non-current liabilities		-	-
Non-cash items:			
Doubtful debts expense	3.6	(5,930)	(2,526)
Write off of receivables	6.1.1	19,653	1,106
Adj commensurate with Government restructure (provision for doubtful debts)	6.1.1	-	(235)
Receivables amount recovered during the period	6.1.1	(21)	-
Depreciation and amortisation expense	5.1.1, 5.2.2	(106,176)	(101,045)
Net gain/(loss) from disposal of non-current assets	4.6	(240)	(20)
Interest paid by Department of Health		(222)	(315)
Capitalisation of finance lease charges		(10,304)	(13,385)
Capitalisation of fees for finance leases	7.1	-	(1,142)
Net donation of non-current assets		333	-
Services received free of charge		(76,557)	(94,545)
Write down of property, plant and equipment		-	(12,105)
Revaluation decrement – land		(2,990)	(2,870)
Adjustment for other non-cash items		-	-
Net cost of services (statement of comprehensive income)		**(999,661)**	**(1,003,815)**

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

	Notes	2018 $000	2017 $000
Notional cash flows			
Service appropriations as per statement of comprehensive income		914,400	924,725
Capital contributions credited directly to contributed equity	9.9	65,628	69,795
		980,028	**994,520**
Less notional cash flows:			
Items paid directly by the Department of Health for the Health Service and are therefore not included in the statement of cash flows:			
Interest paid to Department of Treasury		(222)	(315)
Repayment of interest-bearing liabilities to Department of Treasury		(2,626)	(2,506)
Transfer of FSH construction savings to Treasury		(17,752)	-
Accrual appropriations		(112,894)	(118,214)
Other non cash adjustments to service appropriations		-	36,762
		(133,494)	**(84,273)**
Cash flows from state government as per statement of cash flows		**846,534**	**910,247**

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.

7.5 Commitments

The commitments below are inclusive of GST where relevant.

7.5.1 Operating lease commitments

Commitments in relation to non-cancellable leases contracted for at the end of the reporting period but not recognised as liabilities are payable as follows:

Within 1 year	1,797	1,912
Later than 1 year, and not later than 5 years	1,684	2,808
Later than 5 years	-	-
	3,481	**4,720**

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. Operating leases are expenses on a straight line basis over the lease term as this represents the pattern of benefits derived from the leased properties.

Leases in which the lessor retains significantly all of the risks and rewards of ownership are classified as operating leases.

	2018 $000	2017 $000

7.5.2 Capital expenditure commitments

Capital expenditure commitments, being contracted capital expenditure additional to the amounts reported in the financial statements are payable as follows.

Within 1 year	6,432	705
Later than 1 year, and not later than 5 years	-	-
Later than 5 years	-	-
	6,432	**705**

7.5.3 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	174,189	174,898
Later than 1 year, and not later than 5 years	698,328	626,571
Later than 5 years	34,800	147,734
	907,317	**949,203**

7.5.4 Other expenditure commitments

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

Within 1 year	201,465	222,634
Later than 1 year, and not later than 5 years	427,299	695,790
Later than 5 years	56,076	1,425
	684,840	**919,849**

8. Risk and Contingencies

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

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

8.1 Financial risk management

Financial instruments held by the Health Service are cash and cash equivalents, restricted cash and cash equivalents, 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.

(a) Summary of risks and risk management

Credit risk

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

The maximum exposure to credit risk at the end of the reporting period in relation to each class of recognised financial assets is the gross carrying amount of those assets inclusive of any allowance for impairment as shown in the table at note 8.1 (c) Aged analysis of financial assets and note 6.1 Receivables.

8.1 Financial risk management (continued)

(a) Summary of risks and risk management (continued)

Credit risk associated with the Health Service's financial assets is generally confined to patient fee debtors (see note 6.1 Receivables). The main receivable of the Health Service is the amounts receivable for services (holding account). For receivables other than government agencies and patient fee debtors, the Health Service trades only with recognised, creditworthy third parties. The Health Service has policies in place to ensure that sales of products and services are made to customers with an appropriate credit history. In addition, receivable balances are monitored on an ongoing basis with the result that the Health Service's exposure to bad debts is minimised. At the end of the reporting period, there were no significant concentrations of credit risk.

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

Allowance for impairment of financial assets is calculated based on objective evidence such as observable data indicating changes in client credit ratings. For financial assets that are either past due or impaired, refer to note 8.1 Credit risk.

Liquidity risk

Liquidity risk arises when the Health Service is unable to meet its financial obligations as they fall due. The Health Service is exposed to liquidity risk through its 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 loans and finance leases (fixed rates with varying maturities). The interest rate risk for the loans is managed by Department of Treasury 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:

	2018 $000	2017 $000
Financial Assets		
Cash and cash equivalents	19,353	23,856
Restricted cash and cash equivalents	9,688	28,610
Loans and receivables (a)	773,244	663,261
Financial Liabilities		
Financial liabilities measured at amortised cost	263,883	324,103

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

8.1 Financial risk management (continued)

(c) Aged analysis of financial assets

Credit risk

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

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

		Past due but not impaired					
	Carrying amount	Not past due and not impaired	1–3 months	3–12 months	1–5 years	More than 5 years	Impaired financial assets
	$000	$000	$000	$000	$000	$000	$000
2018							
Cash and cash equivalents	19,353	19,353	-	-	-	-	-
Restricted cash and cash equivalents	9,688	9,688	-	-	-	-	-
Receivables (a)	49,560	26,653	3,724	13,084	6,098	1	
Amounts receivable for services	723,685	723,685	-	-	-	-	-
	802,286	**779,379**	**3,724**	**13,084**	**6,098**	**1**	**-**
2017							
Cash and cash equivalents	23,856	23,856	-	-	-	-	-
Restricted cash and cash equivalents	28,610	28,610	-	-	-	-	-
Receivables (a)	52,470	34,260	7,822	10,388	-	-	-
Amounts receivable for services	610,791	610,791	-	-	-	-	-
	715,727	**697,517**	**7,822**	**10,388**	**-**	**-**	**-**

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

(d) Liquidity risk and interest rate exposure

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

8.1 Financial risk management (continued)

(d) Liquidity risk and interest rate exposure (continued)

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

	Interest rate exposure				
	Weighted average effective interest rate	Carrying amount	Fixed interest rate	Variable interest rate	Non-interest bearing
	%	$000	$000	$000	$000
2018					
Financial Assets					
Cash and cash equivalents	-	19,353	-	-	19,353
Restricted cash and cash equivalents	-	9,688	-	-	9,688
Receivables – non interest bearing (a)	-	49,560	-	-	49,560
Receivables – interest bearing	2.00%	-	-	-	-
Amounts receivable for services	-	723,685	-	-	723,685
		802,286	**-**	**-**	**802,286**
Financial Liabilities					
Payables	-	92,996	-	-	92,996
Department of Treasury Loans	3.15%	5,628	-	5,628	-
Finance Lease – Data Centres	-	-	-	-	-
Finance Lease – Fiona Stanley Hospital	5.40%	165,259	165,259	-	-
Finance Lease – Other	-	-	-	-	-
		263,883	**165,259**	**5,628**	**92,996**
2017					
Financial Assets					
Cash and cash equivalents	-	23,856	-	-	23,856
Restricted cash and cash equivalents	-	28,610	-	-	28,610
Receivables – non interest bearing (a)	-	52,470	-	-	52,470
Receivables – interest bearing	2.00%	-	-	-	-
Amounts receivable for services	-	610,791	-	-	610,791
		715,727	**-**	**-**	**715,727**
Financial Liabilities					
Payables	-	93,031	-	-	93,031
Department of Treasury Loans	3.24%	8,253	-	8,253	-
Finance Lease – Data Centres	-	-	-	-	-
Finance Lease – Fiona Stanley Hospital	5.34%	222,819	222,819	-	-
Finance Lease – Other	-	-	-	-	-
		324,103	**222,819**	**8,253**	**93,031**

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

		Maturity dates			
	Nominal amount	Up to 3 months	3 months to 1 year	1-5 years	More than 5 years
	$000	$000	$000	$000	$000
	19,353	19,353	-	-	-
	9,688	9,688	-	-	-
	49,560	49,560	-	-	-
	-	-	-	-	-
	723,685	-	-	-	723,685
	802,286	**78,601**	**-**	**-**	**723,685**
	92,996	92,996	-	-	-
	5,896	730	2,191	2,975	-
	-	-	-	-	-
	186,873	14,423	43,268	111,038	18,144
	-	-	-	-	-
	285,765	**108,149**	**45,459**	**114,013**	**18,144**
	23,856	23,856	-	-	-
	28,610	28,610	-	-	-
	52,470	52,470	-	-	-
	-	-	-	-	-
	610,791	-	-	-	610,791
	715,727	**104,936**	**-**	**-**	**610,791**
	93,031	93,031	-	-	-
	8,796	722	2,165	5,910	-
	-	-	-	-	-
	254,736	16,966	50,897	153,920	32,952
	-	-	-	-	-
	356,563	**110,719**	**53,062**	**159,830**	**32,952**

8.1 Financial risk management (continued)

(e) Interest rate sensitivity analysis

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

		-100 basis points		+100 basis points	
	Amount Exposed to Interest Rate Risk	Surplus	Equity	Surplus	Equity
	$000	$000	$000	$000	$000
2018					
Financial Liabilities					
Department of Treasury Loans	5,628	56	56	(56)	(56)
Total Increase/(Decrease)		**56**	**56**	**(56)**	**(56)**
2017					
Financial Liabilities					
Department of Treasury Loans	8,253	83	83	(83)	(83)
Total Increase/(Decrease)		**83**	**83**	**(83)**	**(83)**

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.

8.2 Contingent liabilities and contingent assets

Contingent assets and contingent liabilities are not recognised in the statement of financial position but are disclosed and, if quantifiable, are measured at nominal value.

Contingent assets and liabilities are presented inclusive of GST receivable or payable retrospectively.

8.2.1 Contingent assets

At the reporting date, the Health Service is not aware of any contingent assets.

8.2.2 Contingent liabilities

In addition to the liabilities included in the financial statements, the Health Service has the following contingent liabilities.

Other

There are facilities management matters under negotiation that may or may not become liabilities. The negotiations are an ongoing part of contract management processes invoking formal contractual dispute mechanisms. These matters have not progressed to the 'litigation in process' stage.

	2018 $000	2017 $000
	23,878	7,471
Number of disputes	16	7

Payroll – time off in lieu

A review of the interpretation of the industrial instruments related to the accumulation of the time off in lieu, for working during a public holiday, has indicated some variation in application within the payroll system exists. The consequence of the standardisation of interpretation may result in both positive and negative adjustments to the employee entitlements. The extent and range of classifications to be affected is yet to be determined. At this time the outcome is not clear and may or may not result in an increase in the liabilities for the Health Service.

Contaminated sites

Under the *Contaminated Sites Act 2003* the Health Service is required to report known and suspected contaminated sites to the Department of Environment Regulation. In accordance with the Act, Department of Environment Regulation 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.

Hospital cladding

The Department of Health is conducting a review of all Health Service's hospitals that have aluminium composite panels (ACPs), following concerns about the potential fire risk associated with the use of some ACP cladding products. The review has identified Rockingham General Hospital (RGH) site where ACPs may not meet the requirements of the amended building code of Australia. The cladding at the site is undergoing additional testing to determine the need for remediation work. Any costs associated with the potential remediation work at RGH cannot be reliably estimated at this time and we await advice from the system manager as to quantum and source.

8.3 Fair value measurements

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)
3) inputs for the asset that are not based on observable market data (unobservable input) (level 3).

	Level 1 $000	Level 2 $000	Level 3 $000	Total $000
Assets measured and recognised at fair value at 30 June 2018.				
Land				
Vacant land	-	-	-	-
Residential	-	-	-	-
Specialised	-	2,811	71,794	74,605
Buildings				
Residential and commercial car park	-	-	59,927	59,927
Specialised	-	1,519	1,660,235	1,661,754
	-	**4,330**	**1,791,956**	**1,796,286**
Assets measured and recognised at fair value at 30 June 2017.				
Land				
Vacant land	-	-	-	-
Residential	-	-	-	-
Specialised	-	2,901	76,744	79,645
Buildings				
Residential and commercial car park	-	-	56,680	56,680
Specialised	-	970	1,679,217	1,680,187
	-	**3,871**	**1,812,641**	**1,816,512**

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

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

Market approach (comparable sales)

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

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

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

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

8.3 Fair value measurements (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. Staff accommodation on hospital grounds is also considered as specialised buildings for valuation purpose. This approach uses the depreciated replacement cost method which estimates the current cost of reproduction or replacement of the buildings, on its current site, less deduction for physical deterioration and relevant forms of obsolescence. Depreciated replacement cost is the current replacement cost of an asset less, where applicable, accumulated depreciation calculated on the basis of such cost to reflect the already consumed or expired future economic benefits of the asset.

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

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

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

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

   - nursing posts and medical centres
   - metropolitan secondary hospitals

c) measurement of the general floor areas

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

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

The maximum effective age used in the valuation of specialised buildings 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.

8.3 Fair value measurements (continued)

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

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 per cent of current replacement costs). All specialised buildings are assumed to have a residual value of 25 per cent 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.

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 2018.

	Land $000	Buildings $000
2018		
Fair value at start of period	76,744	1,735,897
Additions	-	(174)
Revaluation increments/(decrements) recognised in profit or loss	(2,900)	-
Revaluation increments/(decrements)	-	30,887
Transfers from/(to) level 2	(2,050)	-
Disposals	-	(1,090)
Depreciation	-	(45,358)
Fair value at end of period	**71,794**	**1,720,162**

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

2017		
Fair value at start of period	79,344	1,715,420
Additions	-	2,908
Revaluation increments/(decrements) recognised in profit or loss	(2,600)	
Revaluation increments/(decrements)	-	60,565
Transfers from/(to) level 2	-	-
Disposals	-	-
Depreciation	-	(42,996)
Fair value at end of period	**76,744**	**1,735,897**

Valuation processes

The Health Service manages its own valuation processes. This includes the provision of property information to a quantity surveyor and Landgate Valuation Services, and the review of valuation reports. Valuation processes and results are discussed with the chief finance officer at least once every year.

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

9. Other disclosures

This section includes additional material disclosures required by accounting standards or other pronouncements, for the understanding of this financial report.

9.1 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.

9.2 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. There has been no early adoption of any other Australian Accounting Standards that have been issued or amended (but not operative) by the Health Service for the annual reporting period ended 30 June 2018. 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*	1 Jan 2018
	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.	
AASB 15	*Revenue from Contracts with Customers*	1 Jan 2019
	This Standard establishes the principles that the Health Service shall apply to report useful information to users of financial statements about the nature, amount, timing and uncertainty of revenue and cash flows arising from a contract with a customer. The Health Service has not yet determined the application or the potential impact of the Standard.	

Title		Operative for reporting periods beginning on/after
AASB 16	*Leases* This Standard introduces a single lessee accounting model and requires a lessee to recognise assets and liabilities for all leases with a term of more than 12 months, unless the underlying asset is of low value. The Health Service has not yet determined the application or the potential impact of the Standard.	1 Jan 2019
AASB 1058	*Income of Not-for-Profit Entities (Appendix D)* Appendix D of this standard makes amendments to AASB 1058 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 2019
AASB 1059	*Service Concession Arrangements: Grantors* This Standard addresses the accounting for a service concession arrangement (a type of public private partnership) by a grantor that is a public sector entity by prescribing the accounting for the arrangement from the grantors perspective. Timing and measurement for the recognition of a specific asset class occurs on commencement of the arrangement and the accounting for associated liabilities is determined by whether the grantee is paid by the grantor or the users of the public service provided.	1 Jan 2019
AASB 2010-7	*Amendments to Australian Accounting Standards arising from AASB 9 (December 2010) [AASB 1, 3, 4, 5, 7, 101, 102, 108, 112, 118, 120, 121, 127, 128, 131, 132, 136, 137, 139, 1023 & 1038 and Int 2, 5, 10, 12, 19 & 127]* This Standard makes consequential amendments to other Australian Accounting Standards and Interpretations as a result of issuing AASB 9 in December 2010. The mandatory application date of this Standard has been amended by AASB 2012-6 and AASB 2014-1 to 1 January 2018. The Health Service has not yet determined the application or the potential impact of the Standard.	1 Jan 2018
AASB 2014-1	*Amendments to Australian Accounting Standards* Part E of this standard makes amendments to AASB 9 and consequential amendments to other Standards. 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

Title		Operative for reporting periods beginning on/after
AASB 2014-7	*Amendments to Australian Accounting Standards arising from AASB 9 (December 2014)*	1 Jan 2018
	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.	
AASB 2015-8	*Amendments to Australian Accounting Standards – Effective Date of AASB 15*	1 Jan 2019
	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.	
AASB 2016-3	*Amendments to Australian Accounting Standards – Clarifications to AASB 15*	1 Jan 2018
	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.	
AASB 2016-7	*Amendments to Australian Accounting Standards - Deferral of AASB 15 for Not-for-Profit Entities*	1 Jan 2018
	This standard defers, for not-for-profit entities, the mandatory application date of AASB 15 to 1 January 2019, and the consequential amendments there were originally set out in AASB 2014-5. There is no financial impact arising from this standard.	
AASB 2016-8	*Amendments to Australian Accounting Standards – Australian Implementation Guidance for Not-for-Profit Entities*	1 Jan 2019
	This Standard makes amendments to AASB 9 Financial Instruments (December 2014) and AASB 15 Revenue from Contracts with Customers (December 2014). The amendments arise from the issuance of AASB 1058 Income of Not-for-Profit Entities. The Health Service has not yet determined the application or the potential impact.	

9.3 Compensation of Key Management Personnel

The Health Service has determined that key management personnel include Ministers, members, and, senior officers of the Authority. However, the Health Service is not obligated to compensate Ministers and therefore disclosures in relation to Ministers' compensation may be found in the Annual Report on State Finances.

The total fees, salaries, superannuation, non-monetary benefits and other benefits for senior officers of the for the reporting period are presented within the following bands:

	2018	2017
Compensation of members of the accountable authority		
Compensation band ($)		
70,001–80,000	1	1
60,001–70,000	-	-
50,001–60,000	-	-
40,001–50,000	9	8
30,001–40,000	-	-
20,001–30,000	-	1
Compensation of senior officers		
Compensation band ($)		
580,001–590,000	1	-
570,001–580,000	-	1
560,001–570,000	-	1
460,001–470,000	1	-
400,001–410,000	1	-
360,001–370,000	-	1
280,001–290,000	-	2
230,001–240,000	2	1
220,001–230,000	1	1
210,001–220,000	2	1
200,001–210,000	1	1
190,001–200,000	1	2
160,001–170,000	2	-
150,001–160,000	-	1
140,001–150,000	-	1
110,001–120,000	1	-
70,001–80,000	1	-
50,001–60,000	-	1
10,001–20,000	1	-

	$000	$000
Short term employee benefits	3,513	3,602
Post employment benefits	347	383
Other long term benefits	125	144
Termination benefits	-	-
Total compensation of key management personnel	**3,985**	**4,129**

Total compensation includes the superannuation expense incurred by the Health Service in respect of senior officers.

9.4 Related Party Transactions

The Health Service is a wholly owned and controlled entity of the State of Western Australia. In conducting its activities, the Health Service is required to pay various taxes and levies to the State and entities related to the State. The payment of these taxes and levies, is based on the standard terms and conditions that apply to all tax and levy payers.

Related parties of the Health Service include:

- all senior officers and their close family members, and their controlled or jointly controlled entities
- all cabinet ministers and their close family members, and their controlled or jointly controlled entities
- other departments and public sector entities, including related bodies included in the whole of government consolidated financial statements
- associates and joint ventures, that are included in the whole of government consolidated financial statements
- GESB.

All related party transactions have been entered into on an arms length basis.

Significant transactions with government-related entities

Significant transactions include:

- income from State Government (note 4.1)
- capital appropriations (note 9.9)
- superannuation payments to GESB (note 3.1(a))
- lease rentals payments for accommodation and fleet leasing to the Department of Finance (note 3.6)
- commitments for future lease payments to the Department of Finance (note 7.5)
- insurance transactions with the Insurance Commission (note 3.1(a) and Riskcover fund note 3.6)
- remuneration for services provided by the Office of the Auditor General (note 9.8)
- utility payments to Water Corporation (note 3.2)
- utility payments to Electricity Generation and Retail Corporation (Synergy) (note 3.2)
- payments for legal advice to Department of the Attorney General (note 3.6)
- maintenance transactions with the Department of Fire and Emergency Services (note 3.4 and note 3.5)
- funding agreement with Disability Services Commision (note 3.3)
- transactions with the Department of Health and other metropolitan and country health services.

Material transactions with related parties

The Health Service had no material related party transaction with Ministers/senior officers or their close family members or their controlled (or jointly controlled) entities for disclosure.

9.5 Related bodies

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

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

9.6 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.

9.7 Special purpose accounts

Mental Health Commission Fund (South Metropolitan Health Service) Account

The purpose of the special purpose account is to receive funds from the Mental Health Commission, to fund the provision of mental health services as jointly endorsed by the Department of Health and the Mental Health Commission, in the South Metropolitan Health Service, in accordance with the annual Service Agreement and subsequent agreements.

	2018 $000	2017 $000
Balance at the start of period	-	(56)
Add Receipts		
Service delivery agreement		
Commonwealth contributions	(32,118)	(28,303)
State contributions	(89,366)	(85,575)
Other	(178)	(2,672)
	(121,662)	(116,550)
Payments	121,587	116,606
Balance at the end of period	**(75)**	**-**

9.8 Remuneration of auditor

Remuneration payable to the Auditor General in respect of the audit for the current reporting period is as follows:

Auditing the accounts, financial statements controls and key performance indicators	236	160
	236	**160**

9.9 Equity

Contributed Equity

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

Balance at start of period	2,308,640	-
Contributions by owners (c)		
Transfer from Metropolitan Health Service (abolished) (a)	-	2,241,747
Capital appropriation (b)	65,628	69,795
Transfer of assets	(27)	1,999
	65,601	**2,313,541**

9.9 Equity (continued)

Contributed Equity (continued)

	2018 $000	2017 $000
Distributions to owners (c) (d) (e) (f)		
Transfer of FSH construction savings to Treasury (f)	(17,752)	-
Transfer of net assets (other than cash) to other agencies (e)	(2,921)	(4,901)
	(20,673)	**(4,901)**
Balance at end of period	**2,353,568**	**2,308,640**

a) Transfer from Metropolitan Health Service represents assets and liabilities contributed as a result of establishment of South Metropolitan Health Service under the new *Health Service Act 2016 effective 1 July 2016*.

Summary of assets and liabilities contributed are as follows:

Assets	
Cash and cash equivalents	36,762
Receivables	544,359
Inventories	6,735
Property, plant and equipment	2,212,979
Intangible assets	30,563
Other current assets	(803)
	2,830,595
Liabilities	
Payables	91,577
Borrowings	291,582
Provisions	205,646
Other liabilities	43
	588,848
Net Contribution	**2,241,747**

b) 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) Transfer of net assets (other than cash) to other agencies is made up of the following items:

Transfer of land and buildings to Ministerial Body for sale		(4,156)
Deferred salaries adjustment		(43)
Transfer of land and buildings to Child and Adolescent Health Service	(2,921)	
Adjustment commensurate with Government restructure		(702)
	(2,921)	**(4,901)**

f) In October 2007, the FSH construction account was established under the *FSH Construction Account Act 2007*. The construction account is a Department of Treasury administered special purpose account (SPA) established for the purchase of land, and construction and establishment of FSH. In 2014–15 a cash surplus resulted in the FSH construction project, with the return of savings from the managing contractor. As these residual funds were considered special purpose funds under the *FSH Construction Account Act 2007*, plus the hospital was declared operational in December 2013 and there were no additional construction or establishment costs anticipated, the funds were returned to the Department of Treasury during the year.

9.9 Equity (continued)

	2018 $000	2017 $000
Reserves		
Asset revaluation reserve (a)		
Balance at start of period	60,585	-
Net revaluation increments/(decrements) (b):		
Land	-	-
Buildings	30,736	60,585
Balance at end of period	**91,321**	**60,585**
Asset revaluation decrements recognised as an expense (b):		
Land	2,990	2,870
Buildings	-	-
	2,990	**2,870**

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

b) Any increment is credited directly to the asset revaluation reserve, except to the extent that any increment reverses a revaluation decrement previously recognised as an expense.

Accumulated deficit		
Balance at start of period	15,259	-
Result for the period	(8,671)	15,259
Balance at end of period	**6,588**	**15,259**

9.10 Supplementary financial information

(a)	**Revenue, public and other property written off**		
	Revenue and debts written off under the authority of the Accountable Authority	16,065	1,260
	Public and other property written off under the authority of the Accountable Authority	75	5
	Revenue and debts written off under the authority of the Minister	231	-
		16,371	**1,265**
(b)	**Losses of public moneys and other property**		
	Losses of public moneys and public or other property through theft or default	-	-
	Less amount recovered	-	-
	Net losses	**-**	**-**
(c)	**Gifts of public property**		
	Gifts of public property provided by the Health Service	**-**	**-**

9.11 Explanatory statement

All variances between estimates (original budget) and actual results for 2018, and between the actual results for 2017 and 2018 are shown below. Narratives are provided for selected significant variances, which generally greater than 5 per cent and $25 million.

9.11.1 Statement of Comprehensive Income

		2018 Estimates $000	2018 Actual $000	2017 Actual $000	Variance estimates and actuals $000	Variance actual 2017 and actual 2018 $000
COST OF SERVICES						
Expenses						
Employee benefits expense		919,686	955,545	935,597	35,859	19,948
Fees for visiting medical practitioners		13,030	11,888	12,677	(1,142)	(789)
Contracts for services		141,673	140,411	134,140	(1,262)	6,271
Patient support costs	1	281,879	351,346	358,063	69,467	(6,717)
Finance costs		10,592	10,516	13,749	(76)	(3,233)
Depreciation and amortisation expense		103,082	106,176	101,045	3,094	5,131
Asset revaluation decrement		-	2,990	2,870	2,990	120
Loss on disposal of non-current assets		-	240	20	240	220
Repairs, maintenance and consumable equipment		49,430	49,479	49,365	49	114
Other supplies and services		52,488	57,067	59,011	4,579	(1,944)
Other expenses	2	176,092	129,362	144,746	(46,730)	(15,384)
Total		**1,747,952**	**1,815,020**	**1,811,283**	**67,068**	**3,737**
INCOME						
Revenue						
Patient charges		90,378	93,073	87,264	2,695	5,809
Other fees for services		53,721	70,227	78,485	16,506	(8,258)
Commonwealth grants and contributions		567,079	547,686	538,329	(19,393)	9,357
Other grants and contributions		91,233	91,657	90,388	424	1,269
Donation revenue		389	608	417	219	191
Interest revenue		-	9	9	9	-
Other revenue		8,932	12,099	12,576	3,167	(477)
Total		**811,732**	**815,359**	**807,468**	**3,627**	**7,891**
Gains						
Gain on disposal of non-current assets		-	-	-	-	-
Total		**-**	**-**	**-**	**-**	**-**
Total income other than income from State Government		**811,732**	**815,359**	**807,468**	**3,627**	**7,891**
NET COST OF SERVICES		**936,220**	**999,661**	**1,003,815**	**63,441**	**(4,154)**
INCOME FROM STATE GOVERNMENT						
Service appropriations		873,069	914,400	924,725	41,331	(10,325)
Assets (transferred)/assumed		-	33	(196)	33	229
Services received free of charge		62,887	76,557	94,545	13,670	(17,988)
Total income from State Government		**935,956**	**990,990**	**1,019,074**	**55,034**	**(28,084)**
SURPLUS/(DEFICIT) FOR THE PERIOD		**(264)**	**(8,671)**	**15,259**	**(8,407)**	**(23,930)**
OTHER COMPREHENSIVE INCOME/(LOSS)						
Items not reclassified subsequently to profit or loss						
Changes in asset revaluation reserve	3	-	30,736	60,585	30,736	(29,849)
Total other comprehensive income / (loss)		**-**	**30,736**	**60,585**	**30,736**	**(29,849)**
TOTAL COMPREHENSIVE INCOME/ (LOSS) FOR THE PERIOD		**(264)**	**22,065**	**75,844**	**22,329**	**(53,779)**

9.11.1 Statement of Comprehensive Income

Significant variances between estimated and actual for 2018

1. Patient support costs

The results were $70 million higher than the estimates due to various factors including delivery of higher levels of activity by 1.9 per cent ($11 million), dispensing of higher level of high cost antiviral drugs ($15 million), higher outsourced services costs ($11 million), and pathology shared services allocation being received later in the year ($22 million).

2. Other expenses

Transitioning towards a more sustainable health service underpinned the 2018 estimates in redirecting resources to this item. Many improvements were achieved during the year, however with the delivery of higher activity levels this resulted in costs being greater than desired especially in the employee cost area.

3. Changes in asset revaluation reserve

As per note 5.1 Property, plant and equipment. The increase in the reserve mainly relates to the net increase in the revaluation of building assets.

Significant variances between actual for 2017 and 2018

3. Changes in asset revaluation reserve

As per note 5.1 Property, plant and equipment. The increase in the reserve mainly relates to the net increase in the revaluation of building assets.

9.11.2 Statement of Financial Position

		2018 Estimates $000	2018 Actual $000	2017 Actual $000	Variance estimates and actuals $000	Variance actual 2017 and actual 2018 $000
ASSETS						
Current Assets						
Cash and cash equivalents		27,944	19,353	23,856	(8,591)	(4,503)
Restricted cash and cash equivalents		28,610	9,688	28,610	(18,922)	(18,922)
Receivables		47,045	53,284	55,045	6,239	(1,761)
Inventories		5,277	5,208	5,277	(69)	(69)
Other current assets		1,732	4,949	1,732	3,217	3,217
Total Current Assets		**110,608**	**92,482**	**114,520**	**(18,126)**	**(22,038)**
Non-Current Assets						
Restricted cash and cash equivalents		7,296	7,148	3,648	(148)	3,500
Amounts receivable for services	4	714,103	723,685	610,791	9,582	112,894
Property, plant and equipment	5	2,244,612	2,093,730	2,166,154	(150,882)	(72,424)
Intangible assets		27,287	23,709	27,287	(3,578)	(3,578)
Total Non-Current Assets		**2,993,298**	**2,848,272**	**2,807,880**	**(145,026)**	**40,392**
Total Assets		**3,103,906**	**2,940,754**	**2,922,400**	**(163,152)**	**18,354**
LIABILITIES						
Current Liabilities						
Payables		93,031	92,996	93,031	(35)	(35)
Borrowings		64,417	52,894	60,187	(11,523)	(7,293)
Provisions		166,418	176,502	166,418	10,084	10,084
Other current liabilities		401	283	170	(118)	113
Total Current Liabilities		**324,267**	**322,675**	**319,806**	**(1,592)**	**2,869**
Non-Current Liabilities						
Borrowings	6	106,467	117,993	170,885	11,526	(52,892)
Provisions		47,225	48,609	47,225	1,384	1,384
Total Non-Current Liabilities		**153,692**	**166,602**	**218,110**	**12,910**	**(51,508)**
Total Liabilities		**477,959**	**489,277**	**537,916**	**11,318**	**(48,639)**
NET ASSETS		**2,625,947**	**2,451,477**	**2,384,484**	**(174,470)**	**66,993**
EQUITY						
Contributed equity	7	2,524,982	2,353,568	2,308,640	(171,414)	44,928
Reserves	8	88,926	91,321	60,585	2,395	30,736
Accumulated deficit		12,039	6,588	15,259	(5,451)	(8,671)
TOTAL EQUITY		**2,625,947**	**2,451,477**	**2,384,484**	**(174,470)**	**66,993**

9.11.2 Statement of Financial Postition

Significant variances between estimated and actual for 2018

5. Property, plant and equipment

Prior year revaluations adjustments in 2016–17 had not been captured in time for the 2017–18 estimates resulting in the variance.

7. Contributed equity

Prior year revaluations adjustments in 2016–17 had not been captured in time for the 2017–18 estimates resulting in the variance.

Significant variances between actual for 2017 and 2018

4. Amounts receivable for services

Refer to note 6.2 Amounts receivable for services. The movement between the years is due to the accrual funding received from Government in 2017–18.

6. Borrowings

Refer to note 7.1 Borrowings. The reduction in balances is largely due to the principle repayment of the FSH finance lease liabilities in 2018–19.

8. Reserves

Refer to note 5.1 Property, plant and equipment. The movement in the reserve is due to the revaluation of land and buildings, with the increase mainly attributable to an upward valuation in the buildings category.

9.11.3 Statement of Cash Flows

		2018 Estimates $000	2018 Actual $000 Inflows (Outflows)	2017 Actual $000 Inflows (Outflows)	Variance estimates and actuals $000	Variance actual 2017 and actual 2018 $000
CASH FLOWS FROM STATE GOVERNMENT						
Service appropriations		769,757	801,284	806,196	31,527	(4,912)
Capital appropriations		69,167	45,250	67,289	(23,917)	(22,039)
Cash transferred from Metropolitan Health Service (abolished)	9	-	-	36,762	-	(36,762)
Net cash provided by State Government		838,924	846,534	910,247	7,610	(63,713)
Utilised as follows:						
CASH FLOWS FROM OPERATING ACTIVITIES						
Payments						
Employee benefits		(919,686)	(940,689)	(931,842)	(21,003)	(8,847)
Supplies and services		(643,705)	(662,204)	(632,260)	(18,499)	(29,944)
Finance costs		(59)	-	(57)	59	57
GST payments on purchases		-	(1,150)	-	(1,150)	(1,150)
Receipts						
Receipts from customers		90,378	85,555	84,664	(4,823)	891
Commonwealth grants and contributions		567,079	547,686	538,329	(19,393)	9,357
Other grants and contributions		91,233	91,657	90,388	424	1,269
Donations received		389	275	417	(114)	(142)
Interest received		-	9	9	9	-
Other receipts		62,652	86,916	75,996	24,264	10,920
Net cash used in operating activities		(751,719)	(791,945)	(774,356)	(40,226)	(17,589)
CASH FLOWS FROM INVESTING ACTIVITIES						
Payments						
Payment for purchase of non-current physical and intangible assets		(15,253)	(6,738)	(2,857)	8,515	(3,881)
Receipts						
Proceeds from sale of non-current physical assets		-	87	14	87	73
Net cash used in investing activities		(15,253)	(6,651)	(2,843)	8,602	(3,808)
CASH FLOWS FROM FINANCING ACTIVITIES						
Payments						
Repayment of finance lease liabilities		(67,864)	(67,863)	(76,934)	1	9,071
Net cash used in financing activities		(67,864)	(67,863)	(76,934)	1	9,071
Net increase / (decrease) in cash and cash equivalents		4,088	(19,925)	56,114	(24,013)	(76,039)
Cash and cash equivalents at the beginning of the period		56,114	56,114	-	-	56,114
Cash transferred to Department of Treasury		3,648	-	-	(3,648)	-
CASH AND CASH EQUIVALENTS AT THE END OF PERIOD		**63,850**	**36,189**	**56,114**	**(27,661)**	**(19,925)**

9.11.3 Statement of Cash Flows

Significant variances between actual for 2017 and 2018

9. Cash transferred from Metropolitan Health Service (abolished)

The *Health Services Act 2016*, enabled the creation of the SMHS from 1 July 2016. As SMHS was a new entity there was no opening cash balance for 2016–17, instead the Cash was subsequently transferred via contributions from owners and the abolishment of the Metropolitan Health Services. The same entry was not required for 2017–18.

Certification of key performance indicators

SOUTH METROPOLITAN HEALTH SERVICE

CERTIFICATION OF KEY PERFORMANCE INDICATORS FOR THE YEAR ENDED 30 JUNE 2018

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

Mr Rob McDonald
Chair
South Metropolitan Health Service Board
21 September 2018

Mr David Rowe
Board Member
South Metropolitan Health Service Board
21 September 2018

Key performance indicators

OUTCOME 1 – EFFECTIVENESS KPI

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

Rationale

After a successful hospital stay, the most important task for WA public hospital patients and staff is preparing for a successful discharge home. Tracking the number of patients who experience unplanned readmissions to WA health system hospitals, within 28 days for selected surgical procedures, assists in assessing the quality of hospital services provided to the community. Unplanned readmissions are those readmissions where the principal diagnosis and readmission interval indicate that the readmission may be related to the care provided by the hospital in an index surgical episode of care. This indicator measures readmissions to any public hospital or as a public patient in Contracted Health Entities (CHEs).

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 within our health system, and lessons can be learnt from a higher than target unplanned readmission rate through the creation of a variety of improvement strategies.

The surgeries selected to be measured by this indicator have a risk associated with post-surgery complications. Good discharge plans can help to decrease the likelihood of unplanned hospital readmissions by providing patients with the care instructions they need after a hospital stay and by helping patients recognise symptoms that may require immediate medical attention. However, it is important to note that unplanned hospital readmissions may or may not be related to the previous visit, and some unplanned readmissions are not preventable.

Target

The target is represented as the upper limit per 1000 separations. Improved or maintained performance is demonstrated by a result below or equal to the target.

For 2017 the targets are based on the best statewide results achieved within the previous five calendar years.

Results

There are some conditions that may require numerous admissions to enable the optimum level of care to be provided. In those incidences the hospital readmission is planned.

For the period January to December 2017, the rate of unplanned readmission to the SMHS for a selected procedure is presented in the following table. The data indicates rates of unplanned readmission being on target or below target for knee replacement, hip replacement and appendicectomy. The positive results for the other selected procedures demonstrates effective health care treatment within the inpatient setting in combination with appropriate discharge planning and follow-up in outpatient clinics, therefore reducing the risk of readmission for patients.

SMHS reviews cases for these selected procedures on a quarterly basis as a part of the monthly WA Health Service Performance Reporting (HSPR). A low number of cases impacted SMHS performance against target for tonsillectomy and adenoidectomy, hysterectomy and prostatectomy procedures.

Tonsillectomy and adenoidectomy

Clinical review of the tonsillectomy and adenoidectomy cases indicated the majority involved a readmission overnight due to small secondary bleeds; however, these required no further operative treatment, and a portion of these patients had other comorbidities, which contributed to the complexity of their care. Additionally, it was also noted that patients are always encouraged to err on the side of caution and return to hospital if they have any concerns, especially in relation to bleeding. As an outcome of the clinical review, an adjustment to the medication management for these patients is currently being evaluated to reduce the risk of readmission.

Hysterectomy

Hysterectomy cases that contributed to the SMHS unplanned readmission rate being above target underwent clinical review and were found to be uncomplicated procedures and recovery, with no contributing clinical care or system factors identified for readmission. A number of these cases were readmitted due to known post-operative complications, such as minor bleeding that spontaneously resolved, and the patients were discharged home the following day. A small proportion of the unplanned readmits at one SMHS site involved patients with complex conditions, extended theatre times, significant blood loss and a high body mass index (BMI); however, no other issues were identified.

Prostatectomy

Clinical review of the unplanned readmissions for prostatectomy revealed the majority of patients were readmitted due to known complications of this surgery such as urinary or blood clot retention. The procedures for these patients were found to be uncomplicated with no indication of any system or clinical care issues.

Cataract surgery

For the first quarter of 2017 the SMHS rate of unplanned readmissions for cataract surgery were below the target, the rate increased to above the target in the subsequent two quarters and in the last quarter, commenced trending down. The patients related to the increased rate were all reviewed and whilst they were readmitted due to known complications, such as an infection requiring oral antibiotics, no adverse clinical care or system issues were identified.

As SMHS was newly formed on 1 July 2016, the data for 2016 year encapsulates the period 1 July 2016 to 31 December 2016.

Table 7: Rate of unplanned readmissions within 28 days for selected surgical procedures

Surgical Procedure	Calendar Year		
	2016 (part year) Actual (per 1000)	2017 Actual (per 1000)	Target (per 1000)
Knee replacement	**21**	**19.2**	≤26.2
Hip replacement	**10**	**13.1**	≤17.2
Tonsillectomy and adenoidectomy	**97**	**82.6**	≤61.0
Hysterectomy	**49**	**61.5**	≤41.3
Prostatectomy	**30**	**53.1**	≤38.8
Cataract surgery	**1**	**3.7**	≤1.1
Appendicectomy	**32**	**32.1**	≤32.9

Data source: Hospital Morbidity Data System. **Note:** As these are calendar KPIs the latest and most up to date information is reported in the current year, being the 2017 calendar year results.

OUTCOME 1 – EFFECTIVENESS KPI

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

Rationale

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

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

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

Reportable cases are defined as: All waiting list cases that are not listed on the Elective Services Wait List Data Collection (ESWLDC) Commonwealth Non-Reportable Procedures list. This list is consistent with the Australian Institute of Health and Welfare (AIHW) list of Code 2 (other) procedures that do not meet the definition of elective surgery. It also includes additional procedure codes that are intended to better reflect the procedures identified in the AIHW Code 2 list.

Target

The target requires that no patients (0 per cent) on elective waiting lists for reportable procedures wait longer than the clinically recommended time, according to their urgency category.

Results

While the proportion of over boundary elective wait list patients for reportable procedures was over target in all categories, there were marked reductions in the percentage of over boundary category 2 and 3 cases in 2017–18. Further, reductions in actual over boundary numbers were seen across all urgency categories. SMHS worked intensively to improve the timeliness of treatment for elective wait list patients this financial year by implementing a range of initiatives under the banner of the SMHS Elective Surgery Wait List Reduction Strategy. Implementation of the strategy resulted in approximately 170 fewer cases waiting longer than the clinically recommended timeframe for their reportable elective surgery procedure at the end of June 2018, compared to the same time last year. Taking non-reportable procedures into account, this figure becomes approximately 900 fewer cases waiting over-boundary in the same time period. SMHS intends to build on this work in 2018–19 to make further progress towards 100 per cent of patients treated within clinically appropriate timeframes.

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

	2016–17 Actual (%)	2017–18 Actual (%)	Target (%)
Urgency Category 1	**22.6**	**25.3**	0
Urgency Category 2	**30.9**	**20.6**	0
Urgency Category 3	**4.8**	**1.9**	0

Data source: Elective Services Wait List Data Collection.

OUTCOME 1 – EFFECTIVENESS KPI

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

Rationale

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

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

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

Target

The target is an infection rate of ≤1.0 per 10,000 occupied bed days in public hospitals.

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

Results

For 2017–18 a rate of 0.9 per 10,000 occupied bed days was achieved, which fell below the required target.

This is a new indicator for 2017–18, therefore there are no prior year comparisons.

Table 9: Hospital infection rate

	2017–18 Actual (%)	Target (%)
Infection rate per 10,000 bed days	0.9	≤1.0

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

OUTCOME 1 – EFFECTIVENESS KPI

Survival rates for sentinel conditions

Rationale

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

These three conditions have been chosen as they are particularly significant for the health care of the community and are leading causes of death and hospitalisation in Australia. Patient survival after being admitted for one of these three sentinel conditions can be affected by many factors including the diagnosis, the treatment given or procedure performed, age, co-morbidities at the time of the admission and complications, which may have developed while in hospital.

Hospital survival indicators, including this KPI, are considered screening tools as they are not definitively diagnostic of poor quality and/or safety.

Target

The target is based on the state average result for the previous five calendar years. An improved or maintained performance is demonstrated by a result exceeding or equal to the target.

The following table illustrates the target for each condition by age group.

Table 10: Survival target rates for sentinel conditions, by age group

Age group (years)	Sentinel conditions		
	Stroke (%)	AMI (%)	FNOF (%)
0–49	≥94.3	≥99.2	Not reported
50–59	≥92.4	≥98.9	Not reported
60–69	≥92.8	≥98.1	Not reported
70–79	≥89.5	≥96.1	≥98.9
80+	≥80.9	≥91.7	≥95.3

Results

For the period January to December 2017, the SMHS hospitals exceeded targets for the majority of age groups and conditions. The survival rate for acute myocardial infarction was below target in the 60-69 age group.

SMHS reviews in-hospital mortality rates of patients admitted for AMI, stroke, FNOF and pneumonia on a monthly basis as a part of the HSPR. For 2017 there were 221 episodes of care involving patients with a diagnosis of AMI from the 60-69 year age group, and six of these were associated with an outcome of patient death. In the majority of these cases the patients were brought into an emergency department following an AMI in the community, where bystanders, family and St. John's Ambulance had attempted resuscitation. Each of the patients had a history of significant heart disease and other co-morbidities. Despite extensive and exhaustive intervention, including surgery and treatment in the coronary care and intensive care units, the complications that arose from these AMIs were so severe that they were unable to be reversed and resulted in patient death.

As SMHS was newly formed on 1 July 2016, the data for 2016 year encapsulates the period 1 July 2016 to 31 December 2016.

Table 11: Survival rate for stroke, by age group

Age group (years)	Calendar year		
	2016 (part year) (%)	2017 (%)	Target (%)
0–49	96.5	96.8	≥94.3
50–59	98.8	95.2	≥92.4
60–69	91.2	97.4	≥92.8
70–79	93.4	92.9	≥89.5
80+	86.7	88.5	≥80.9

Data source: Hospital Morbidity Data System.
Note: As these are calendar KPIs the latest and most up to date information is reported in the current year, being the 2017 calendar year results.

Table 12: Survival rate for acute myocardial infarction, by age group

Age group (years)	Calendar year		
	2016 (part year) (%)	2017 (%)	Target (%)
0–49	98.7	99.4	≥99.2
50–59	100.0	98.8	≥98.9
60–69	100.0	97.2	≥98.1
70–79	97.2	97.6	≥96.1
80+	94.3	93.4	≥91.7

Data source: Hospital Morbidity Data System.
Note: As these are calendar KPIs the latest and most up to date information is reported in the current year, being the 2017 calendar year results.

Table 13: Survival rate for fractured neck of femur, by age group

Age group (years)	Calendar year		
	2016 (part year) (%)	2017 (%)	Target (%)
70–79	100.0	100.0	≥98.9
80+	97.1	98.1	≥95.3

Data source: Hospital Morbidity Data System.
Note: As these are calendar KPIs the latest and most up to date information is reported in the current year, being the 2017 calendar year results.

OUTCOME 1 – EFFECTIVENESS KPI

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

Rationale

WA health system public hospitals employ a range of initiatives to ensure the delivery of culturally secure health services to Aboriginal people. The inclusion of this new KPI will assist in measuring the success of these initiatives. A high percentage reported for this KPI will reflect the need for improved responses by the WA health system to the needs of Aboriginal patients and provides a measure of the quality of the services provided.

Patients who left against medical advice (also called discharged against medical advice or DAMA) have been found to cost the health system 50 per cent more than the cost of patients who are discharged by physicians.[1] Published data contends that high DAMA rates reflect the need for improved responses by the health care system to the needs of Aboriginal patients and provides a measure of the safety, quality and cultural security of the services provided.

Monitoring this indicator enables identification of performance improvement opportunities, as well as the collaborative and effective addressing of the underlying factors in achieving an equitable treatment outcome for Aboriginal patients.

Target

The target is ≤0.77 per cent.

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

Results

From the results the SMHS is below target for the Non-Aboriginal patients and above target for the Aboriginal patients.

SMHS reviews DAMA cases on a monthly basis as a part of the HSPR, and given the DAMA rate for Aboriginal patients, a number of strategies continue to be implemented to specifically target this vulnerable group. These strategies have been implemented by SMHS hospitals using a collaborative approach with Aboriginal Health Liaison Officers, and the SMHS Aboriginal Health Strategy Unit, through the application of the *SMHS Aboriginal Community and Consumer Engagement Framework*.

This is a new indicator for 2017–18; therefore, there are no prior year comparisons.

Table 14: Percentage of patients who discharge against medical advice

	Calendar Year	
Discharge against medical advice	2017 (%)	Target (%)
Aboriginal	2.89	≤0.77
Non-Aboriginal	0.60	≤0.77

Data source: Hospital Morbidity Data System.
Note: As these are calendar KPIs the latest and most up to date information is reported in the current year, being the 2017 calendar year results.

1 Aliyu ZY. Discharge against medical advice: sociodemographic, clinical and financial perspectives. International journal of clinical practice 2002; 56(5):325-327

OUTCOME 1 – EFFECTIVENESS KPI

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

Rationale

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

The Apgar[2] 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. Apgar scores range from zero to two for each condition with a maximum final total score of ten. The higher the Apgar score the better the health of the newborn infant.

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

The indicator aligns to the National Core Maternity Indicators (2016) Health, Standard 2 February 2016.

Target

The target for live born infants with an Apgar score of seven or less at five minutes post-delivery is 1.8 per cent.

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

Results

An Apgar score of less than seven at five minutes after birth is considered to be an indicator of complications and compromise for the infant. For the period ending December 2017, the SMHS achieved a positive result at a score of 1.3 per cent, which is below the target level of 1.8 per cent. This positive outcome was the result of the development and implementation of appropriate clinical care plans across hospital sites.

The SMHS was newly formed on 1 July 2016, the data for the 2016 year encapsulates the period of 1 July 2016 to 31 December 2016.

Table 15: Percentage of live born infants with an Apgar score of less than seven, five minutes post-delivery

	Calendar Year		
	2016 (%)	2017 (%)	Target (%)
Percentage of live born infants	1.1	1.3	≤1.8

Note: Public births at contracted private hospitals have been included in the calculation of this indicator.

Note: As these are calendar KPIs the latest and most up to date information is reported in the current year, being the 2017 calendar year results.

Data source: Midwives Notification System.

2 Apgar is an acronym of the following words: Appearance, Pulse, Grimace, Activity, and Respiration

OUTCOME 1 – EFFECTIVENESS KPI

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

Rationale

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

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

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

Target

The target is ≤12 per cent.

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

Results

The SMHS readmission rate for 2017 was above target at 19 per cent; however, no system or clinical care issues were identified as contributing to this higher rate. A clinical review found the majority of readmissions involved adults with Borderline Personality Disorder (BPD) or Emotionally Unstable Personality Disorders (EUPD). Patients with BPD or EUPD can often present in a crisis, which is a typical characteristic of many patients with these disorders. These patients may present with a range of symptoms and behaviours, including behavioural disturbance, self-harm, impulsive aggression, and short-lived psychotic symptoms, as well as intense anxiety, depression and anger. These patients also have a wide range of health issues, including alcohol and substance abuse, and external stress factors. The patients are encouraged to seek help if unable to cope with their situation, and the majority of readmissions are due to this. As such the model of care in place for these patients is one based on crisis intervention, where patients have an agreed management plan that encourages them to return to hospital for brief admissions at any time when they are experiencing situations that trigger distress, or increase the risk of them harming themselves or others. Whilst this model of care is in line with international evidence-based best practice, additional strategies have been implemented by SMHS hospitals to further support the care and services provided to these patients

This is a new indicator for 2017–18; therefore, there are no prior year comparisons.

Table 16: Rate of total hospital readmissions within 28 days to an acute designated mental health inpatient unit

	Calendar Year	
	2017 (%)	Target (%)
Readmissions rate	19	≤12

Data source: Hospital Morbidity Data System.
Note: As these are calendar KPIs the latest and most up to date information is reported in the current year, being the 2017 calendar year results.

OUTCOME 1 – EFFECTIVENESS KPI

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

Rationale

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

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

A responsive community support system for persons who have experienced a psychiatric episode requiring hospitalisation is essential to maintain their clinical and functional stability and to minimise the need for hospital readmissions. Patients leaving hospital after a psychiatric admission with a formal discharge plan, involving linkages with public community based services and support, are less likely to need avoidable readmission.

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

Target

The target is ≥75 per cent.

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

Results

From the results, 80 per cent of people who were admitted to a SMHS mental health unit were contacted by a community-based mental health non-admitted service within seven days of discharge. This is above target.

Table 17: Percentage of contacts with community-based public mental health non-admitted services within seven days post discharge from an acute public mental health inpatient unit

	Calendar Year		
	2016 (%)	2017 (%)	Target (%)
Post discharge community based contact	79	80	≥75

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

Note: As these are calendar KPIs the latest and most up to date information is reported in the current year, being the 2017 calendar year results.

3 National Health Survey 2014/15

OUTCOME 1 – EFFICIENCY KPI

Service 1: Public Hospital Admitted
Average admitted cost per weighted activity unit

Rationale

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

The measure ensures a consistent methodology is applied to calculating and then measuring the performance of HSPs against the funding they receive through the Government Budget Statement and subsequent Service Agreements, and the activity delivered by each hospital site (reported at an aggregated entity level). As admitted services received approximately 47 per cent of the WA Health 2017–18 budget allocation, it is imperative that efficiency of this service delivery is accurately monitored and reported.

Target

There are two targets noted for this KPI: An initial target that aligns to the Government's Budget Statements (refer 2017–18 WA State Budget Paper 2) for 2017–18 and a revised target.

During the 2016–17 annual report preparations, the Office of the Auditor General identified changes to the KPI calculations in WA Health, to include the costs of the teaching, training and research programs and the PathWest Resources Received Free of Charge. The amendments occurred after the release of the published budget statements by Government, and had a flow-on impact on the calculation of the 2017–18 KPI targets. As a consequence, both targets are shown in this report.

The original target for this KPI was $6,868 and the revised target is now $7,285 per weighted activity units.

A result on or below the target is desirable.

Results

The average admitted cost per weighted activity unit is below the revised target at $7,273.

This is a new indicator for 2017–18, therefore there are no prior year comparisons.

Table 18: Average admitted cost per weighted activity unit

	2017–18 ($)
Average cost	$7,273
Initial target per Government Budget Statements	$6,868
Revised target	$7,285

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

OUTCOME 1 – EFFICIENCY KPI

Service 2: Public Hospital Emergency Services
Average Emergency Department cost per weighted activity unit

Rationale

This indicator is a measure of the cost per weighted activity unit compared with the HSPs HSAP set each year in the WA ABF Operating Model.

The measure ensures that a consistent methodology is applied to calculating and then measuring the performance of HSPs against the funding they receive through the Government Budget Statement and subsequent Service Agreements, and the activity delivered by each hospital site (reported at an aggregated entity level). As emergency department (ED) services received approximately 9 per cent of the 2017–18 budget allocation, and with the ever increasing demand on EDs and health services, it is imperative that ED service provision is continually monitored to ensure the efficient delivery of safe and high-quality care.

Target

There are two targets noted for this KPI: An initial target that aligns to the Government's budget statements (refer 2017–18 WA State Budget Paper 2) for 2017–18 and a revised target.

During the 2016–17 annual report preparations, the Office of the Auditor General identified changes to the KPI calculations in WA Health, to include the costs of the teaching, training and research programs and the PathWest Resources Received Free of Charge. The amendments occurred after the release of the published budget statements by Government, and had a flow-on impact on the calculation of the 2017–18 KPI targets. As a consequence, both targets are shown in this report.

The original target for this KPI was $6,642 and the revised target is now $7,043 per weighted activity units.

A result on or below the target is desirable.

Results

The average admitted cost per weighted activity unit is below target at $6,132. The below target position was achieved as the result of higher activity levels, a refinement in the costing data and a reduction in the share services costs since the target setting assumptions were prepared.

This is a new indicator for 2017–18; therefore, there are no prior year comparisons.

Table 19: Average Emergency Department cost per weighted activity unit

	2017–18 ($)
Average cost	$6,132
Initial target per Government Budget Statements	$6,642
Revised target	$7,043

Note: This key performance indicator includes Peel Health Campus.

Data source: Emergency Department Data Collection, health service financial systems, OBM Allocation Application.

OUTCOME 1 – EFFICIENCY KPI

Service 3: Public Hospital Non-Admitted Services
Average non-admitted cost per weighted activity unit

Rationale

This indicator is a measure of the cost per weighted activity unit compared with the HSPs HSAP set each year in the ABF Operating Model.

The measure ensures that a consistent methodology is applied to calculating and then measuring the performance of HSPs against the funding they receive through the Government Budget Statement and subsequent Service Agreements, and the activity delivered by each hospital site (reported at an aggregated entity level). As non-admitted services received approximately 9 per cent of the 2017–18 budget allocation, it is imperative that efficiency of this service delivery is accurately monitored and reported.

Target

There are two targets noted for this KPI: An initial target that aligns to the Government's Budget Statements (refer 2017–18 WA State Budget Paper 2) for 2017–18 and a revised target.

During the 2016–17 annual report preparations, the Office of the Auditor General identified changes to the KPI calculations in WA Health, to include the costs of the teaching, training and research programs and the PathWest Resources Received Free of Charge. The amendments occurred after the release of the published budget statements by Government, and had a flow-on impact on the calculation of the 2017–18 KPI targets. As a consequence, both targets are shown in this report.

The original target for this KPI was $6,738 and the revised target is now $7,160 per weighted activity units.

A result on or below the target is desirable.

Results

The average admitted cost per weighted activity unit is below target at $7,024. The below target position was achieved as the result of higher activity levels, a refinement in the costing data and a reduction in the share services costs since the target setting assumptions were prepared.

This is a new indicator for 2017–18; therefore, there are no prior year comparisons.

Table 20: Average non-admitted cost per weighted activity unit

	2017–18 ($)
Average cost	$7,024
Initial target per Government Budget Statements	$6,738
Revised target	$7,160

Note: This key performance indicator includes Peel Health Campus

Data source: Non Admitted Patient Activity and Wait List Data Collection, Interim Collection of Aggregate Data, health service financial systems, OBM Allocation Application.

OUTCOME 1 – EFFICIENCY KPI

Service 4: Mental Health Services
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 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 health care and enable the reallocation of funds to appropriate alternative non-admitted care.

Target

There are two targets noted for this KPI: An initial target that aligns to the Government's Budget Statements (refer 2017–18 WA State Budget Paper 2) for 2017–18 and a revised target.

During the 2016–17 annual report preparations, the Office of the Auditor General identified changes to the KPI calculations in WA Health, to include the costs of the teaching, training and research programs and the PathWest Resources Received Free of Charge. The amendments occurred after the release of the published budget statements by Government, and had a flow-on impact on the calculation of the 2017–18 KPI targets. As a consequence, both targets are shown in this report.

In addition, the original target also incorrectly excluded the relevant Fremantle Hospital details from the denominator. The original target for this KPI was $3,211 and the revised target is now $1,534 per bed day.

A result on or below the target is desirable.

Results

From the results, the average cost per bed day in specialised mental health inpatients units was $1,594, which is above the target. Higher costs were noted after inclusion of a portion of the depreciation and shared services costs.

Introduction of the Outcome Based Management model in 2017–18 has impacted the calculations underpinning this KPI. The 2016–17 results were generated using different outcomes structures and assumptions leading to a significant variation in the results between the years; therefore, comparison and interpretation between the years is not appropriate.

Table 21: Average cost per bed-day in specialised mental health inpatient units

	2016–17 ($)	2017–18 ($)	Initial target per Government Budget Statements ($)	Revised target ($)
Average cost per bed day	2,098	1,594	3,211	1,534

Data source: Mental Health Information System, Bed State, health service financial systems, OBM Allocation Application.

OUTCOME 1 – EFFICIENCY KPI

Service 4: Mental Health Services
Average cost per treatment day of non-admitted care provided by public clinical mental health services

Rationale

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

The majority of services provided by public community-based mental health services are for people in acute phase of a mental illness who are receiving post-acute care. This indicator gives a measure of the cost effectiveness of treatment for public psychiatric patients under public community mental healthcare (non-admitted/ambulatory patients).

Target

There are two targets noted for this KPI: An initial target that aligns to the Government's Budget Statements (refer 2017–18 WA State Budget Paper 2) for 2017–18 and a revised target.

The system manager advised that the original target was calculated using an inaccurate denominator, requiring a correction. Although the change did not impact the aggregate WA health system target, it did have an impact on the specific target for the HSPs. As a consequence, both targets are shown in this report.

The original target for this KPI was $346 and the revised target is now $541 per treatment day of non-admitted care provided by public clinical mental health services.

A result below the target is desirable.

Results

The average admitted cost per weighted activity unit is above target $584. Higher costs were noted after inclusion of a portion of the depreciation and shared services costs.

This is a new indicator for 2017–18; therefore, there are no prior year comparisons.

Table 22: Average cost per treatment day of non-admitted care provided by public clinical mental health services

	2017–18 ($)
Average cost	$584
Initial target per Government Budget Statements	$346
Revised target	$541

Data source: Mental Health Information System, Bed State, health service financial systems, OBM Allocation Application.

OUTCOME 2 – EFFICIENCY KPI

Service 6: Public and Community Health Services
Average cost per person of delivering population health programs by 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 2017–2021*. This is based on the growing understanding of the social, cultural and economic factors that contribute to a person's health status.

Target

The target for this KPI is $3 per person of delivering health programs by population health units.

A result below the target is desirable.

Results

For 2017–18, the average cost per capital of Population Health Units was above target at $17. The large variance is due to a realignment of funding for services during 2017–18 from other OBM categories, where this realignment occurred after the targets had been defined.

Introduction of the OBM model in 2017–18 has impacted the calculations underpinning this KPI. The 2016–17 results were generated using different outcomes structures and assumptions leading to a significant variation in the results between the years; therefore, comparison and interpretation between the years is not appropriate.

Table 23: Average cost per person of delivering programs by Population Health Units

	2016–17 ($)	2017–18 ($)	Target ($)
Average cost per person	25	17	3

Data source: 2017 population projected by the Epidemiology Branch, health service financial systems OBM Allocation Application.

Ministerial directives

SMHS did not receive any ministerial directives in 2017–18.

Other financial disclosures

Pricing policy

The National Health Reform Agreement sets the policy framework for the charging of public hospital fees and charges. Under the agreement, an eligible person who receives public hospital services as a public patient 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 for eligible war service veterans are determined under a separate Commonwealth-State agreement with the Department of Veterans' Affairs. Under this agreement, the WA Department of Health does not charge medical treatment to eligible war service veteran patients. Instead medical charges are fully recouped from the Department of Veterans' Affairs.

- **The following fees and charges also apply:**

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

Capital works

SMHS continues to facilitate re-modelling and development of health infrastructure within its area of responsibility.

There were no capital works projects completed by SMHS during 2017–18.

Table 24: Capital works in progress in 2017–18

Project Name	Estimated total cost in 2017–18 ($'000)	Reported in 2016–17 ($'000)	Variance ($'000)	Expected completion date	Variation to cost explanation
FSH ICT Commissioning	32,114	32,114		2019	
FH Reconfiguration [refer note (d)]	5,221	5,221		2019	
FSH ICT – Pharmacy Automation [refer note (e)]	9,600	9,600		2019	
PHC – development stage 1	2,369	2,369		2019	
FSH – development	1,701,524	1,701,524		2019	
FSH ICT – Intensive Care Clinical Information Systems [refer note (f)]	4,200	4,200		2019	
FSH – Critical ICT Upgrades	15,188	1,590		2019	Additional funding [refer note (g)]
FSH – da Vinci System	4,950	–	4,950	2019	New project

Notes of relevance

a) The above information is based on the '2017–18 Service Level Agreement', and includes the Budgeted Expense Capital allocation.

b) Allocations from the medical equipment and minor works programs are not included as these are reported by Department of Health.

c) Completion timeframes are updated for latest expectations at the time of reporting.

d) The expected completion date was revised to 2019 to accommodate additional compliance requirements relating to the fire services upgrade project.

e) The expected completion date was revised to 2019 taking into consideration changes in the BOSSnet automation program impacting the project.

f) The expected completion date was revised to 2019 to capture variations in the project scope.

g) Additional funding was allocated for the replacement and upgrade of FSH equipment and software to meet obligations under the Facilities Management Service Contract.

Employment profile

Government agencies are required to report a summary of the number of employees, by category, compared to the preceding financial year.

Table 25: SMHS total full-time employees by category

Category	Definition	2016–17	2017–18
Administration and clerical	Includes all clerical-based occupations together with patient-facing (ward) clerical support staff	1,045.65	1,064.66
Agency nursing	Includes workers engaged on a 'contract for service' basis. Does not include workers employed by NurseWest	45.95	33.11
Assistants in nursing	Support registered nurses and enrolled nurses in delivery of general patient care	115.00	183.44
Dental nursing	Includes dental nurses and dental clinic assistants	1.00	1.00
Hotel services	Includes catering, cleaning, stores/supply, laundry and transport occupations	418.78	353.29
Maintenance services	Includes engineering, garden and security-based occupations.	59.26	62.69
Medical	Includes all salary-based medical occupations including interns, registrars and specialist medical practitioners	1,111.26	1,162.72
Medical support	Includes all allied health and scientific/technical related occupations	1,069.08	1,086.77
Nursing and Midwifery	Includes enrolled and registered nurses, nurse practitioners, and midwives. Does not include agency nurses and midwives.	2,908.51	2,944.27
Other occupations	Not limited to but primarily includes Aboriginal and ethnic health specialist positions	14.71	11.74
Sessional	Includes specialist medical practitioners that are engaged on a sessional basis	91.14	76.00

***Notes:**

1. Data source: HR Data Warehouse
2. Year-to-date FTE divides the total FTE paid in every pay fortnight to date by the number of periods possible during the financial year up to the date specified.
3. FTE includes ordinary hours, overtime, all paid leave categories, public holidays, time-off-in-lieu and workers compensation. Penalties, allowances, unpaid leave, leave cash-outs and terminations do not incur FTE.

Industrial relations

SMHS is responsible for:

- the application of the WA public sector legislative and regulatory frameworks regulating employment and industrial relations
- management of misconduct matters
- representation and advocacy in industrial tribunals and courts
- engagement with unions and other external stakeholders in industrial matters.

Key activities for 2017–18 included:

- representation on up to 10 occasions on matters before various industrial tribunals and courts
- coordination of submissions informing the System Manager of upcoming enterprise bargaining negotiations affecting SMHS nursing and salaried officer employment groups
- provision of workplace change management advice for the FSFHG Allied Health Review and FH ward reconfiguration projects, the introduction of flexible working hours arrangements (such as 12-hour shifts), and complex employment contract matters
- negotiation with unions and other relevant external stakeholders in response to workplace industrial disputes.

Staff development

Education and development programs are driven by strategic and operational plans, policies and health service requirements. In 2017–18 the SMHS Safety Skills Training Framework was finalised following staff feedback and extensive consultation. This framework outlines the mandatory training requirements for all SMHS staff and reinforces SMHS commitment to providing relevant training that assists in the delivery of safe and quality care.

Each SMHS site delivers extensive induction and orientation programs and specific role-related training and education, available face-to-face or online. In addition, staff have access to external training to meet professional, departmental and organisation requirements.

SMHS also continued to deliver training through the IHI with in excess of a 130 staff completing the IHI Open School Basic Certificate in Quality and Safety and a further 81 certificates issued for other courses (refer to page 36).

Workers' compensation

SMHS is committed to providing staff with a safe and healthy work environment, and recognises this is essential to attracting and retaining the workforce needed to deliver effective and efficient healthcare services.

A total of 174 workers' compensation claims were made in 2017–18 (see table 26).

For further details on the occupational safety, health and injury management processes within SMHS, please refer to the Occupational Safety, Health and Injury section of this report (page 156).

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

- **administration and clerical** – includes administration staff and executives, ward clerks, receptionists and clerical staff
- **medical support** – includes physiotherapists, speech pathologists, medical imaging technologists, pharmacists, occupational therapists, dieticians and social workers
- **hotel services** – includes cleaners, caterers and patient service assistants.

Table 26: Number of workers' compensation claims in 2017–18.

Employee category	Number of claims in 2017–18
Nursing and midwifery services/ Dental Care Assistants	91
Administration and clerical	23
Medical support	12
Hotel services	39
Maintenance	5
Medical (salaried)	4
Total	**174**

Governance disclosures

Pecuniary interests

Senior officers of government are required to declare any interest in or proposed contract that has, or could result in, the member receiving a financial benefit. There were no pecuniary interests declared by SMHS senior officers in 2017–18.

Unauthorised use of credit cards

Relevant SMHS staff are authorised and issued with corporate credit (purchasing) cards if their job function requires usage of this facility. Credit cards are not for personal use by the cardholder. Should a cardholder use a credit card for personal purposes, they must give written notice to SMHS within five working days and refund the total amount of expenditure.

Despite being made aware of obligations pertaining to the use of corporate credit cards, three SMHS cardholders used their card for personal purposes in error. The full amount $321.58 was refunded before the end of the reporting period.

Table 27: Personal use expenditure by SMHS cardholders

Credit card personal use expenditure	July 2017 –June 2018 $
Aggregate amount of personal use expenditure for the reporting period	321.58
Aggregate amount of personal use expenditure settled by the due date (within 5 working days)	321.58
Aggregate amount of personal use expenditure settled after the period (after 5 working days)	Nil
Aggregate amount of personal use expenditure outstanding at the end of the reporting period	Nil

Governance policy

Summary of board and committee remuneration

The total annual remuneration for each board and committee is listed in table 28. For details of individual board or committee members' remuneration refer to Appendix 2 on page 168.

Table 28: Summary of State Government boards and committees within the SMHS

Board/Committee name	Total remuneration $
South Metropolitan Health Service Provider Board	460,576
Community Advisory Council, Rockingham General Hospital	7,230
Rockingham Peel Group Mental Health Service Clinical Governance Committee	240
Peel Mental Health Consumer Advisory Group	3,900
Rockingham Mental Health Consumer Advisory Group	4,320

Government building contracts

SMHS did not award any contracts in 2017–18 that were subject to the Government Building Training Policy.

Substantive equality

In delivering services to the diverse Western Australian public, SMHS is committed to eliminating systemic discrimination. This commitment is evidenced by SMHS embracing the *WA Health Substantive Equality Policy* through projects targeted at vulnerable community groups.

Aboriginal health

The SMHS Aboriginal Health Strategy Unit, now in its second year of operation, continued to focus on workforce, cultural security, and consumer and community engagement. Initiatives and programs developed or implemented in 2017–18 included:

- The **Patient Centred Cultural Care Guidelines** support SMHS health professionals to deliver safe and culturally responsive care to Aboriginal patients by increasing their understanding of Aboriginal culture.
- The **Aboriginal Health Champions Program** equips non-Aboriginal staff to champion better health outcomes for Aboriginal patients within their work area and acknowledges SMHS staff who consistently demonstrate culturally responsive care.
- **Aboriginal consumer and community engagement** continued to expand with the establishment of a database of Aboriginal community and consumer representatives available to participate in SMHS operational and strategic development.
- The **SMHS Aboriginal Health and Wellbeing Implementation Action Plan**, developed in consultation with key stakeholders, aims to create strong foundations for the provision of culturally safe and responsive health care and embeds the principles of the *WA Aboriginal Health and Wellbeing Framework 2017–20* within SMHS.
- **Yarning Circle workshops** is a six-part series covering identification, equity in care, communication, gender, patients' family and community obligations and hospital supports. Workshops commenced at FSH in January 2018. The yarning circle is an important and collaborative communication process within Aboriginal culture to preserve and pass on cultural knowledge.
- A **Section 51 pilot program** continued to evolve with a dedicated Aboriginal workforce group exploring how to engage with schools and universities to reach more Aboriginal applicants.

CELEBRATING NAIDOC WEEK AT FIONA STANLEY HOSPITAL

Mental health

Ensuring better outcomes in the community for those with a mental illness continued as a SMHS priority area during 2017–18. Outcomes achieved through partnering with multiple non-government agencies to improve access to housing for consumers with severe and persistent mental illness included:

- coordinating Individualised Community Living Service (ICLS) packages for people who require accommodation with tailored, wrap-around support services
- working with Foundation Housing, Access Housing and the Department of Children and Families to consolidate and expand longer-term mental health accommodation options.

Economic disadvantage

SMHS continued to provide strategic coordination of the Fremantle Food Relief (FFR) network to deliver practical assistance to people who experience food insecurity and are living in the local government areas of Cockburn, Fremantle and Melville.

During 2017–18, the development and launching of the 'Healthy Food Donation Checklist' resource assisted to increase the nutritional value of foods donated to various registered charities. Additionally, a SMHS-facilitated workshop at the WA Council of Social Security Charitable Food Sector forum resulted in the production of a suite of resources and guidelines for health food options in this sector.

Occupational safety, health and injury management

Commitment to occupational safety, health and injury management

The safety, health and welfare of staff, volunteers, students, contractors and visitors is a priority within the health service. SMHS is committed to creating a safe workplace and promoting staff health and wellbeing by:

- striving towards a zero harm environment for its staff, both physically and psychologically
- not tolerating physical or verbal aggression against staff
- continually engaging with staff to improve workplace safety
- improving reporting systems to ensure SMHS can measure its performance and meet work health and safety (WHS) targets
- refining the WHS Management System to ensure it supports and meets the needs of staff, and complies with relevant legislation and standards.

This commitment is expressed within the WHS Commitment statement and through the SMHS Work Health and Safety Plan, which is aligned to the SMHS strategic priorities. These clearly establish goals, strategies and monitoring systems, and articulate staff responsibilities. This information, along with relevant policies, is available to all SMHS staff through the SMHS work health and safety intranet pages.

WHS performance is monitored and reported through the SMHS WHS Executive Committee and to the SMHS Board.

Compliance with occupational safety, health and injury management

The SMHS WHS Management System complies with the *Workers' Compensation and Injury Management Act 1981*. An injury management system, documented in the SMHS Injury Management Policy and Procedure, is available on the SMHS work health and safety intranet pages.

Injury management consultants are a vital component of the injury management system. The consultants provide valuable support to managers in workers' compensation, injury management and return to work processes, ensuring the rehabilitation goal of injured employees is achieved.

Staff consultation

Consultative mechanisms in SMHS include a hierarchy of health and safety committees from departmental, service and hospital level through to SMHS Executive. These committees are important to the consultation and issue resolution process. SMHS also supports a network of more than 270 elected safety and health representatives each representing their work area at health and safety committees.

Staff rehabilitation

In the event of a work-related injury or illness, SMHS is committed to assisting injured workers to return to work as soon as medically appropriate through a return to work (RTW) program. Dedicated injury management professionals at each hospital provide consultative advice and services to promote early return to work and best practice case management strategies.

RTW programs are developed for all injured staff according to legislative requirements. The development of RTW programs is a multi-disciplinary process that includes the active participation of employees, managers, treating medical practitioners and injury management consultants. This approach ensures the programs are appropriate to the employees' capacity and workplace.

Occupational safety, health assessment and performance indicators

The annual performance reported for SMHS in relation to occupational safety, health and injury for 2017–18 is summarised in Table 29.

Table 29: Occupational safety, health and injury performance 2017–18

Measure	Actual results		Results against target	
	2016–17	2017–18	Target	Comment on result
Number of fatalities	0	0	0	Achieved
Lost time injury and/or disease incident rate	1.87	1.11	0 or 10% reduction	Achieved
Lost time injury and/or disease severity rate	42.97	55.2	0 or 10% reduction	Not achieved
Percentage of injured workers returned to work within 13 weeks	55.24%	44.12%	≥80%	Not achieved
Percentage of injured workers returned to work within 26 weeks	66.67%	56.3%	≥80%	Not achieved
Percentage of managers trained in occupational, health and injury management responsibilities	45%	72%	≥80%	Not achieved

Note: The severity rate is a measure of the actual or estimated workers compensation claims with a lost time period of 60 days or more. The ratio indicates that 55.2 of 100 lost time injury claims were over 60 days in duration and therefore classified as severe.

SMHS recognises OSH performance needs to be an area of focus in 2018–19 . Actions are being taken to address process issues. In addition, the SMHS Board is intending to review its committee governance to ensure greater oversight of OSH going forward.

Other legal requirements

Advertising

SMHS incurred a total advertising expenditure of $326,348 for 2017–18.

Table 30: SMHS advertising by class of expenditure

Expenditure	Supplier	Amount $
Advertising agencies		0
Market research organisations	Press Ganey Associates	324,016
Polling organisations		0
Direct mail organisations		0
Media advertising organisations	Adcorp	2,332
Total advertising expenditure		**326,348**

Disability access and inclusion

During 2017–18, SMHS undertook numerous initiatives to ensure it continued to meet its commitment to providing people with a disability, their families and carers with full access to its services and facilities.

Integral to SMHS commitment was the endorsement of the SMHS Disability Advisory Committee. Members represent different services and departments across the organisation and include two consumer representatives with 'lived experience'. The committee aims to ensure all SMHS facilities, services and programs are accessible and inclusive to all people with disabilities including staff, patients, their families, carers and visitors.

In addition, RkPG established a Disability Access and Inclusion action group and FSFHG amalgamated the Disability Access and Inclusion committees at its two sites into one cohesive joint committee. Both groups implement *SMHS Disability Access and Inclusion Plan (DAIP)* strategies, with the Chairs of these groups providing a vital connection between SMHS and its sites.

Outcome 1: People with disabilities have the same opportunities as other people to access the services of, and events organised by, a public authority.

- FSFHG identified opportunities to enhance the delivery of care for patients with cognitive impairments. After consulting patients with lived experience of cognitive impairment, colour coded signage was installed on ward V5 at FH to better support patients with dementia or cognitive impairment. These modifications were then rolled out more broadly across FSFHG by the cognitive impairment project team.
- To assist people with permanent disability to access the support they need over their lifetime, RkPG developed alternative systems for improving service integration with the National Disability Insurance Scheme (NDIS). FSFHG also communicated with people living in the Fremantle Community Aids and Equipment Program (CAEP) catchment area regarding transition to the NDIS.

Outcome 2: People with disabilities have the same opportunities as other people to access the buildings and other facilities of a public authority.

- Volunteers at all SMHS hospitals continued to assist patients, carers and families, who are often unfamiliar with the hospital sites, to locate the services they require.
- The installation of automatic sliding doors on levels 7 (orthogeriatric and geriatric services) and 8 (general surgery and orthopaedics services) at FH made it easier for patients, consumers and visitors, particularly those with mobility issues, to access services.
- Adding fencing on FH's ward V5 provided cognitively impaired patients with safe and secure access to areas outside their immediate room without the risk of becoming disorientated.
- To ensure access to people with disability, PHC has procedures in place to enable project development and an Operations Manager to review proposals for redevelopment and new work projects.

Outcome 3: People with disabilities receive information from a public authority in a format that will enable them to access the information as readily as other people are able to access it.

- All hospital websites were optimised, becoming mobile-device friendly. The sites were tested by a consumer with a significant visual impairment using assistive technology (screen-reader). The feedback on accessibility was positive.
- Discharge paperwork on FH ward V5 was altered to improve usability for elderly patients. Providing information in a larger format to patients and carers on discharge improved readability for those with visual impairment.

Outcome 4: People with disabilities receive the same level and quality of service from the staff of a public authority as other people receive from the staff of that public authority.

- SMHS signed up to Patient Opinion Australia, an online social media platform through which members of the public can anonymously share their experiences. The website meets accessibility guidelines, can be read in various languages, and allows for pictures to be added to further describe experiences.

Outcome 5: People with disabilities have the same opportunities as other people to make complaints to a public authority.

- SMHS continued to provide multiple methods for patients with disability to make complaints or provide feedback. For example, FSH feedback forms can be completed electronically and the hospital developed specific forms that suit the needs of adolescent and paediatric patients.

Outcome 6: People with disabilities have the same opportunities as other people to participate in any public consultation by a public authority.

- Teams consulting with the public liaise with SMHS Corporate Communications when planning public forums. Events promoted are open to all members of the community (where appropriate) and held in accessible venues. Attendance is encouraged from a diverse range of groups to ensure the broader community is represented.
- All advertising material is compliant with SMHS Publication Policy and State Government guidelines. To support the effective communication of information to the community, material is reviewed by the relevant consumer advisory council, site consumer representatives or relevant external community groups or individuals.

Outcome 7: People with disability have the same opportunities as other people to obtain and maintain employment.

- SMHS was successful in its application to participate in the Public Sector Commission's 'Adult People with Disability Traineeship Program' with 3.5 full-time equivalent positions being approved for commencement in 2018–19.

Compliance with Public Sector Standards

Public Sector Standards

SMHS is committed to ensuring ongoing compliance with the Public Sector Standards in Human Resource Management through:

- informing staff through the SMHS intranets and regular electronic newsletter reminders of the need to comply with the standards and relevant SMHS policies
- providing Human Resource consultants and Industrial Relations consultants to assist managers and staff with matters relating to these standards
- training panel members in the recruitment and selection process, providing refresher courses and advising applicants of the breach process.
- ensuring redeployment of staff is managed in accordance with the Public Sector Commission's Employment and Redeployment Standards, the Public Sector Commissioner's Instructions and the Public Sector Management (Redeployment and Redundancy) Regulations 2014.

During 2017–18:

- five (5) claims were lodged against the Employment Standard with no claims carried over from the previous year.
- three (3) claims were resolved by SMHS and did not result in a breach of standards.
- two (2) claims were sent to the Public Sector Commission for review
  - one (1) no breach of standards
  - one (1) resulted in a new recruitment process being completed.

Code of Conduct

SMHS works within WA Health's Employment Framework and Code of Conduct, which are underpinned by the WA Public Sector Code of Ethics.

SMHS demonstrates its commitment to the codes of conduct in the following ways:

- all SMHS Human Resource consultants having completed a Certificate IV in Government Investigations
- the commencement of training for decision makers appointed as a result of misconduct (discipline) matters
- quarterly reports to the SMHS Board and Executive, which provides analysis in relation to breaches of misconduct (discipline) matters
- revising relevant corporate governance policies and frameworks to reflect current requirements, including:
  - SMHS Safety Skills Training Framework
  - additional Employment, Attendance Records and Public Comment policies
  - SMHS Authorisations and Delegations Schedule
- continual emphasis on staff completing Accountable and Ethical Decision Making training, with 91 per cent of SMHS compliant at 30 June 2018.

Staff compliance with the WA Health Code of Conduct is monitored via reports of Breaches of Discipline. During 2017–18, a total of 118 complaints of suspected breaches of discipline were finalised:

- 62 matters assessed as not meeting the threshold of either minor or serious misconduct and were finalised in line with the WA Health Discipline Policy
- 36 matters assessed as meeting the threshold of minor misconduct and reportable to the Public Sector Commission
- 20 matters assessed as meeting the threshold of serious misconduct and reportable to the Corruption and Crime Commission.

Of these 118 matters:

- 37 were either fully or partially substantiated
- 32 matters resulted in either no suspicion being formed or the allegations were not substantiated
- 2 were not substantiated
- 36 were progressed via a non-disciplinary pathway
- 11 resulted in the allegation being dropped or withdrawn.

Recordkeeping plans

SMHS continues to develop and implement recordkeeping initiatives, and has commenced a review of the SMHS Recordkeeping Plan as required under the *State Records Act 2000*.

Key activities in 2017–18 included:

- agreement to the phased implementation of a single corporate records management system across SMHS and the subsequent development of an implementation plan
- developing a Business Classification Scheme to align with SMHS corporate functions and activities
- creation of a comprehensive record management site on the SMHS intranet as a dedicated resource for best practice recordkeeping guidelines, information sheets and business rules
- commencing a review of the SMHS Record Management Policy in consultation with internal stakeholders.

Undertaking Recordkeeping Awareness Training continues within SMHS with an 85 per cent staff completion rate.

Annual estimates

The SMHS annual operational budget estimates for the following financial year are reported to the Minister for Health under Section 40 of the *Financial Management Act 2006*, and Treasurer's Instruction 953. The annual estimates for 2018–19 as approved by the Minister for Health are as follows.

Table 31: 2017–18 budget estimates for SMHS

Statement of comprehensive income	2019 Estimate $'000s
COST OF SERVICES	
Expenses	
Employee benefits expense	955,398
Fees for visiting medical practitioners	10,348
Contracts for services	141,731
Patient support costs	318,051
Finance costs	7,744
Depreciation and amortisation expense	101,097
Asset revaluation decrement	-
Loss on disposal of non-current assets	-
Repairs, maintenance and consumable equipment	48,573
Other supplies and services	64,617
Other expenses	144,087
Total cost of services	**1,791,646**
INCOME	
Revenue	
Patient charges	100,510
Other fees for services	63,915
Commonwealth grants and contributions	553,097
Other grants and contributions	89,833
Donation revenue	732
Interest revenue	-
Other revenue	9,103
Total revenue	**817,190**
Gains	
Gain on disposal of non-current assets	-
Total gains	**-**
Total income other than income from State Government	**817,190**
NET COST OF SERVICES	**974,456**
INCOME FROM STATE GOVERNMENT	
Service appropriation	897,687
Assets (transferred)/ assumed	-
Services received free of charge	76,498
Total income from State Government	**974,185**
DEFICIT FOR THE PERIOD	**(271)**
OTHER COMPREHENSIVE INCOME	
Items not reclassified subsequently to profit or loss	
Changes in asset revaluation reserve	-
Total other comprehensive income	**-**
TOTAL COMPREHENSIVE LOSS FOR THE PERIOD	**(271)**

Statement of financial position	2019 Estimate $'000s
ASSETS	
Current Assets	
Cash and cash equivalents	33,381
Restricted cash and cash equivalents	9,688
Receivables	45,925
Inventories	5,209
Other current assets	4,948
Total Current Assets	**99,151**
Non-Current Assets	
Restricted cash and cash equivalents	10,848
Amounts receivable for services	824,931
Property, plant and equipment	2,011,759
Intangible assets	23,709
Total Non-Current Assets	**2,871,247**
Total Assets	**2,970,398**
LIABILITIES	
Current Liabilities	
Payables	92,946
Borrowings	40,946
Provisions	186,502
Other current liabilities	433
Total current liabilities	380,827
Non-current liabilities	
Borrowings	77,046
Provisions	48,609
Other non-current liabilities	-
Total Non-Current Liabilities	**125,655**
Total Liabilities	446,482
Net assets	2,523,916
Equity	
Contributed equity	2,426,146
Reserves	90,762
Accumulated surplus	7,008
Total Equity	**2,523,916**

Statement of cash flows	2019 Estimate $'000s
CASH FLOWS FROM STATE GOVERNMENT	
Service appropriation	796,440
Capital appropriations	69,832
Holding account drawdown	-
Royalties for Regions Fund	-
Net cash provided by State Government	**866,272**
CASH FLOWS FROM OPERATING ACTIVITIES	
Payments	
Employee benefits	(945,398)
Supplies and services	(642,909)
Grants and subsidies	-
Finance costs	2,708
Contribution to Capital Works Fund	-
GST payments on purchases	-
Other payments	-
Receipts	
Receipts from customers	100,510
Commonwealth grants and contributions	553,097
Other grants and contributions	89,833
Donations received	732
Interest received	-
GST receipts on sales	-
GST refunds from taxation authorities	-
Other receipts	73,019
Net cash used in operating activities	**(768,408)**
CASH FLOWS FROM INVESTING ACTIVITIES	
Payments	
Payment for purchase of non-current physical assets and intangible assets	(23,386)
Receipts	
Proceeds from the sale of non-current physical assets	-
Net cash used in investing activities	**(23,386)**
CASH FLOWS FROM FINANCING ACTIVITIES	
Payments	
Repayment of borrowings	-
Repayment of finance lease liabilities	(60,450)
Repayment of other liabilities	-
Net cash used in financing activities	**(60,450)**
Net increase/(decrease) in cash and cash equivalents	**14,028**
Cash and cash equivalent at the beginning of the period	36,189
Cash and cash equivalents transferred to other agency	3,700
Cash and cash equivalents at the end of the period	**53,917**

Appendices

Appendix 1: Addresses and contacts

South Metropolitan Health Service

11 Robin Warren Drive,
MURDOCH WA 6150

Postal address: Locked Bag 100,
PALMYRA DC WA 6961

Phone: (08) 6152 2222

Enquiries email:
SMHS.GeneralEnquiries@health.wa.gov.au

www.southmetropolitan.health.wa.gov.au

Fiona Stanley Fremantle Hospitals Group

Fremantle Hospital

South Terrace (near Alma Street),
FREMANTLE WA 6160

Postal address:
PO Box 480, FREMANTLE WA 6959

Phone: (08) 9431 3333
Fax: (08) 9431 2921

Enquiries email:
FH.GeneralEnquiries@health.wa.gov.au

www.fhhs.health.wa.gov.au

Fiona Stanley Hospital

11 Robin Warren Drive,
MURDOCH WA 6150

Postal address:
Locked Bag 100, PALMYRA DC WA 6961

Phone: (08) 6152 2222

Enquiries email:
FSH.GeneralEnquiries@health.wa.gov.au

www.fsh.health.wa.gov.au

Rottnest Island Nursing Post

2 Abbott Street, ROTTNEST WA 6161

Postal address: RINP, c/o Fiona Stanley Hospital, PO Box 100,
PALMYRA DC WA 6961

Phone: (08) 9292 5030
Fax: (08) 9292 5121

Enquiries email:
FSH.GeneralEnquiries@health.wa.gov.au

www.fsh.health.wa.gov.au

Rockingham Peel Group

Rockingham General Hospital

Elanora Drive, COOLOONGUP WA 6168

Postal address:
PO Box 2033, ROCKINGHAM WA 6968

Phone: (08) 9599 4000
Fax: (08) 9599 4619

Enquiries email:
RkPG.GeneralEnquiries@health.wa.gov.au

www.rkpg.health.wa.gov.au

Murray District Hospital

McKay Street, PINJARRA WA 6208

Postal address:
PO Box 243, PINJARRA WA 6208

Phone: (08) 9531 7222
Fax: (08) 9531 7241

Enquiries email:
RkPG.GeneralEnquiries@health.wa.gov.au

www.rkpg.health.wa.gov.au

Peel Mental Health Service (Adult)

110 Lakes Road, MANDURAH WA 6210

Postal address: PO BOX 162, MANDURAH WA 6210

Phone: (08) 9531 8080
Fax: (08) 9531 8070

Enquiries email:
RkPG.GeneralEnquiries@health.wa.gov.au

www.rkpg.health.wa.gov.au

Rockingham Peel Group Mental Health Service (Adult and Older Adult)

Cnr Clifton and Ameer Streets, ROCKINGHAM WA 6168

Postal address:
PO Box 288, ROCKINGHAM 6968

Phone: (08) 9528 0600
Fax: (08) 9529 1266

Enquiries email:
RkPG.GeneralEnquiries@health.wa.gov.au

www.rkpg.health.wa.gov.au

Kwinana Community Health

1 Peel Row, KWINANA WA 6167

Postal address:
PO Box 187, KWINANA WA 6966

Phone: (08) 9419 2266
Fax: (08) 9419 1088

Enquiries email:
RkPG.GeneralEnquiries@health.wa.gov.au

www.rkpg.health.wa.gov.au

Mandurah Community Health Centre

112 Lakes Road, MANDURAH WA 6210

Postal address:
112 Lakes Road, MANDURAH WA 6210

Phone: (08) 9586 4402
Fax: (08) 9586 4499

Enquiries email:
RkPG.GeneralEnquiries@health.wa.gov.au

www.rkpg.health.wa.gov.au

Peel Health Campus (Public)*

110 Lakes Road, MANDURAH WA 6210

Phone: (08) 9531 8000
Fax: (08) 9531 8578

Enquiries email:
Enquiries.PHC@ramsayhealth.com.au

www.peelhealthcampus.com.au

** Public health services provided by Ramsay Health Care Australia Pty Ltd on behalf of the WA State Government.*

Appendix 2: Board and committee remuneration

South Metropolitan Service Provider Board

(Referred to as South Metropolitan Health Service Board)

Position	Name	2017–18 period of membership	Type of remuneration	Gross/actual remuneration $
Chair	Robert McDonald	12 months	Annual	72,355
Deputy Chair	Robyn Collins	12 months	Annual	43,414
Member	Amanda Boudville	12 months	Annual	40,909
Member	Kim Gibson	12 months	Annual	43,414
Member	Julian Henderson	12 months	Annual	43,414
Member	Mark Khangure	12 months	Annual	43,414
Member	Michelle Manook	12 months	Annual	43,414
Member	Yvonne Parnell	12 months	Annual	43,414
Member	David Rowe	12 months	Annual	43,414
Member	Fiona Stanton	12 months	Annual	43,414
Total				**460,576**

Community Advisory Council Rockingham Peel Group

Position	Name	2017–18 period of membership	Type of remuneration	Gross/actual remuneration $
Chair	Debra Letica	12	Per meeting	1,710
Deputy Chair	Elizabeth Philips	12	Per meeting	660
Member	Judith Balfe	9	Per meeting	360
Member	Brian Dry	9	Per meeting	495
Member	Glenice Garvie	12	Per meeting	1,035
Member	Phoenix Huege De Serville	12	Per meeting	1,020
Member	Joy Jeffes	12	Per meeting	750
Member	Sharyn Pickett	12	Per meeting	810
Member	Christina Tuira-Waldon	9	Per meeting	390
Total				**7,230**

Rockingham Peel Group Mental Health Service Clinical Governance Committee

(Previously: PaRK Mental Health Service Clinical Governance Committee)

Position	Name	Type of Remuneration	2017–18 period of membership	Gross/actual remuneration ($)
Chair	Dr Gordon Shymko	Not applicable	12	0
Member	Steve Batson	Not applicable	12	0
Member as consumer representative	Ingrid Bentsen	Per meeting	12	240
Member	Hilary Carse	Not applicable	12	0
Member	Ophelia Cassir	Not applicable	12	0
Member	Eve Coker	Not applicable	12	0
Member	Anthony Collier	Not applicable	12	0
Member	Christine Cullen	Not applicable	12	0
Member	Claire De San Miguel	Not applicable	2	0
Member	Ailsa Mylotte	Not applicable	12	0
Member as carer representative	Sharyn Pickett	Per meeting*	12	0
Member	Vicki Price	Not applicable	12	0
Member	Sue Thistlethwaite	Not applicable	12	0
Member	Dr Biju Thomas	Not applicable	6	0
Member	Dr Matthew Sewell	Not applicable	12	0
Member	Teresa Stevenson	Not applicable	12	0
Member	Adam Stewart	Not applicable	12	0
Member	Dr Huw Williams	Not applicable	6	0
Total				**240**

*Note: renumerated by Carers WA

Peel Mental Health Consumer Advisory Group

Position	Name	Type of remuneration	2017–18 period of membership	Gross/actual remuneration $
Chair	Helen Abbott	Per meeting	12	660
Member	Anniee Ellis	Per meeting	12	120
Member	Raymond Hendra	Per meeting	12	660
Member	Lowanna Hugall	Per meeting	12	600
Member	Sue Jowett	Per meeting	12	600
Member	Saffron Murfitt	Per meeting	12	660
Member	Anni (Edwina) Ross	Per meeting	12	600
Total				**3,900**

Rockingham Mental Health Consumer Advisory Group

Position	Name	Type of remuneration	2017–18 period of membership	Gross/actual remuneration $
Chair	Ingrid Bentsen	Per meeting	12	540
Member	Jim Charters	Per meeting	12	540
Member	Michelle Hughes	Per meeting	12	120
Member	Lesley Jardine	Per meeting	12	600
Member	Lisa Langlands	Per meeting	12	600
Member	Linda Maddocks	Per meeting	12	420
Member	Shane Miller	Per meeting	12	420
Member	Kathryn Porter	Per meeting	12	600
Member	Maureen Sexton	Per meeting	12	120
Member	Pamela Sutton	Per meeting	12	360
Total				**4,320**

Appendix 3: List of acronyms

Acronym	Explanation
AAS	Australian Accounting Standards
ABF	Activity Based Funding
ACHS	Australian Council for Healthcare Standards
AIHW	Australian Institute of Health and Welfare
AMI	Acute myorcardial infarction
Apgar	Appearance, pulse, grimace, activity and respiration
ATO	Australian Taxation Office
BPD	Borderline personality disorder
BUC	Building Utilisation Categories
CAEP	Community Aids and Equipment Program
CHEs	Contracted Health Entities
CoNeCT	Complex Needs Coordination Team
CPS	Community Physiotherapy Service
DAIP	Disability Access and Inclusion Plan
DAMA	Discharge against medical advice

Acronym	Explanation
DER	Department of Environment Regulation
ED	Emergency department
ENT	Ear, nose and throat
ESR	External service recoup
ESWL	Elective Surgery Wait List
ESWLDC	Elective Services Wait List Data Collection
EUPD	Emotionally unstable personality disorders
FBT	Fringe Benefits Tax
FFR	Fremantle Food Relief
FFS	Fee for service
FH	Fremantle Hospital
FMA	Financial Management Act 2006
FNOF	Fractured neck of femur
FSFHG	Fiona Stanley Fremantle Hospitals Group
FSH	Fiona Stanley Hospital
GESB	Government Employees Superannuation Board
GP	General Practitioner
GSS	Gold State Superannuation
GST	Goods and services tax
HAI	Healthcare associated infections
HA-SABSI	Healthcare associated Staphylococcus aureus bloodstream infections
HISWA	Healthcare Infections Surveillance WA
HSAP	Health Service Allocation Price
HSP	Health Service Provider
HSPR	Health Service Performance Reporting
HSS	Health Support Services
ICLS	Individualised Community Living Space
ICU	Intensive Care Unit
IV	Intravenous
KPIs	Key Performance Indicators
LGA	Local Government Authority
MDH	Murray District Hospital
NDIS	National Disability Insurance Scheme
NGR	Nominated Group Representative

Acronym	Explanation
OBM	Outcome Based Management
PHC	Peel Health Campus
RAC	Rapid Assessment Clinic
RGH	Rockingham General Hospital
RHW	Recognised Healthy Workplace
RITH	Rehabilitation-in-the-Home
RkPG	Rockingham Peel Group
RTW	Return to work
SABSI	Staphylococcus aureus bloodstream infections
SAC	Severity assessment code
SHR	Sustainable Health Review
SMHS	South Metropolitan Health Service
SRS	State Rehabilitation Service
TI	Treasurer's Instruction
UTI	Urinary tract infections
WACHS	WA Country Health Service
WALSA	Western Australian Limb Service for Amputees
WEAT	Western Australian emergency access target
WHAMI	Wound, home transport, appointments, medication, important advice
WHS	Work health and safety
WSS	West State Superannuation

"Everyone from the nurses to the doctors to the cleaners and the catering staff were so professional, caring and friendly." **Patient**, cared for at Rockingham General Hospital

"I have been able to take back control of my life. I have learnt new life skills and am now making new experiences and memories." **Patient**, cared for by Rockingham Peel Group Community Mental Health

"I just wanted to say how much I appreciated the kindness and professionalism displayed by every member of the team. I felt safe, valued and respected." **Diane**, cared for at Fremantle Hospital

"In what could have been a stressful time we were kept completely calm and happy. A big congrats to the wonderful staff you have in your ED." **Jana**, cared for at Peel Health Campus

"The care, consideration and professionalism given by all was beyond words." **Rodney**, cared for at Rockingham General Hospital

"I was so impressed by the teamwork and lengths staff would go to make sure patients were well looked after." **Michael**, cared for at Rockingham General Hospital

"I was yet again very impressed with the friendly and professional staff. We are very fortunate to have such an excellent hospital here in Mandurah." **Earl**, cared for at Peel Health Campus

"Doctors have been so lovely, non-judgemental and patient and made me feel very relaxed about the surgery." **Sara**, cared for at Fiona Stanley Hospital.

"Special thanks to you all for the dignity you showed me." **Patricia**, cared for at Peel Health Campus

"The dedication, professionalism and competence of all staff was faultless. Clear communication and the use of humour was very reassuring." **Roy**, cared for at Fiona Stanley Hospital

"Treatment, condition and course of action was so well-explained it eased concerns for me and my family." **Peter**, cared for at Fiona Stanley Hospital

"My son has been unwell for so long and I feel that he is finally getting the right care. He is happy and smiling again." **Jayne**, cared for at Fremantle Hospital

This document can be made available in alternative formats on request.

South Metropolitan Health Service
Fiona Stanley Hospital, Administration Building, Second Floor
14 Barry Marshall Parade, Murdoch WA 6150

Postal address: Locked Bag 100 Palmyra DC WA 6961

southmetropolitan.health.wa.gov.au

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