Peel Health Service

Annual Report 2004-05

Department of Health
Government of Western Australia

Statement of Compliance

To the Hon Jim McGinty MLA
MINISTER FOR HEALTH

In accordance with Section 66 of the *Financial Administration and Audit Act 1985,* I hereby submit for your information and presentation to Parliament, the Report of the Peel Health Services Board for the year ended 30 June 2005.

This report has been prepared in accordance with the provisions of the *Financial Administration and Audit Act 1985.*

Dr Neale Fong
Acting Director General
Accountable Authority

30 August 2005

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Director General's Overview

2004-05 has undoubtedly marked the biggest turning point in the history, and future, of Western Australia's public health system as the process of sweeping reform was begun in earnest following the release of the report *"A Healthy Future for Western Australians"* in March 2004.

For the first time, we have a solid vision for the long-term needs of our health care system through this landmark report, which provides a clear and logical plan for major reform and fundamental reconfiguration of WA public health system services and infrastructure over the next 10 to 15 years.

The reform process was galvanised in August 2004 with the establishment of the Health Reform Implementation Taskforce, led by myself as Executive Chairman. There is no question that the breadth and scope of changes ahead has presented a complex and highly challenging mission for the taskforce, and WA Health in general. I have been impressed with the energy and drive that staff throughout the system have demonstrated to allow progress through a structured project management approach.

With the resignation of former Director General Mike Daube, I was appointed Acting Director General of Health on 24 November 2004. I consider my dual roles in providing leadership, guidance and support in both the reform process and the day-to-day running of our health system a major responsibility and genuine honour. I also firmly believe that while WAs health system is already a very good one in comparison with others around the world, we do have the ability to make it an even greater one.

The State Government has committed $1.7 billion of capital funding to implement reform across the public health system over the next decade. There are more than 120 specific projects on the agenda, with many activated during 2004-05 and are now at various stages of execution.

Having completed my first year at the helm, I feel optimistic about the progress we have made so far and the momentum that has gathered. I have been very encouraged by the willingness of all the metropolitan and regional health services to look forward and embrace change through the reform agenda.

Developing Strategic Directions
Integral to ensuring success for our system has been the need to focus towards the reform's six strategic directions of:

- *Healthy* Workforce;
- *Healthy* Hospitals;
- *Healthy* Partnerships;
- *Healthy* Communities;
- *Healthy* Resources; and
- *Healthy* Leadership.

The formulation of these key priority areas for the WA Health Strategic Directions 2005 began in November 2004, and was subsequently endorsed by the Department of Health's State Health Executive Forum in mid December 2004.

Together with our operational plan, this plan has guided our activity for the remainder of the year and signaled the first critical stage in the entire reform process.

Coordinating activities from the six key areas has provided clearer direction to ensure our health system is more accountable and sustainable. They also provide a way to not only *meet* the health needs of Western Australians today, but also to respond to the State's health needs in the future.

Laying the foundations for major systemic change is nearly always characterised by a degree of resistance and reservation. But it also provides opportunities for uncertainties to be resolved and a clear course to be restored, and that too has been the case in this first year of reform.

Director General's Overview

The WA Health Strategic Intent 2005-2010, which encompasses our workforce, clinical systems and facilities, provides an integrated, cohesive and common direction for the whole of the WA health system and emphasises the role of community partnerships, stronger leadership, a well-supported workforce and infrastructure, and effective stewardship of resources.

Healthy Workforce
The Health workforce is fundamental to the successful delivery of health reform. It is therefore essential that our health system has appropriate workforce planning tools to enable the system to prepare workforce to meet demand.

An extensive strategic workforce plan was developed this year together with the WA Health Strategic Plan 2005-2010 to provide a solid framework for addressing health workforce issues. Its aim is to ensure that workforce shortages are minimised, opportunities are provided for training and professional development, and that a high standard of knowledge and skills is achieved and recognised.

***Healthy* Hospitals**
A significant proportion of health system activity still relates to hospitals and health services with the key task of delivering safe, high quality clinical services to patients. We are totally focused on providing a range of quality health care services and improving efficiency and access to hospital services throughout the community, particularly through the notion of community-based primary care services and ambulatory care services such as Hospital in the Home. This includes a significant hospital building and capital redevelopment program over the next 13 years, resulting in better alignment and integration of clinical services and processes, and increased statewide clinical support networks.

Healthy Partnerships
Creating stronger links and partnerships with other government agencies, non-government organisations, consumers, community groups, private providers, health professionals and the Australian Government has been a major focus for all areas within the public health system this year. A remarkable number of external stakeholders have an interest in the well being of our health system and support the successful implementation of the health reform program. I have personally focused on developing, maintaining and building strong partnerships this year, because I consider them a major factor in the planning and delivery of innovative, cost effective, and high quality health care services.

Healthy Communities
Protecting and improving the health of our community has and is the top priority that drives our health system. Our work in this area has focused very much on what influences the health of individuals and the wider population. The factors we have identified as critical include improving lifestyles, working on the prevention of ill health, and the implementation of a long-term, integrated health promotion program in collaboration with government and non-government agencies, General Practitioners and community groups. Priority has been given to the improvement of community-based chronic disease management and the expansion of equitable and accessible services in the community (such as Hospital in the Home).

Healthy Resources
This year, in line with the health reform agenda, we have focused on sustainable resourcing and effective management of health budgets. Accountability for health system performance and best management of assets is vital if we are to deliver the best health benefits possible, including a continuing focus on safety and quality in our health care services. Major inroads have been made in this area this year through initiatives such as the release of the inaugural Western Australian Audit of Surgical Mortality Annual Report 2004 and a proactive campaign for better clinical governance through the Office of Safety and Quality.

Director General's Overview

Healthy Leadership
I firmly believe that leadership is one of the most fundamental aspects of achieving constructive and long-lasting reform and have personally and actively pursued the development of an organisational culture and environment in our health system that identifies, nurtures and promotes strong leadership at all levels. My vision is to see leadership consistently demonstrated within health care services and the community in their directions, decision-making and delivery of services. I want our focus to recognise, develop and support leaders within the system in order to create a superior health care service and ensure that all strategic directions move forward efficiently and effectively.

Further Information
Details on the Health Reform Implementation Taskforce activities, including program areas, Work Plan and individual reform project, are available at www.health.wa.gov.au/hrit

In summary, 2004-05 has been a tough but necessary year of directional change for WA health. Yet looking back over the past year, I believe I can say our eyes are now well on the ball, and our goal, to deliver a ***Healthy* WA** for all West Australians is well underway.

About Us

Address and Location

Peel Health Service
Corporate Office
Peel & Rockingham Kwinana Health Service
Elanora Drive
COOLOONGUP WA 6168

☎ (08) 9592 0600
🖷 (08) 9592 0619
www.health.wa.gov.au

South Metropolitan Mental Health Service
Postal Address
PO Box 480
FREMANTLE WA 6959
☎ (08) 9431 3333
🖷 (08) 9431 3457

South Metropolitan Population Health
Public Health Unit
Level 2, 7 Pakenham Street
FREMANTLE WA 6160
☎ (08) 9431 0200
🖷 (08) 9431 0222

The Peel Health Service is also made up of the following health care units:

Murray District Hospital
McKay Street
PINJARRA WA 6208
☎ (08) 9531 7222
🖷 (08) 9531 7241

Dwellingup Health Centre
Banksia Road
DWELLINGUP WA 6213
☎ (08) 9538 1052
🖷 (08) 9538 1052

Peel Community Health and Development Centre
Ormsby Terrace
MANDURAH WA 6210
☎ (08) 9535 1644
🖷 (08) 9581 4010

Peel Community Mental Health Service
Peel Health Campus Building
Lakes Road
MANDURAH WA 6210
☎ (08) 9531 8080
🖷 (08) 9531 8070

Peel Aged Care Assessment Team
Peel Health Campus Building
Lakes Road
MANDURAH WA 6210
☎ (08) 9531 8088
🖷 (08) 9531 8099

About Us

Our Purpose

Our purpose is to ensure healthier, longer and better lives for all Western Australians.

Our Vision

Our vision is to improve and protect the health of Western Australians by providing a safe, high quality, accountable and sustainable health care system. We recognise that this care is achieved through an integrated approach to all the components of our health system. These components include **workforce, hospitals** and infrastructure, **partnerships, communities, resources** and **leadership.** We also recognise that WA Health must work with a vast number of groups if it is to achieve the vision of a world-class health system.

Strategic Directions and Intentions

These six strategic directions provide the framework for improving WA Health and the care of Western Australian's over the next five years, and will ensure our success in *delivering a healthier WA*.

Healthy Workforce
Our health system workforce is foundational to the delivery of health care. Our intent is to ensure that WA Health is committed to providing and promoting a healthy working environment, which inspires staff and enables participation in the 'Delivering a *Healthy* WA' agenda.

We need to ensure our workforce continues to be vibrant and engaged and that our workforce planning is responsive to local, national and international workforce pressures. To do this it is essential that WA Health have appropriate workforce planning tools to enable it to prepare and respond to future workforce demands.

The strategic workforce plan will provide a framework for addressing health workforce issues. It aims to ensure that workforce shortages are minimised, opportunities are provided for training and professional development and that a high standard of knowledge and skills is achieved and recognised.

Healthy Hospitals
While a key thrust of the reform agenda is to move the focus of patient care away from hospitals, a significant proportion of health system activity still relates to hospitals. With it comes the key task of delivering safe, comprehensive, high quality clinical services to patients.
Our intent is to commit to improving access and efficiency to hospital and health care services based on population needs now and into the future. This will include a significant hospital building and capital redevelopment program over the next 13 years. The result will be better alignment and integration between our facilities, clinical services and the development of integrated clinical networks.

Healthy Partnerships
The ongoing success of the reform program and the health system as a whole is dependent on strong relations with other health care related bodies. We rely on such partnerships in the planning and delivery of innovative, cost effective, and high quality health care services.

Our intent is to create stronger links and partnerships with other government agencies, non-government organisations, consumers, community groups, private providers, health professionals and the Australian Government, all of who have an interest in the well being of our health system.

About Us

Strategic Directions and Intentions

Healthy Communities
Community health is a critical part of our health system and includes promotion of health, illness prevention, early detection of disease and access to affordable community based health care services for all people.

Our intent is to focus on improving lifestyles, working on the prevention of ill health, and the implementation of a long-term, integrated health promotion program in collaboration with government and non-government agencies, General Practitioners and community groups. Priority will also be given to the improvement of community based chronic and long-term conditions and on expanding equitable and accessible services in the community.

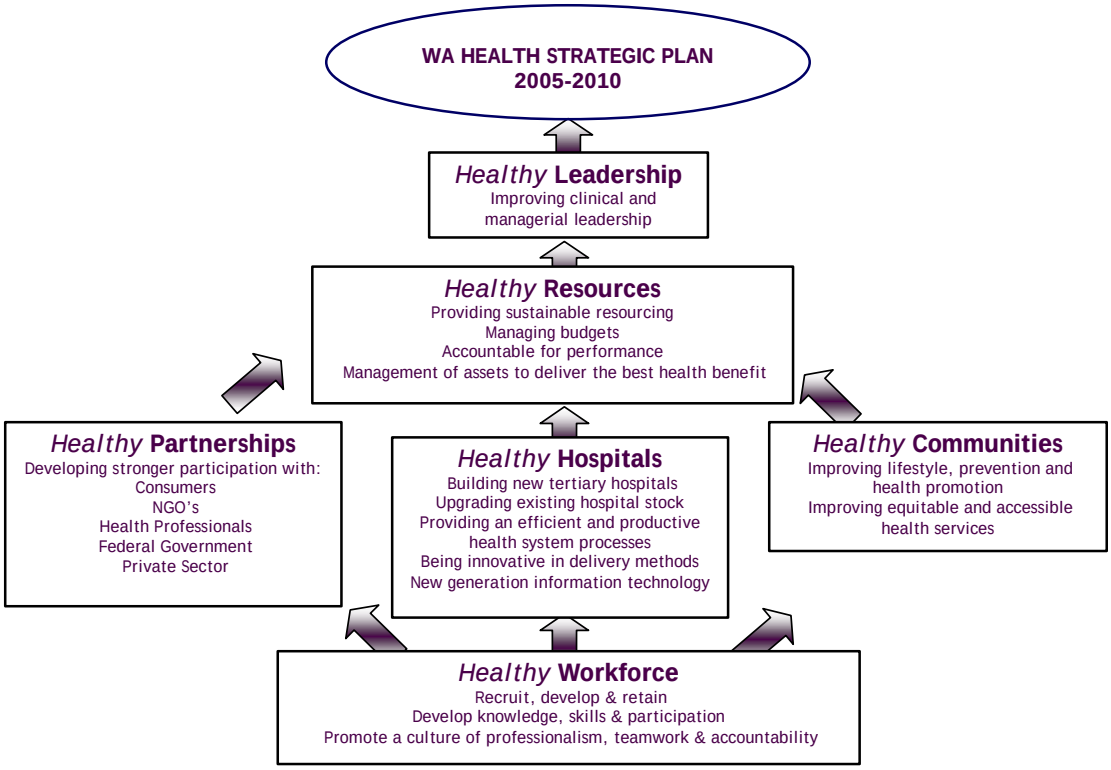
Healthy Resources
A key rationale for reform in the WA Health System is the need to deliver a sustainable, equitable and accountable health care service to the people of Western Australia.

Our intent is on sustainable resourcing and effective management of health budgets and resources. Accountability for health system resourcing and performance reporting will be improved to provide progress reporting to our community.

Healthy Leadership
Healthy Leadership is vital to the effectiveness of the health system into the future. Our intent is to continue to develop the leadership capacity and capability in WA Health by creating an environment that identifies, nurtures and promotes strong leadership at all levels within health care services.

A focus will be on recognising, developing and supporting our leaders in order to deliver continuing superior health care service and to ensure that WA Health has the capacity to identify and respond to the changing community health needs and the delivery of the strategic objectives.

Figure 1: Delivering a Healthy WA



About Us

Services Provided and Core Activities

Peel Health Service is managed as part of the Peel and Rockingham Kwinana (PARK) Health Services. PARK is governed under the South Metropolitan Area Health Service (SMAHS) structure.

Peel Health Service is unique as it services both rural and metropolitan communities and provides health care over boundaries that cover 5,500 square kilometres. The main population town is Mandurah; however, Peel Health Service also provides health care to the communities of Pinjarra, Waroona and Dwellingup.

Corporate services are coordinated through the South Metropolitan Area Health Service and include finance, human resources and support services. Peel Health Service has expanded health services in 2004/05 and maintained safe quality service provision. A favourable end of year budget statement demonstrates effective use of resources under this model.

Direct Patient Services
Acute Medical/General Medicine
Stepdown Surgical
Extended Care Services
Care Awaiting Placement
Palliative Care
Respite Care

Medical Support Services
Medical Imaging
Occupational Therapy
Pathology
Physiotherapy
Pharmacy
Social Work
Speech Pathology

Community Services
Maternal and Child Health
Child development services
School and Youth Health services
Health promotion and community development
Public health services
Adult therapy services
Community Mental Health
Child and Adolescent Mental Health
Aged Care Assessment Program
Community Palliative Care Program

Other Support Services
Hotel Services
Medical Records
Chaplaincy
Meals on Wheels community service

Compliance Reports

Enabling Legislation

The Department of Health is established by the Governor under section 35 of the *Public Sector Management Act 1994.* The Director General of Health is responsible to the Minister for Health for the efficient and effective management of the organisation. The Department of Health supports the Minister in the administration of 45 Acts and 105 sets of subsidiary legislation.

Acts administered
Acts Amendment (Abortion) Act 1998
Alcohol and Drug Authority Act 1974
Anatomy Act 1930
Animal Resources Authority Act 1981
Blood Donation (Limitation of Liability) Act 1985
Cannabis Control Act 2003
Chiropractors Act 1964
Co-opted Medical and Dental Services for the Northern Portion of the State Act 1951
Cremation Act 1929
Dental Act 1939
Dental Prosthetists Act 1985
Fluoridation of Public Water Supplies Act 1966
Health Act 1911
Health Legislation Administration Act 1984
Health Professionals (Special Events Exemption) Act 2000
Health Services (Conciliation and Review) Act 1995
Health Services (Quality Improvement) Act 1994
Hospital Fund Act 1930
Hospitals and Health Services Act 1927
Human Reproductive Technology Act 1991
Human Tissue and Transplant Act 1982
Medical Act 1894
Mental Health Act 1996
Mental Health (Consequential Provisions) Act 1996
Nuclear Waste Storage and Transportation (Prohibition) Act 1999
Nurses Act 1992
Occupational Therapists Registration Act 1980
Optical Dispensers Act 1966
Optometrists Act 1940
Osteopaths Act 1997
Perth Dental Hospital Land Act 1942
Pharmacy Act 1964
Physiotherapists Act 1950
Podiatrists Registration Act 1984
Poisons Act 1964
Psychologists Registration Act 1976
Public Dental Hospital Land Act 1934
Queen Elizabeth II Medical Centre Act 1966
Radiation Safety Act 1975
Tobacco Control Act 1990
University Medical School Act 1955
University Medical School Teaching Hospitals Act 1955
Western Australian Bush Nursing Trust Act 1936
Western Australian Bush Nursing Trust Act Amendment Act 1947
White Phosphorous Matches Prohibition Act 1912

Acts Passed During 2004-05
Health Legislation Amendment Bill 2004
Human Reproductive Technology Amendment Bill 2003
Human Reproductive Technology Amendment Bill (Prohibition of Human Cloning) 2003

Acts in Parliament at 30 June 2005
Chiropractors Bill 2005
Health Amendment Bill 2005
Occupational Therapists Bill 2005
Optical Dispensers Repeal Bill 2005
Osteopaths Bill 2005
Physiotherapists Bill 2005
Podiatrists Bill 2005
Tobacco Products Control Bill 2005

Amalgamation and Establishment of Boards
There were no Boards amalgamated or established during 2004-05.

Ministerial Directives

The Minister for Health did not issue any directives on Department of Health operations during 2004-05.

Compliance Reports

Statement of Compliance with Public Sector Standards

In the administration of the Peel Health Services Board, I have complied with the *Public Sector Standards in Human Resources Management,* the *Western Australian Public Sector Code of Ethics* and our *Code of Conduct.*

I have put in place procedures designed to ensure such compliance and have undertaken appropriate internal processes to satisfy myself the statement made above is correct.

Such processes include:

- The health service continues to review documentation to ensure transparent processes are evident.
- Human Resource Consultants review investigations and when necessary direct appropriate action to avoid future occurrences.
- Statistics are reviewed for trends, which are actioned identified.
- Human Resource Consultants review and authorise recruitment processes and selection reports.
- Detailed advice to panel convenors and a checklist of requirements to ensure compliance with Public Sector Standards in Human Resource Management.
- Provision of the health services Code of Conduct to all new employees as part of mandatory induction.

Summary of extent of compliance with public sector standards
There were no applications made in 2004-05 to report a breach in standards.

The Peel Health Services Board has not been investigated or audited by the Office of Public Sector Standards Commissioner for the period to 30 June 2005.

Dr Neale Fong
Acting Director General
Accountable Authority

30 August 2005

Management Structure

Accountable Authority

The Acting Director General of Health Dr Neale Fong is the Accountable Authority for the Peel Health Service.

Pecuniary Interests

Senior officers of the Peel Health Service have declared the following pecuniary interests:

- Area Chief Executive, Mr Russell McKenney was the Director of Statewest Credit Society Limited, which rents floor space at Fremantle Hospital. Mr McKenney was not involved in negotiations.

Senior Officers

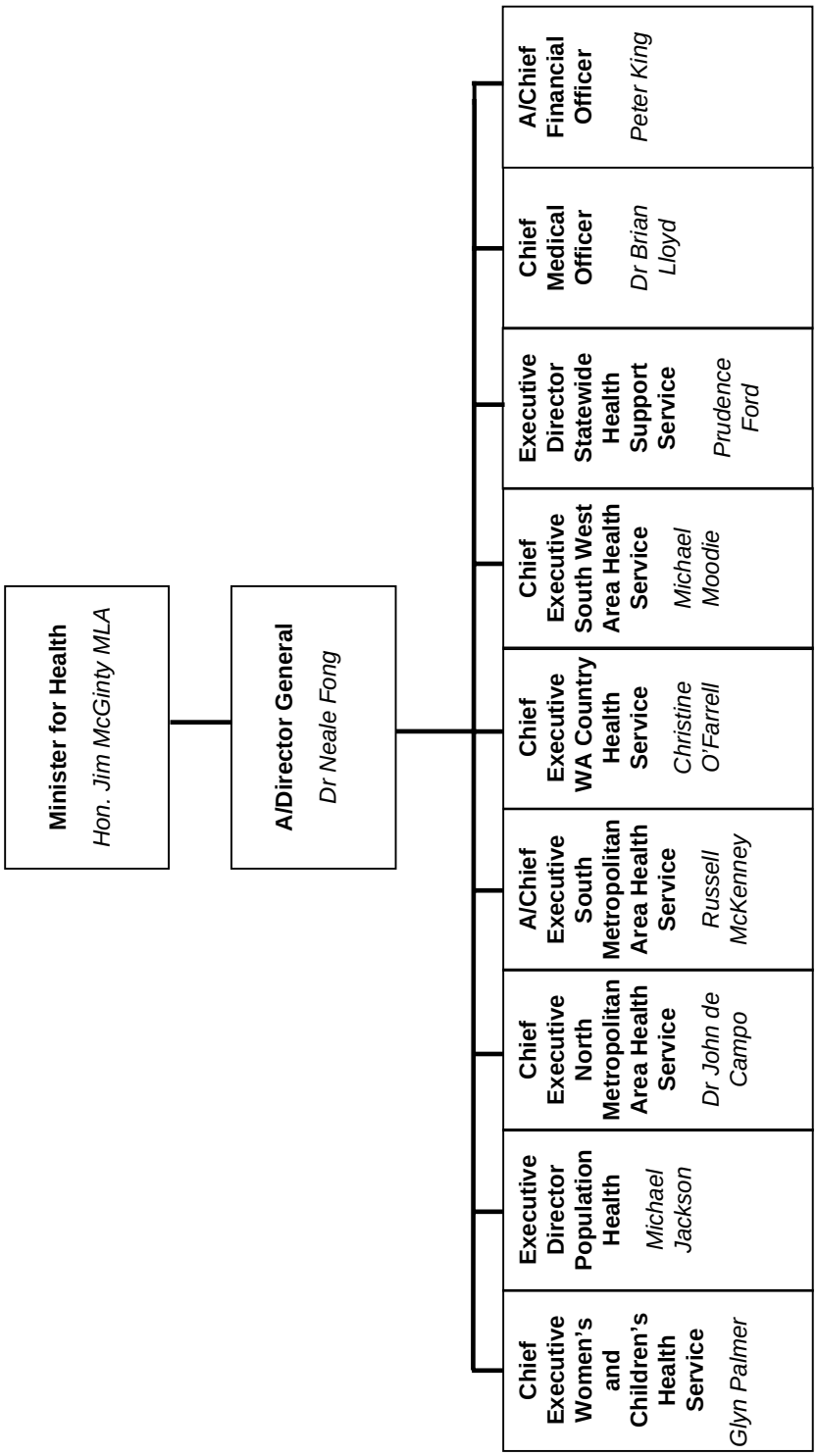
The Peel Health Service reports administratively to the Chief Executive of the South Metropolitan Area Health Service. The senior officers of the Peel Health Service as at 30 June 2005 are listed below:

Table 1: Senior Officers

Area of Responsibility	Title	Names	Basis of Appointment
Corporate Management	Area Chief Executive	Mr Russell McKenney	Acting
Peel & Rockingham Kwinana Health Service (Area Corporate Services-Human Resources)	General Manager	Mr Garry England	Substantive
Nursing Services	Director of Nursing and Acute Services	Mrs Geraldine Carlton	Substantive
Medical Services	Director of Medical Services	Vacant	
Mental Health Services	Area Clinical Director Mental Health	Dr Mark Rooney	Substantive
Population Health	Area Director Population Health	Dr Mandy Seel	Acting

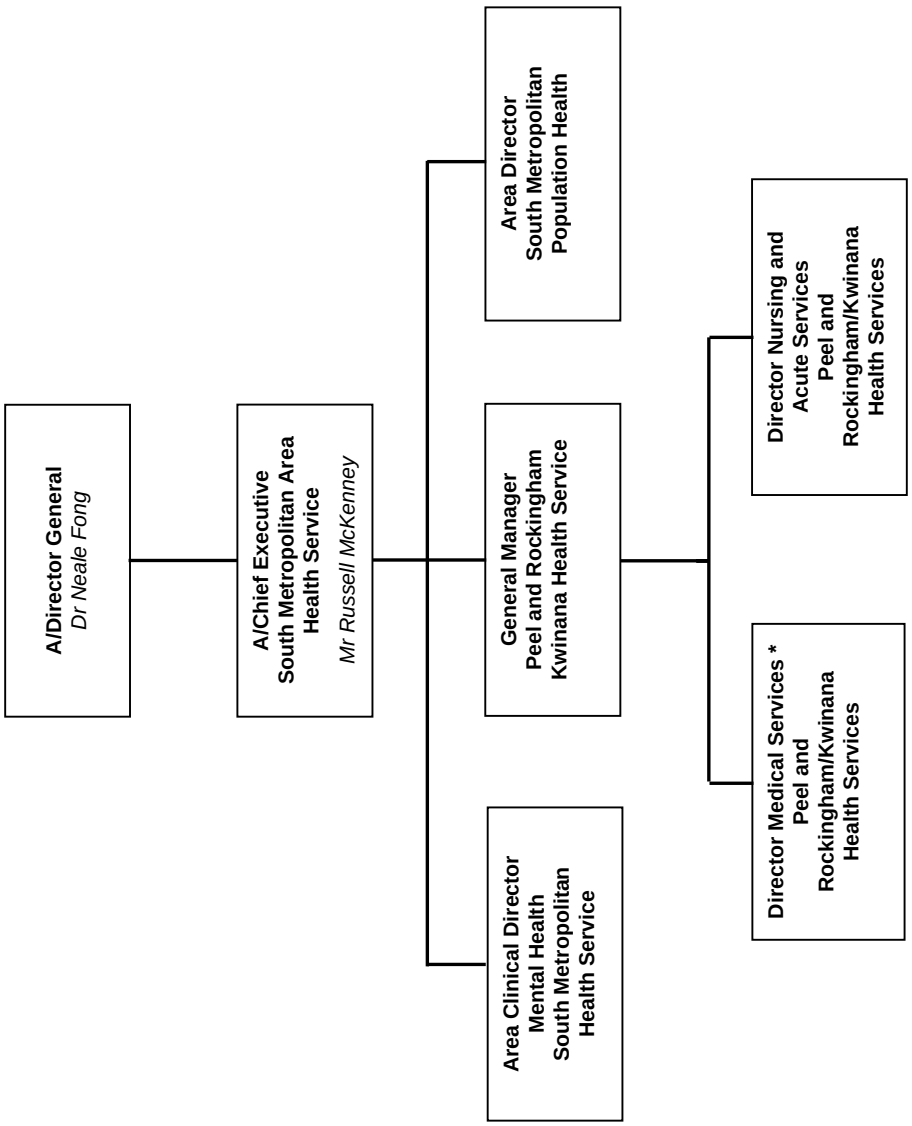
Management Structure

Department of Health State Health Executive Forum (as at 30 June 2005)



Management Structure

Peel Health Service Structure as at 30 June 2005



* Director Medical Services has responsibility for clinical and professional management of medical staff working in the program

Achievements and Highlights

Healthy Hospitals

Peel Health Service delivers health care to one of the most rapidly growing populations in Western Australia.

To assist the challenge in providing effective health care, PARK Health Service in collaboration with the South Metropolitan Public Health Unit and the Peel community conducted a health needs analysis of the population of Peel in 2004. The report "Murray-Waroona Health Needs Analysis" published in January 2005 outlines the outcomes of the analysis. The following recommendations are being progressed:

Primary Health Care
Peel Health Service will continue to focus on the major health issues facing the population such as cardiovascular disease, cancer and mental health, as the main focus of health service resources for the region.

Mental Health
Peel Health Service will increase resources for mental health services in the region.

General Practitioners
Peel Health service will initiate consultation with local GP's, local health authorities and local shires to identify incentives to attract and retain GP's.

Aged Care
Peel Health Service will investigate options to increase the provision of community aged packages for the region.

Alcohol and Drugs
Peel Health Service will consult with Next Step to consider the location of a specific alcohol and drug service in Pinjarra.

Youth Health
Community Health will implement strategies to address Youth Health issues (eg, sexual health, building resilience for primary schools).

Increase Community Awareness of available services and improve access.
Peel Health Service in partnership with the local community will implement strategies to improve community awareness about available services and access to these services.

A working group has been established and has commenced implementation of the above recommendations. Working group members include health care professionals, local shire officers, and community members.

Healthy Workforce

To support the above recommendations, recruitment is current to resource areas of high need. Recruitment in Mental Health and Youth Health is being targeted to provide services to the local communities of Pinjarra, and Waroona, and hence improve access to health care.

Communication is current with the Mental Health Rural Training Program, to establish a position for a full-time psychiatric register in Pinjarra. The health service, community and local GPs are in support of this option to provide essential mental health services.

Achievements and Highlights

Healthy Communities

Health service planning in 2004 has been conducted in close collaboration with key community stakeholders and the local shire officers. This has resulted in improved relationships with the health service and a culture of working in partnership to address the health needs of the community.

Indirect health issues being addressed include transport services, which have been identified as both minimal and patchy to the region. Addressing the transport issues can only assist in improving the health and wellbeing of the local community. Since completing the health needs analysis a trial public bus service has been launched linking Pinjarra and Waroona to Mandurah, the objective being to increase access to health care available in Mandurah.

Healthy Resources

Budget management strategies at Peel Health Service have resulted in a favourable outturn for 2004-05. Commendable strategies have been adopted to ensure maximum staff responsiveness to demands. Key Performance Indicators (KPIs) are effectively monitored to ensure resource is directed efficiently and effectively.

Healthy Leadership

Peel Health Service is led within the Peel and Rockingham Kwinana Health Service, clinical and corporate structure.

Clinical governance will be further supported with the planned appointment of a full-time medical director.

Safety and Quality systems are maturing, with complaints, compliments and incident analysis closely monitored by the management team.

The Australian Council on Healthcare Standards (ACHS) surveyed Peel Health Service in October 2004. This survey resulted in ongoing accreditation with a number of commendations provided to the organisation.

People and Communities

Demography

Age distribution of the Peel area
The population of the Peel Health District increased from 24,704 in 1981 to 71,163 in 2004. This represents an average increase of 2,019 persons per year.

The number of Aboriginal people in 2003 was 1,203, which represents 1.8% of the Peel Health District population.

In 2004, the dependency ratio (ie the ratio of people aged less than 15 and more than 64 years of age to those aged 15 to 64) in the Peel Health District was 0.60 (State: 0.46).

When compared to the State the Peel Health District has a similar proportion of children aged 0-14 years of age, however the greater proportion of people aged 65 years and over substantially increases the dependency ratio.

Population estimates for Statistical Local Areas (SLA)/shires within the Peel Health District
The largest percentage of Peel Health District residents lives in the City of Mandurah SLA (78.0%), a further 16.8% are resident in the Shire of Murray and the remaining 5.1% are resident in the Shire of Waroona.

Map 1: Peel region demography

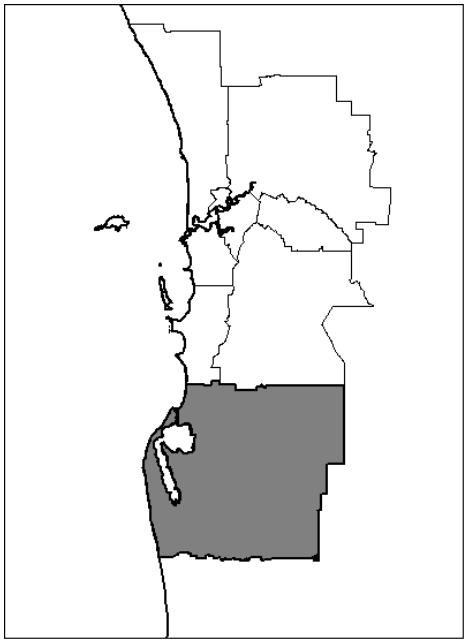


Table 2: Demography - Aboriginal and non-Aboriginal by age

Year	Sex	Ethnicity	0-4	5-14	15-24	25-44	45-64	65+	Total
2004	Male	Aboriginal	51	193	141	127	83	7	602
		non-Aboriginal	1,863	4,952	4,160	8,166	9,218	6,355	34,714
	Female	Aboriginal	78	170	140	162	54	9	613
		non-Aboriginal	1,877	4,788	3,996	8,663	9,411	6,499	35,234
	Total		3,869	10,103	8,437	17,118	18,766	12,870	71,163

People and Communities

Disability Service Plan Outcomes

Our Policy
The Peel Health Service is committed to ensuring all people with disabilities can access the facilities provided by and within the Health Service.

Programs and Initiatives
The Peel Health Service has aimed to improve its disability services plan during 2004-05, according to objectives outlined in the *Disability Services Act 1993*. This goal has been achieved through programs and initiatives run on behalf of the following five key outcome areas:

OUTCOME 1
Existing services are adapted to ensure they meet the needs of people with disabilities.

- At Peel Health Service the Disability Services Policy and Disability Services Plan are current and have been endorsed.
- Disability services issues are always considered when new policies are developed and endorsed.
- All public events are now conducted in accessible venues.
- Appropriate patient transport can be organised for patients with disabilities.

OUTCOME 2
Access to buildings and facilities is provided.

- Appropriate changes to existing facilities are made as funds become available.
- Regular reviews are undertaken to ensure access to all buildings and facilities.
- Toilets and bathrooms have been upgraded to allow wheelchair access.
- Access ramps on entrances comply with the Act.

OUTCOME 3
Information about services is provided in formats, which meet the communication requirement of people with disabilities.

- Publications are designed and produced according to standards for font size to improve legibility for people with vision impairment.
- TTY telephones are available to assist people with a hearing impairment.

OUTCOME 4
Advice and services are delivered by staff who are aware of and understand the needs of people with disabilities.

- New staff are provided with disability awareness training as part of their orientation program within the Peel Health Region.
- Regular training and updates are provided to existing staff.

OUTCOME 5
Opportunities are provided for people with disabilities to participate in public consultations, grievance mechanisms and decision-making processes.

- The Peel Health Service ensures that community consultation programs are undertaken as part of planning processes.
- Complaint procedures have been redesigned to meet the needs of clients who are unable to make written complaints.
- Grievance mechanisms are in place that allows people with disabilities to participate without impediment.

Future Direction
The Peel Health Service will continue to review and amend its policies, practices and procedures to identify possible barriers experienced by people with disabilities. The Disability Services plan is currently being amended to reflect adoption of standard 9 as published by the commission in 2004-05.

People and Communities

Cultural Diversity and Language Services Outcomes

The Western Australian Government seeks to ensure that language is not a barrier to services for people who require assistance in English. The Western Australian Government also recognises cultural diversity of the indigenous communities, the complexity and diversity of indigenous languages, and that for many indigenous people English is a second language.

Programs and Initiatives
The Peel Health Service operates in conjunction with the *Western Australian Government Language Service Policy*, and has the following strategies and plans in place to assist people who experience cultural barriers or communication difficulties while accessing the service's facilities:

- Staff members who interpret are accredited with the National Accreditation Authority for Translators and Interpreters (NAATI) and are available when necessary. Language Service Policy requirements have been budgeted for, and all the important information about this region have been translated into the languages relevant to their client base.
- All staff are aware of the requirements when presented with a Western Australian Interpreter Card.
- Procedures have been put in place to record feedback from clients.
- Staff are trained in working with interpreters.
- Before producing multilingual information for clients, consultation with appropriate groups takes place.
- Peel Health Service has implemented procedures to monitor and evaluate implementation of the Language Services Policy.

Prior existing programs/initiatives continued during 2004-05
Senior clinicians present information on multicultural standards at induction to all new staff. This session is also available to current staff. Evaluations of this education have demonstrated it to be effective and valuable. Information Posters are displayed in all waiting rooms and clinical areas. These outline consumer's rights, interpreter services, and other patient information. This information is published in multiple languages. Complaint and consumer feedback systems are closely monitored to ensure compliance with multicultural standards.

People and Communities

Youth Outcomes

The Peel Health Service acknowledges the rights and special needs of youth and endeavours to provide appropriate services, supportive environments and opportunities for young people. The Service is committed to the objectives outlined in*: A State Government Plan for Young People, 2000–2003*:

1. Promoting a positive image of young people.
2. Promoting the broad social health, safety and wellbeing of young people.
3. Better preparing young people for work and adult life.
4. Encouraging employment opportunities for young people.
5. Promoting the development of personal and leadership skills.
6. Encouraging young people to take on roles and responsibilities, which lead to active adult citizenship

Programs and Initiatives
The Haven
The "Haven" Youth Service opened in 2004. This innovative service provides a "one stop access" to youth health services in Mandurah. Services provided include access to health promotion, sexual health and GP services.

Murray – Waroona Health Needs Analysis.
Interview information obtained from the above analysis is being used to drive improvement in youth health care. Information highlighted pressure on youth and family service in the region. The finding was not unexpected, given the socio-economic status of the area.

Strategies being implemented to address youth issues include increased education in schools to address sexual health and building resilience for primary schools.

A youth health nurse has been appointed to increase provision of youth services within the school setting, as this was reported to be the best location that would enable youth to access services.

Youth On Health Drama Festival- Peel and Rockingham Kwinana
This festival was organised by 40 young people in the Peel region and attracted 85 entries in drama, dance and art. The 'Smarter than Smoking' health message was promoted.

The Economy, The Environment and The Regions

Major Capital Works

Please refer to the Department of Health annual report for this section.

Waste Paper Recycling

Peel Health Service (Murray District Hospital) has progressed its wastepaper recycling during 2004-05. Confidential waste bins were introduced in January 2004. This initiative allows the collection of high-grade paper for shredding and recycling by a specialised security firm.

Community buildings in Peel Health Service are also participating in this program.

Peel Health Service now processes 3.25 tonnes of confidential paper annually. Cardboard and other recyclables are also separated and collected.

Energy Smart Government Policy

Please refer to the Department of Health annual report for this section.

Regional Development Policy

Peel and Rockingham Health Service is part of a network of metropolitan hospitals and health services that together form the SMAHS.

The SMAHS drives clinical and corporate governance through an established area committee structure. All sites including Peel Health Service are represented within the area structure, which reports to the SMAHS Area Executive Group.

Regional Development Policy Implementation

Peel Health Service systems that are being developed into an Area Framework include:

- Credentialling.
- Risk Management.
- Service Planning.
- Financial Accounting.
- Facilities Management.
- Human Resource Management.

Peel Health Service has integrated both its clinical and corporate structures into the area model.

Risk Management
Safety and Quality systems are being matured at an area level, with the establishment of the South Metropolitan Area Risk Management Committee. The objective is to provide a forum to address and action risk management matters both clinical and corporate, to ensure the safety and health of all persons within the SMAHS are protected. Initial work in progress includes the development of an Area Risk Register.

This will provide a standardised system for recording, monitoring and reporting processes across the region, which is linked to an area wide, risk management policy and risk assessment matrix.

Governance – Human Resources

Employee Profile

The table below show the annual average of full-time equivalent staff employed by the Peel Health Service by category and in comparison with 2003-04.

Integration with the SMAHS resulted in the combining of individual mental health and population health services into a single area wide service therefore the FTE for these programs are not shown in this report but are included in the SMAHS figures in the Metropolitan Health Service annual report. The Peel annual report only contains those FTE associated with the acute hospital program.

Table 3: Total FTE by Category

Category	2003-04	2004-05
Nursing Services	28.0	24.31
Administration & Clerical*	11.2	9.55
Medical Support*	3.57	3.10
Hotel Services*	15.72	17.17
Maintenance	3.29	2.78
Medical (Salaried)	0.47	0.46
Total	**62.25**	**57.38**

***Note**
These categories include the following:

- **Administration and Clerical** – health project officers, ward clerks, receptionists and clerical staff.
- **Medical Support** – physiotherapists, speech pathologists, medical imaging technologists, pharmacists, occupational therapists, dieticians and social workers.
- **Hotel Services** – cleaners, caterers and orderly staff. (Expanded services/Meals on Wheels community program)

Recruitment

Education to support compliance with public sector standards was provided by the human resource department in 2004-05. A survey of staffs' awareness of legislation was also undertaken, which demonstrated a healthy awareness of public sector standards.

Recruitment strategies have been successful in the areas of allied health and nursing disciplines. KPIs are effectively monitored to ensure resource is used both effectively and efficiently.

As a result of the Health Needs Analysis undertaken in 2005, recruitment in Mental Health is current. Early evaluation is demonstrating strategies to be successful.

Governance – Human Resources

Staff Development

Peel Health Service staff development is committed to facilitating personal growth, confidence and competence of staff through planned learning experiences in formal and informal settings.

Peel Health Service employees as part of the SMAHS can access Fremantle Hospital's extensive staff development program.

A Staff needs analysis was undertaken in 2004. A number of strategies are being implemented as a result of the analysis. Education is targeted at areas identified as a result of KPI monitoring and staff feedback systems. Programs conducted in 2004-05 include aggression management and staff bullying. Evaluation has demonstrated programs to be effective and well received by staff.

External programs have also been provided to ensure continuing education that reflects the changing needs of the organisation and health care environment.

Worker's Compensation and Rehabilitation

The following table shows the number of workers' compensation claims made through the Peel Health Service.

Table 4: Workers' Compensation and Rehabilitation

Category	2004-05
Nursing Services	0
Administration & Clerical	0
Medical Support	0
Hotel Services	0
Maintenance	1
Medical (Salaried)	0
Other	0
Total	**1**

Occupational Injury Prevention
Staff in the occupational safety and health department continue to provide pro-active education through *Unit Based Occupational Safety and Health Focus Groups.* The objective is to identify and assess hazards and develop management strategies to reduce risk potential. Extensive education on aggression management has been targeted in 2004-05 with the acute program staff, early evaluation has demonstrated the training to be well received by staff.

Employee Rehabilitation
Internal Rehabilitation programs are designed with the guidance of the injured employee, their treating doctor and the employer. Regular meetings are held to discuss return to work programs and to evaluate the effectiveness of the programs.

Industrial Relations

The Health Services policy is consistent with Government policy on Industrial Relations and is based on a consultative approach with staff and unions and an emphasis on prevention of disputes rather than resolution of conflict.

Industrial relations issues arising in 2004-05

- Enterprise Agreements being registered for support workers, health workers, and enrolled nurses.
- Enterprise Agreements negotiated for registered nurses.

Governance - Reports on other Accountable Issues

Evaluations

Peel Health Service underwent review by the Australian Council on Healthcare Standards in October 2004.

This survey resulted in ongoing accreditation status, with a number of commendations provided to the organisation.

Recommendations for system improvement have been well received across the organisation, and are being progressed within the governance structure.

Peel Health Service will be surveyed in 2006, in alignment with Rockingham, Bentley, Armadale and Fremantle as part of the South Metropolitan Area Health Service. This framework of evaluation supports internal benchmarking and assists the maintenance of a continuous improvement culture, within a rapidly changing organisation.

Freedom of Information

Peel Health Service received and managed the following applications under Freedom of Information guidelines during 2004-05.

Table 5: Freedom of Information

Applications	Number
Total Received	9
Carried over from 2003-04	0
Granted – full access	9
Granted – partial or edited access (1)	0
Withdrawn by applicant	0
Refused	0
Other (2)	0

Description

1. Includes the number accessed in accordance with Section S28 of the *Freedom of Information Act*.
2. Includes exemptions, deferments or transfers to other departments/agencies.

Documents held by the agency include patient and client records, pamphlets and other documentation as prepared for health service patient/clients, annual reports and departmental manuals.

Pamphlets providing information on the Act are displayed in public areas at all health service sites. These documents inform the public on the procedure to follow to access information under the Act.

All FOI inquiries and applications are sent to the FOI Officer who is responsible for coordinating the application. Formal policies and procedures are continually reviewed to ensure they comply with the Act.

Inquiries can be made to:
Freedom of Information Coordinator
Phone: (08) 9592 0797
Facsimile: (08) 9592 0619

Applications can be lodged:
Freedom of Information Coordinator
Peel & Rockingham/Kwinana Health Service
PO Box 2033
ROCKINGHAM WA 6967

The coordination of Peel & Rockingham/Kwinana Freedom of Information requests is completed as part of the corporate services provided by the Peel & Rockingham Kwinana Health Services. Freedom of Information statistics are reported as two separate legal entities, **Peel Health Service** and **Rockingham/Kwinana Health Services.**

Governance - Reports on other Accountable Issues

Recordkeeping

The State Records Commission approved the Department of Health's Recordkeeping Plan in December 2004 with a compliance date of 2008. A multi-year program has been developed and implemented to ensure compliance with the Recordkeeping Plan. The plan is available online at: http://intranet.health.wa.gov.au/Records/state_records_act.cfm.

In addition to the Recordkeeping plan, the Department of Health has implemented a functional Thesaurus, which will facilitate structured file titling and the application of approved retention and disposal schedules at the time of the file creation.

In support of the Recordkeeping Plan three additional policies have been promulgated. These are:

- Long-term management of electronic records.
- IT service continuity as related to the management of electronic records.
- Non-patient records management.

Implementation of all aspects of the plan is dependent on the purchase of a whole-of-health records management system. The Department of Health is currently evaluating a document management system, which may have functionality to cover paper and electronic records.

Funding for computer systems and staff positions to comply with the State Records Act is yet to be approved at State Health Executive Forum.

The Department of Health has developed two information brochures on recordkeeping aimed at new and existing employees. These brochures describe each staff member's obligations when creating, storing and deleting or disposing of departmental records.

Advertising and Sponsorship

The following table lists the expenditure on advertising and sponsorship made by the Peel Health Service, by category, published in accordance with Section 175ZE of the *Electoral Act 1907.*

Total expenditure for 2004-05 was $4,375.

Table 6: Advertising and Sponsorship

Expenditure Category	2003-04	2004-05
Advertising Agencies	-	-
Market Research Organisations	-	-
Polling Organisations	-	-
Direct Mail Organisations	-	-
Media Advertising Organisations - Market Force	$6,715	$4,375
Total	**$6,715**	**$4,375**

Governance - Reports on other Accountable Issues

Sustainability

Please refer to the Department of Health annual report for this section.

Equity and Diversity

Our Policy
The Peel Health Service aims to achieve equity and diversity in the workplace by eliminating any discrimination in employment based upon grounds of marital status, pregnancy, family status, race, religious or political conviction, gender history, sexual orientation or age, and by promoting equal opportunity for all people.

Programs and Initiatives
The Peel Health Service as governed by Area Human Resources (SMAHS) aims to promote equal opportunity for all persons, according to the *Equal Opportunity Act 1984*. This goal is achieved through activities and programs run on behalf of the following outcomes:

OUTCOME 1
The organisation values EEO and diversity, and the work environment is free from racial and sexual harassment.
The Peel Health Service have a commitment to EEO and diversity in the workplace. All new employees are informed of current EEO and diversity trends. Introduction to policies and principles are provided at induction. Evaluation of this education has demonstrated favourable satisfaction results.

Policies and procedures are available throughout the Health Service both in hard copy and electronically.

All job description forms and performance agreements have been reviewed and reflect EEO knowledge, principles and practices as essential criteria.

OUTCOME 2
Workplaces are free from employment practices that are biased or discriminate unlawfully against employees or potential employees.
Recruitment and selection policies and procedures and forms are reviewed to ensure they comply with Public Sector Standards and no discriminatory language or practices exist.

Recruitment and selection training encompassing EEO/Diversity principles is provided to staff.

Part time, job share and flexible working arrangement policies and practices are supported and available to all staff.

A network of contact and grievance officers who can be contacted for information and can mediate on EEO/Diversity issues is currently being established.

OUTCOME 3
Employment programs and practices recognise and include strategies for EEO groups to achieve workforce diversity.
The Recruitment and Selection Policy, Guidelines and Processes comply with *Public Sector Standards in Human Resource Management.* Furthermore, they are continuously reviewed and improved to achieve best practice and maintain compliance.

The process guidelines have controls in place to ensure EEO principles are applied when advertising a position and when selecting an interview panel. Furthermore, when the panel is progressing the interview and selection process, it must ensure the job criteria, as set out in the job description form, are the basis for selecting the right candidate.

Governance - Reports on other Accountable Issues

Equity and Diversity (cont)

Table 7: Equity and Diversity – EEO Level of Achievement

Indicators	Level of Achievement
EEO Management Plan	Implemented
Organisational Plans Reflect EEO	Programs in progress
Polices & Procedures Encompass EEO Requirements	Implemented
Establishment of EEO Officers	Program in progress
Training & Staff Awareness	Implemented
Diversity	Programs in progress

Risk Management

Peel Health Service aims to achieve the best possible practice in the management of all risks that threaten to adversely impact upon the overall health service, its patients, clients, consumers, staff and operations.

The risk management process and policy is consistent with directives outlined in Treasurer's Instruction 825 and the recommendations detailed in AS 4360:1999.

Peel Health Service has a comprehensive clinical risk management framework established to deal with clinical risks identified through their adverse incidents monitoring system, complaints and consumer feedback systems, clinical audit and patient safety indicator analysis.

Peel Health Service as part of the SMAHS has recently developed an Area Risk Management Committee and is progressing the development of an Area Risk Register. This supports the strategic direction of the Area Health Service.

Corruption Prevention
Peel Health Service has established clear lines of responsibility and accountability by developing its organisational and committee structure within a clinical and corporate governance framework.

Policies and procedures are developed to support current legislation and operational standards.

Risk Management policy, procedures and reporting tools are compliant with the Australian/New Zealand standard.

Governance - Reports on other Accountable Issues

Public Interest Disclosures

Appointments
Due to the size and complexity of the Department of Health, a number of Public Interest Disclosure (PID) Officers have been appointed to enable appropriate and easy reporting access for all staff.

To date the following PID officers have been registered with the Office of the Commissioner for Public Sector Standards.

Table 8: Public Interest Disclosure officers

Health Service	PID Officer
Department of Health	Mr Les Marrable
North Metropolitan Area Health Service	Mr Jon Frame
South Metropolitan Area Health Service	Ms Tracey Bennett, Ms Diane Barr and Ms Debbie Bridgeford
Women and Children's Health Service	Ms Delys McGuiness
WA Country Health Service	Mr Steve Gregory

To streamline the communication between the Department and the Office of the Commissioner for Public Sector Standards on matters that fall within the jurisdiction of the *Public Interest Disclosure Act 2003*, the Department has appointed Mr Les Marrable, Manager Accountability, Royal Street, East Perth as the Principal PID officer.

Procedures
The Department of Health has advised and will continually update staff on processes and reporting procedures associated with the *Public Interest Disclosure Act 2003* through global e-mails, staff seminars and staff induction presentations.

The Department's internal procedures have been published on the Department's intranet site and can be accessed by all staff.

The Department of Health's procedures are compliant with the *Public Sector Standards Commission* guidelines.

Protection
The Department of Health has ensured all PID officers are fully aware of their obligations of strict confidentiality in all issues related to public interest disclosure matters.

Files and investigation notes are maintained in locked and secure cabinets at all times with strict access to authorised personnel only.

All efforts are made to ensure maximum confidentiality is maintained in all investigations and follow up action.

Any staff member who attempts to take reprisal action or victimise another officer who has made, or intends to make, a disclosure of public information will be subject to legal action under the *Public Interest Disclosure Act 2003*.

Reports
For the year 2004-05 there were no reports made under the PID legislation.

Governance - Reports on other Accountable Issues

Public Relations and Marketing

A comprehensive public relations team in the SMAHS supports Peel Health Service. Articles on health service planning and initiatives have been published in the local community newspapers.

Internally the regular newsletter has been reviewed and updated to reflect the integration with the SMAHS.

This cost neutral publication is available to staff, clients, visitors and community members.

Publications

During 2004-05 the following publications were available to the public:

- "South Metro" Monthly Health Service publication.
- Patients Rights and Responsibilities brochure.
- Patient Information brochure.
- Brochures on specific conditions and treatments.
- Departmental brochures.
- Annual Report.
- Information on complaints and compliment procedures.
- Murray – Waroona Health Needs Analysis.

Research and Development

Peel Health Service are governed by the SMAHS and have access to the extensive research programs facilitated through the Area Health Service. Maturation of the Area health model has seen the development of committees such as the Area Human Research Ethics Committee.

Internal Audit Controls

Internal Audit has the role of accountability adviser and independent appraiser, reporting directly to the Director General of Health. Audits undertaken were generally planned audits, however, on occasion, management initiated audits or special audits were also carried out. The reviews were predominantly compliance based, however, a number of operational (performance-based) and information systems reviews have also been conducted. Under the direction of the Director, Corporate Governance, external consultants have also been responsible for a number of audits. All audits conducted aim to assist senior management in achieving sound managerial control.

The life of an audit has a number of distinct phases, namely, scoping of the audit, planning, conducting the fieldwork, preparing a draft report and production of a final audit report. When undertaking an audit, discussion between the auditor and auditee is an ongoing process, and management responses are sought for inclusion into the final product. Management responses indicate acceptance of the audit recommendations, the risk rating as well as agreed actions to ensure successful implementation of the recommendations. The final audit report is forwarded to the relevant Executive and is also considered by the Department's Audit Committee.

The Audit Committee has ten members (five internal and five external representatives) and is chaired by Christine O'Farrell (Chief Executive Officer, WA Country Health Service). According to its mandate, this advisory Committee must meet at least 6 times during the year and considers all audits/reviews completed by the Internal Audit Branch. It has oversight of the Strategic Audit Plan and other associated governance issues, to ensure appropriate and timely advice is provided to the Director General.

Governance - Reports on other Accountable Issues

Pricing Policy

The majority of the Department of Health's services are provided free of charge. Some classes of patients are charged fees, for example patients who have elected to be treated as private patients and compensable patients (i.e. patients for whom a third party is covering the costs, such as patients covered by workers' compensation or third party motor vehicle insurance). Where fees are charged, the prices are based on legislation, government policy, or a cost-recovery basis.

Health Finance sets a schedule of fees each year to cover patients for whom fees apply.

These fees are incorporated into the Hospital (Service Charges) Regulations 1984 and the Hospital (Service Charges for Compensable Patients) Determination 2002.

Dental Health Services utilises fees based on the Department of Veterans' Affairs Schedule of Fees with patients charged:

- 50% of fee if holder of a Health Care Card or Pensioner Card.
- 25% of fee if holder of one of the above cards and in receipt of a near full pension or benefit from Centrelink.

Performance Indicators Certification Statement

CERTIFICATION OF PERFORMANCE INDICATORS
for the year ended 30 June 2005

I hereby certify that the performance indicators are based on proper records, are relevant and appropriate for assisting users to assess the performance of the Peel Health Services Board and fairly represent the performance of the health service for the financial year 30 June 2005.

Dr Neale Fong
Acting Director General
Accountable Authority

30 August 2005

Performance Indicators Audit Opinion

AUDITOR **GENERAL**

INDEPENDENT AUDIT OPINION

To the Parliament of Western Australia

PEEL HEALTH SERVICE
PERFORMANCE INDICATORS FOR THE YEAR ENDED 30 JUNE 2005

Audit Opinion
In my opinion, the key effectiveness and efficiency performance indicators of the Peel Health Service are relevant and appropriate to help users assess the Health Service's performance and fairly represent the indicated performance for the year ended 30 June 2005.

Scope
The Director General, Department of Health's Role
The Director General, Department of Health is responsible for developing and maintaining proper records and systems for preparing performance indicators.

The performance indicators consist of key indicators of effectiveness and efficiency.

Summary of my Role
As required by the Financial Administration and Audit Act 1985, I have independently audited the performance indicators to express an opinion on them. This was done by looking at a sample of the evidence.

An audit does not guarantee that every amount and disclosure in the performance indicators is error free, nor does it examine all evidence and every transaction. However, my audit procedures should identify errors or omissions significant enough to adversely affect the decisions of users of the performance indicators.

D D R PEARSON
AUDITOR GENERAL
9 November 2005

Performance Indicators

Introduction

Health is a complex area and is influenced by many factors outside of the provision of health services. Numerous environmental and social factors as well as access to, and use of, other government services have positive or negative effects on the health of the population.

The Performance Indicators outlined in the following pages, address the extent to which the strategies and activities of the Health Services contribute to the broadly stated health outcome, which is, through the delivery of its health services, the improvement of the health of the Western Australian community by:

- A reduction in the incidence of preventable disease, injury, disability and premature death and the extent of drug abuse.
- The restoration of the health of people with acute illness.
- An improvement in the quality of life for people with chronic disease and disability.

Different divisions of the Health Services are responsible for specific areas of the three outcomes. The largest proportion of Health Services activity is directed to Outcome 2 (Diagnosis and Treatment). To ascertain the overall performance of the health system all reports must be read. All entities contribute to the whole of health performance.

These reports are:

- **Department of Health**
- **Metropolitan Health Service**
- **South West Area Health Service**
- **Peel Health Service**
- **WA Country Health Service**

The different service activities, which relate to the components of the outcome, are outlined below.

Prevention and promotion

- Community and public health services.
- Mental health services.
- Dental health services.

Diagnosis and treatment

- Hospital services (emergency, outpatient, inpatient, rehabilitation and community-based post discharge care).
- Community health services (Nursing Posts).
- Mental health services.
- Dental health services.
- Obstetric services.

Continuing care

- Services for frail aged and disabled people (eg Aged Care Assessments, outpatient services for chronic pain and disability, Nursing Home Type hospital care).
- Services for those with chronic illness.
- Mental health services.

There are some services, such as Community Health, which address all three of the components.

Results in this section are presented as both Aboriginal and non-Aboriginal population figures where appropriate.

Comparisons across time are provided where possible and appropriate.

Performance Indicators

Consumer Price Index (CPI) Deflator Series

The index figures are derived from the CPI all groups, weighted average of the eight capital cities index numbers. For the financial year series the index is the average of the December and March quarter and is rebased to reflect a mid year point of the five year series that appears in the annual reports. The average of the December and March quarter is used, because the full year index series is not available in time for the annual reporting cycle.

The calendar year series uses a similar methodology but is based on the average of the June and September quarter.

The financial year costs for the annual report can be adjusted by applying the following formula. The result will be that financial data is converted to 2002-03 dollars:

Cost_n x (100/Index_n) where n is the financial year or calendar year where appropriate.

Table 9: Index figures for the financial and calendar years

Calendar year	2000	2001	2002	2003	2004
Index (Base 2002)	93.118	97.006	100.000	102.644	105.107
Financial year	2000-01	2001-02	2002-03	2003-04	2004-05
Index (Base 2002-03)	94.017	96.866	100.000	102.172	104.701

Efficiency Indicator Note
All calculations for efficiency indicators include administrative overheads in accordance with relevant Treasurer's Instructions for annual reporting purposes only. These figures are not to be used for any other comparative purpose.

Performance Indicators

Outcome 1: Reducing the incidence of preventable disease, injury, disability and premature death and the impact of drug abuse

The services, or outputs, of all parts of the Department of Health contribute to the above outcome. Achievement of this component of the health objective includes activities that reduce the likelihood of disease or injury and reduce the risk of long-term disability or premature death. Strategies include prevention, early identification and intervention and the monitoring of the incidence of disease in the population to ensure primary health measures are working. The impact of drug abuse is also monitored.

The outputs of the Metropolitan Health Service as well as the other divisions of the Department of Health are contained on the table below. The greatest proportion of outputs provided by the Metropolitan Health Service in this outcome is directed to children. Other health services and divisions of Department of Health, provide more services directed to prevention and surveillance of disease, including those affecting the adult population.

Table 10: Respective indicators by health sector for Outcome 1

	Metropolitan Health Service	Peel Health Service	South West Area Health Service	WA Country Health Service	DOH
The achievement of this component of the health objective involves activities which:					
Reduce the likelihood of onset of disease or injury by:					
Immunisation programs	101A 101B	101A 101B	101A 101B	101A 101B	
Dental screening	105 106				
Safety program					R101
Reduce the risk of long term disability or premature death from injury or illness through:					
Surveillance					R101
Monitoring the incidence of disease in the population to ensure primary health measures are effective:					
	103 104	103 104	103 104	103 104	
Monitoring and surveillance of suicide rates and drug and alcohol use:					
					R101

Performance Indicators

101A: Percentage of fully immunised children 0-6 years

This indicator reports the percentage of fully immunised children 0-6 years who reside in the Peel Health Service catchment area.

Rationale

The community sets a very high priority on ensuring that the health and well being of children are safeguarded. It is important not only to restore them to good health when they become ill but also to maintain a state of 'wellness' that allows them to develop to full potential. One of the key components of this is to attempt to ensure that every child experiences the full benefit provided by appropriate and timely immunisation against disease provided by internationally recognised vaccination practices.

Without access to immunisation for children the consequences of any illness or disability are likely to be more disabling and more likely to contribute to a premature death.

The agreed targets in the Public Health Funding Agreement are as follows:

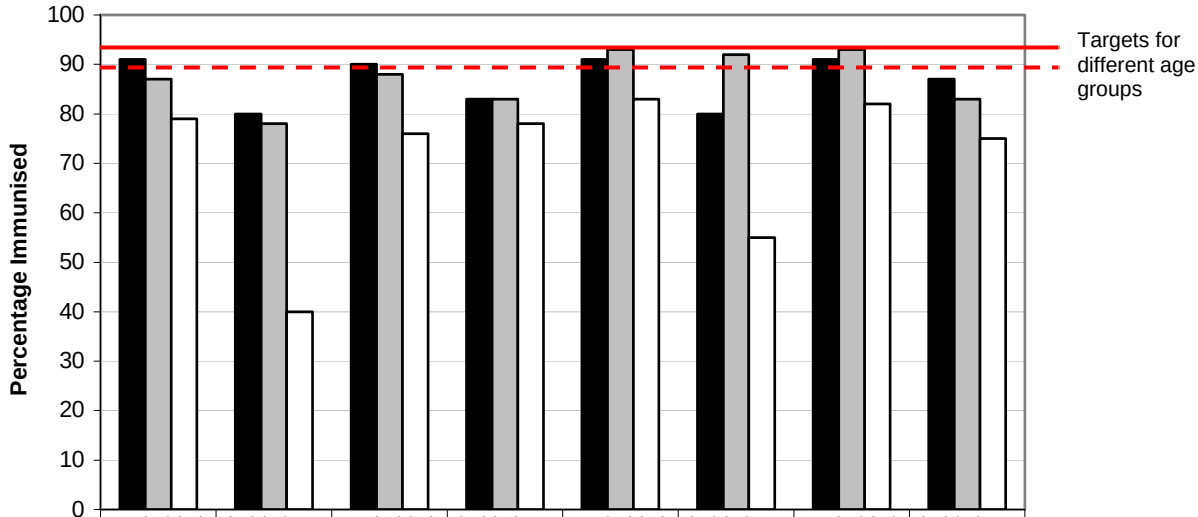
- Proportion of children fully immunised at 12-15 months – progress towards greater than 90% coverage.
- Proportion of children fully immunised at 24-27 months – progress towards greater than 90% coverage.
- Proportion of children fully immunised at 72-75 months (six years) - progress towards greater than 95% coverage.

Results

In 2004 the target was reached in the non-Aboriginal 12-15 months and 24-27 months age group. The percentage of fully immunised Aboriginal children in the 12-15 months bracket increased by 7% and in the 72-75 months age group there was an increase of 20%.

The Public Health Funding Agreement targets have not been reached for the 72-75 month age bracket in the Peel Health Service area.

Figure 2: Percentage of fully immunised children



	non-Aboriginal	Aboriginal	non-Aboriginal	Aboriginal	non-Aboriginal	Aboriginal	non-Aboriginal	Aboriginal
	2002 (Mar Quarter)		2002 (Dec Quarter)		2003 (Dec Quarter)		2004 (Dec Quarter)	
12-15 months	91	80	90	83	91	80	91	87
24-27 months	87	78	88	83	93	92	93	83
72-75 months	79	40	76	78	83	55	82	75

Data Sources

Australian Childhood Immunisation Register (ACIR).
Australian Bureau of Statistics (ABS) population figures.

Performance Indicators

101B: Rate of hospitalisations with an infectious disease for which there is an immunisation program

This indicator reports the rate of hospitalisations with an infectious disease for which there is an immunisation program.

Rationale
There are specific communicable diseases which are preventable by vaccine and thus routine vaccination or immunisation is recommended by the National Health and Medical Research Council (NHMRC).

To provide additional information about the effect of immunisation programs, the rates of hospitalisation for treatment of the infectious diseases of diphtheria, hepatitis B, whooping cough, poliomyelitis, tetanus, measles, mumps, rubella and are reported.

The first five conditions are reported by 0-12 year old age groups while the remainder are reported by 0-17 year old age groups. There should be few or no individuals hospitalised for infectious diseases when an immunisation program is effective.

Results
During 2004 there were two reported hospitalisations for whooping cough and both were non-Aboriginal children.

This provides an indication of the effectiveness of the vaccination and immunisation schedules.

Table 11: Rate of hospitalisations per 1,000 with an infectious disease for which there is an immunisation program – 0-12 years

	2000		2001		2002		2003		2004	
	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal
Diphtheria	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Hepatitis B	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Whooping Cough	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.18	0.00
Poliomyelitis	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Tetanus	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

Table 12: Rate of hospitalisations per 1,000 with an infectious disease for which there is an immunisation program – 0-17 years

	2000		2001		2002		2003		2004	
	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal
Measles	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Mumps	*	*	*	*	*	*	0.00	0.00	0.00	0.00
Rubella	*	*	*	*	*	*	0.00	0.00	0.00	0.00

* Not reported in previous years

Data Sources
Hospital Morbidity Data System (HMDS).
Australian Bureau of Statistics (ABS) population figures.

Performance Indicators

103: Rate of hospitalisation for gastroenteritis in children 0-4 years

This indicator reports the rate of hospitalisation for gastroenteritis in children 0-4 years.

Rationale
Gastroenteritis is a condition for which a high number of patients are treated either in the hospital or in the community. It would be expected that hospital admissions for this condition would decrease as performance and quality of service in many different health areas improves.

The rate of children who are admitted to hospital per 1,000 population for treatment of gastroenteritis may be an indication of improved primary care or community health strategies - for example, health education. Programs are delivered to ensure there is an understanding of hygiene within homes to assist and prevent gastroenteritis.

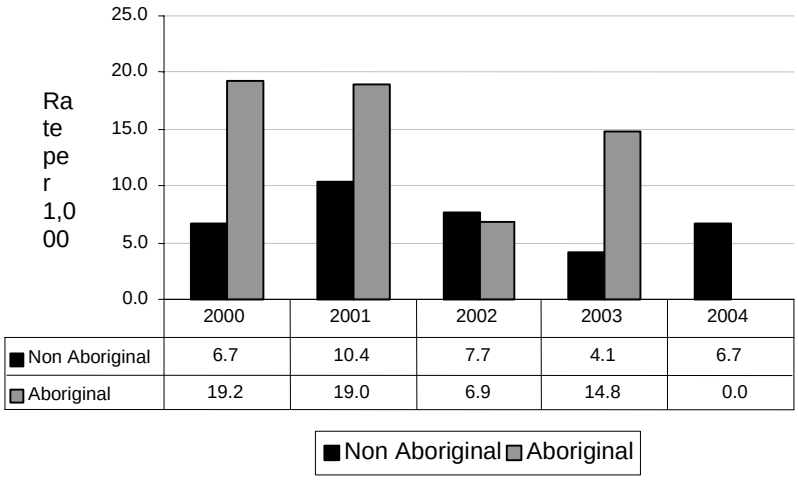
It is important to note, however, that other factors such as environmental issues will also have an impact on the prevalence of transmissible diseases like gastroenteritis.

The Department of Health is also engaged in the surveillance of enteric diseases. Some forms of gastroenteritis for example salmonellosis and shigellosis are notifiable diseases and infection rates are monitored.

Note
This indicator measures hospital separations of children living in a given location who may attend a hospital close to home or in another Health Service area. This indicator is not necessarily a measure of the performance of the Health Service providing the hospitalisation.

Results
During 2004, there were 6.7 per 1,000 hospitalisations for gastroenteritis for non-Aboriginal children. There were no hospitalisations for Aboriginal children.

Figure 3: Rate of hospitalisation for gastroenteritis in 0-4 years



	2000	2001	2002	2003	2004
Non Aboriginal	6.7	10.4	7.7	4.1	6.7
Aboriginal	19.2	19.0	6.9	14.8	0.0

Data Source
Hospital Morbidity Data System (HMDS).
Australian Bureau of Statistics (ABS) population figures.

Performance Indicators

104: Rate of hospitalisation for respiratory conditions

This indicator reports the rate of hospitalisation for respiratory conditions.

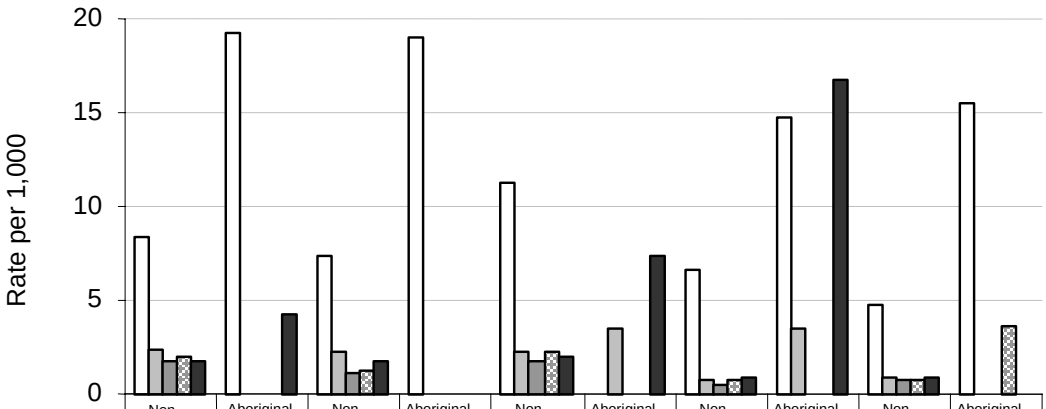
Rationale
The rate of children aged 0-4 years who are admitted to hospital per 1,000 population for treatment of respiratory conditions such as acute bronchitis, bronchiolitis and croup and the rate of all persons admitted for the treatment of acute asthma may be an indication of primary care or community health strategies - for example, health education.

It is important to note however, that other factors may influence the number of people hospitalised with these respiratory conditions. The conditions are ones which have a high number of patients treated either in hospital or in the community. It would be expected that hospital admissions for these conditions would decrease as performance and quality of service increases in primary or community health.

Note
This indicator measures hospital separations of individuals living in a given location who may attend a hospital in their own or another Health Service. The performance of the Health Service providing the hospitalisation is not being measured.

Results of Acute Asthma
In 2004, hospital rates for asthma increased in the Aboriginal population 0-4 age group and 19-34 age group. However, the numbers contributing to this rate are extremely low (two in 0-4 age group and one in the 19-34 age group).

Figure 4: Rate of hospitalisation for acute asthma (all ages)

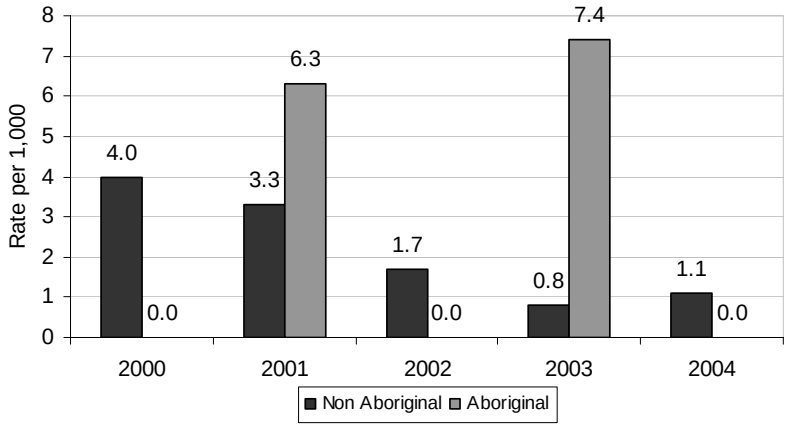


	2000		2001		2002		2003		2004	
	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal
0 to 4	8.4	19.2	7.4	19.0	11.3	0.0	6.6	14.8	4.8	15.5
5 to 12	2.4	0.0	2.2	0.0	2.2	3.5	0.8	3.5	0.9	0.0
13 to 18	1.8	0.0	1.1	0.0	1.8	0.0	0.5	0.0	0.7	0.0
19 to 34	2.0	0.0	1.3	0.0	2.3	0.0	0.8	0.0	0.8	3.6
35+	1.7	4.2	1.7	0.0	2.0	7.4	0.9	16.7	0.9	0.0

Data Sources
Hospital Morbidity Data System.
Australian Bureau of Statistics (ABS) population figures.

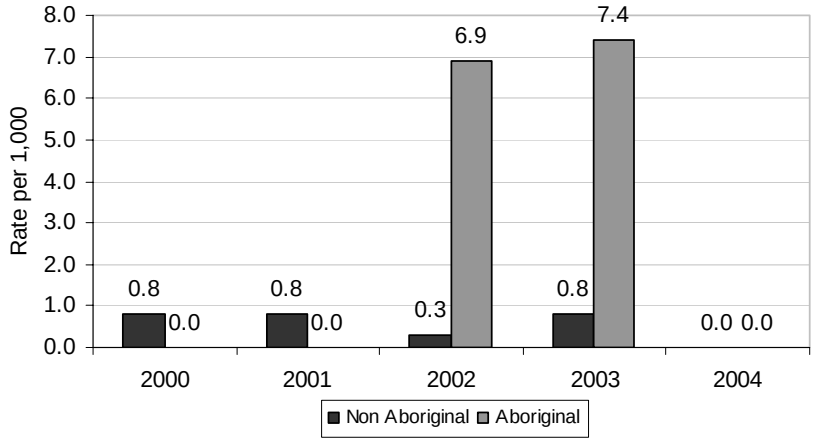
104: Rate of hospitalisation for respiratory conditions (cont)

Figure 5: **Rate of hospitalisation for croup in 0-4 years**



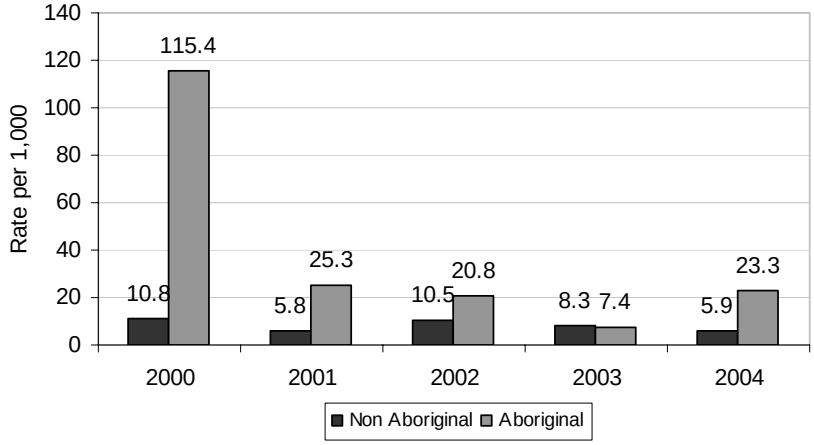
Results
In 2004, the rates of hospitalisation for croup for the non-Aboriginal age group was comparable to last year. There were no hospitalisations for croup in the Aboriginal population for this age group.

Figure 6: Rate of hospitalisation for acute bronchitis in 0-4 years



Results
There were no cases for acute bronchitis in both population groups in 2004.

Figure 7: Rate of hospitalisation for bronchiolitis in 0-4 years



Results
In 2004, the rate of hospitalisation for bronchiolitis in the non-Aboriginal population was lower than the previous year. The rate of hospitalisation for Aboriginal children has increased but the numbers contributing to this rate are extremely low (three).

Data Sources
Hospital Morbidity Data System and Australian Bureau of Statistics (ABS) population figures.

110: Average cost per capita of Population Health Unit

This indicator reports the cost per capita of the Population Health Unit.

Rationale
Population health considers the health of individuals, groups, families and communities by adopting an approach that addresses the determinants of 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. This is based on the growing understanding of the social, cultural and economic factors that contribute to a person's health status.

Population health unit supports individuals, families and communities to increase control over and improve their health. These services and programs include:

- Supporting growth and development, particularly in young children (community health activities).
- Promoting healthy environments.
- Prevention and control of communicable diseases.
- Injury prevention.
- Promotion of healthy lifestyle to prevent illness and disability.
- Support for self-management of chronic disease.
- Prevention and early detection of cancer.

Results
In 2004-05, the per capita cost of Population Health Units for the Peel Health Service was $46.81.

Table 13: Cost per capita of Population Health Unit

	2003-04	2004-05
Actual Cost	$47.39	$46.81
CPI adjusted	$46.38	$44.71

Data Source
Local Health Service Data Systems.

Performance Indicators

Outcome 2: Restoring the health of people with acute illness

The achievement of this component of the health objective involves activities which:

- Ensure that people have appropriate and timely access to acute care services when they are in need of them so that intervention occurs as early as possible. Timely and appropriate access ensures that the acute illness does not progress or the effects of injury do not progress further than is acceptable, increasing the chance of complete recovery from the illness or injury (for example access to elective surgery);
- Provide quality diagnostic and treatment services which ensure the maximum restoration to health after an acute illness or injury;
- Provide appropriate after-care and rehabilitation to ensure that people's physical and social functioning is restored as far as possible; and
- Provide appropriate obstetric care during pregnancy and the birth episode to both mother and child.

Table 14: Respective Indicators by Health Sector for Outcome 2

	Metropolitan Health Service	Peel Health Service	South West Area Health Service	WA Country Health Service	DOH
The achievement of this component of the health objective involves activities which:					
Ensures that people have access to acute care services by:					
Prioritising access to elective surgery.	200		200	200	
Providing timely transport to hospital.					R206
Prioritising access to dental services.	212 213				R207
Provide quality diagnostic services and treatment by:					
Providing appropriate and quality admitted patient services when people are ill or injured.	201 204 205 206 208	204 205	201 204 205 206 208	204 205 206 208	R201 R202 R204 R205
Providing timely and appropriate ambulatory services for people who do not require admitted patient care.			202	202	
Providing appropriate obstetric and neonatal care.	207		207	207	

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

This indicator reports the rate of unplanned hospital readmissions within 28 days to the same hospital for a related condition.

Rationale
Good medical and/or surgical intervention together with good discharge planning will decrease the likelihood of unplanned hospital readmissions. An unplanned readmission is an unplanned return to hospital as an admitted patient for the same or a related condition as the one for which the patient had most recently been discharged. Unplanned readmissions necessitate patients spending additional periods of time in hospital as well as utilising additional hospital resources.

Although there are some conditions that may require numerous admissions to enable the best level of care to be given, in most of these cases readmission to hospital would be planned. A low unplanned readmission rate suggests that good clinical practice is in operation.

Results
The readmission rate has been affected by a patient with motor neuron disease that has had multiple readmission in the period under study. There are also repeat admissions for chronic respiratory conditions.

The low number of separations affects the percentage.

Table 15: Rate of unplanned hospital readmissions within 28 days to the same hospital for a related condition

	2001-02	2002-03	2003-04	2004-05
Unplanned readmission rate	7.5%	11.1%	7.6%	6.2%

Data Source
Hospital Morbidity Data System.

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

This indicator reports the rate of unplanned hospital readmissions within 28 days to the same hospital for a mental health condition.

Rationale
An unplanned readmission for a patient with a mental health condition is an unplanned return to hospital, as an admitted patient, for the same condition as the one for which the patient had most recently been discharged.

While it is inevitable that some patients will need to be readmitted to hospital with 28 days, a high percentage of readmissions may indicate that improvements could be made to discharge planning or to aspects of inpatient therapy protocols. Appropriate therapy, together with good discharge planning will decrease the likelihood of unplanned hospital readmissions. Unplanned readmissions necessitate patients spending additional periods of time in hospital as well as utilising additional hospital resources.

Although there are some mental health conditions that may require numerous admissions to enable the best level of care to be given, in most of these cases, readmission to hospital would be planned. A low unplanned readmission percentage suggests good clinical practice is in operation.

Results
There were no unplanned hospital readmissions with 28 days to the same hospital for a mental health condition for Peel Health Service in 2004.

Table 16: Rate of unplanned hospital readmissions within 28 days to the same hospital for a mental health condition

	2001-02	2002-03	2003-04	2004-05
Unplanned readmissions rate	17.6%	11.0%	10.0%	0.0

Data Source
Hospital Morbidity Data System.

Performance Indicators

225: Average cost per non-admitted hospital based service

This indicator reports the average cost per non-admitted hospital based service.

Rationale
The efficient use of hospital resources can help minimise the overall costs of providing health care, or mean that more patients can be treated for the same amount of resources.

Because of variations in patient characteristics and clinic types between sites and across time, there may be differences in service delivery costs. It is important to monitor the unit cost of this non-admitted component of hospital care in order to ensure their overall quality and cost effectiveness.

Results
A corporate review of Murray District Hospital services was undertaken in 2003. Evaluation in 2003-04 demonstrated a 20% improvement in efficiency with this indicator. Strategies implemented in 03-04 have been maintained in 2004-05.

The increase in costing for this indicator is significantly affected by uncontrollable costs including depreciation and capital user charge, hence efficiency strategies are not reflected. However efficiency has been demonstrated by monitoring FTE and activity indicators.

Table 17: Average cost per non-admitted hospital based service

	2000-01	2001-02	2002-03	2003-04	2004-05
Actual cost	$58.04	$93.90	$84.32	$62.84	$78.28
CPI adjusted	$61.73	$96.94	$84.32	$61.50	$74.76

Data Sources
Local Health Service Data Systems.

227: Average cost per bed-day for admitted patients

This indicator reports the average cost per bed-day for admitted patients.

Rationale
While the use of casemix is a recognised methodology for measuring the cost and complexity of admitted patients in hospitals where there is a wide range of different medical and surgical patients it is not the accepted method of costing patients in small rural hospitals.

Most small hospitals do not have the advantage of economies of scale. Minimum nursing services may have to be rostered for very few patients. Accordingly the hospitals with limited beds which provide acute and Nursing Home Type Patient (NHTP) care report patient costs by bed-days.

Results
Analysis of results demonstrates the significant increase in this indicator is due to the addition of uncontrollable costs in 2004-05, including depreciation and capital user charge.

Efficiency strategies introduced in 2003 have been maintained in 2004-05, this is a demonstrated in FTE and activity indicator monitoring.

Table 18: Average cost per bed-day for admitted patients

	2000-01	2001-02	2002-03	2003-04	2004-05
Actual cost	$543	$682	$870	$693	$892
CPI adjusted	$578	$704	$870	$678	$852

Data Source
Local Health Service Data Systems.

Performance Indicators

228: Average cost of Patient Assisted Travel Scheme (PATS)

This indicator reports the average cost of Patient Assisted Travel Scheme (PATS).

Rationale
The aim of PATS is to allow permanent country residents to access the nearest medical specialist and specialist medical services.

Subsidy is provided towards the cost of travel and accommodation for patients and where necessary an escort for people. Assistance is provided to Peel residents living between 70kms and 100kms from Perth, subject to certain conditions.

Without travel assistance many people would be unable to access the services needed to diagnose or treat some conditions.

Table 19: Average cost of Patient Assisted Travel Scheme (PATS)

	2002-03	2003-04	2004-05
Actual cost	$30.33	$27.10	$25.55
CPI adjusted	$30.33	$26.52	$24.41

Data Source
Local Health Service Data Systems.

Performance Indicators

Outcome 3: Improving the quality of life of people with chronic illness and disability

The achievement of this component of the health objective involves provision of services and programs that improve and maintain an optimal quality of life for people with chronic illness or disability.

If a client suffers from a chronic illness they have access to services and supports through a range of organisations, including non-government organisations, which are managed through the DOH. The effectiveness and efficiency measures for those supports are reported by DOH.

The Health Services in general will only come into contact with those clients when they become acute and require acute care. When this care is completed they are returned to the community where they can again receive ongoing (continuing) care through the other agencies and services provided.

To enable people with chronic illness or disability to maintain as much independence in their every day life as their illness permits, services are provided to enable normal patterns of living. Supports are provided to people in their own homes for as long as possible but when extra care is required long term placement is found in residential facilities. The intent is to support people in their own home for as long as possible. This involves the provision of clinical and other services which:

- Ensure that people experience the minimum of pain and discomfort from their chronic illness or disability.
- Maintain the optimal level of physical and social functioning.
- Prevent or slow down the progression of the illness or disability.
- Make available aids and appliances that maintain, as far as possible, independent living (eg wheelchairs, walking frames).
- Enable people to live as long as possible in the place of their choice supported by, for example, home care services or home delivery of meals.
- Support families and carers in their roles.
- Provide access to recreation, education and employment opportunities.

The significant areas of continuing care provided by the Health Services are in the areas of Mental Health Community Care and Aged Care. The Mental Health Community Care consists of multi-disciplinary teams including mental health nurses providing continued and regular contact with clients to ensure, prevent or delay the onset of acuity and thereby allowing them to continue to maintain as close to normal lifestyles as possible.

An important part of ensuring that services are provided to those frail aged who need them is assessment by Aged Care Assessment Teams (ACAT). Without equal access to ACAT assessments appropriate services/aged care may not be provided.

Where a person has a disability, including a younger person, they will receive support through a number of agencies including Disability Services Commission and the Quadriplegic Centre. The DOH also provides assistance to those with disabilities through the provision of Home and Community Care (HACC) services. The HACC program is administered through the DOH. The effectiveness and efficiency indicators for HACC are reported by DOH. The Health Services will provide acute services to those with disabilities under Outcome 2.

Performance Indicators

Outcome 3: Improving the quality of life of people with chronic illness and disability (cont)

Table 20: Respective Indicators by Health Sector for Outcome 3

	Metropolitan Health Service	Peel Health Service	South West Area Health Service	WA Country Health Service	DOH
The achievement of this component of the health objective involves activities which:					
Supporting people with chronic and terminal illness by:					
Providing palliative care services.					R304
Providing support services to people with chronic illnesses and disabilities.	301	301	301	301	R301
Providing appropriate home care services for the frail aged.	304	304	304	304	R302 R303

Performance Indicators

301: Percent of contacts with community-based public mental health non-admitted services within seven and fourteen days post discharge from public mental health inpatient units

This indicator reports on clients with a principal diagnosis of schizophrenia or bipolar disorder who had contact with community-based public mental health non-admitted services within seven and fourteen days following discharge from public mental health inpatient units.

Rationale
A large proportion of people with a severe and persistent psychiatric illness generally have a chronic or recurrent type illness that results in only partial recovery between acute episodes and a deterioration in functioning that can lead to problems in living an independent life. As a result, hospitalisation may be required on one or more occasions a year with the need for ongoing clinical care from community-based non-admitted services following discharge.

These community services provide ongoing mental health treatment and access to a range of rehabilitation and recovery programs that aim to reduce hospital readmission and maximise an individuals independent functioning and quality of life.

This type of care for persons who have experienced an acute psychiatric episode requiring hospitalisation is essential after discharge to maintain or improve clinical and functional stability and to reduce the likelihood of an unplanned readmission.

A severe and persistent mental illness refers to clients who have psychotic disorders that result in severe and chronic impairment in the conduct of daily life activities. It includes those with a diagnosis of schizophrenia or bipolar disorder.

The time period of seven days has been recommended nationally as an indicative measure of follow up with non-inpatient services for people with a severe and persistent mental illness.
There is currently no agreed target benchmark for the proportion of clients to be seen within a seven-day period. At this stage, there appears to be some consensus among clinicians in Western Australia that a reasonable target is around 70%. The seven-day threshold and 70% target benchmark figure are pending an empirical review on their appropriateness.

Results
In 2004, 68.75% of discharges with a principal diagnosis of schizophrenia or bipolar disorder from public mental health inpatient units resulted in contact with a community-based public mental health non-admitted service within seven days of discharge. Approximately 6% of discharges did not have contact within the year. No contact may indicate that referrals, following discharge, were made to the private sector (eg General Practitioners, Private Psychiatrists, Private Psychologists etc) for which data on contacts is not available.

While the findings indicate that the target benchmark for a seven-day threshold has not as yet been achieved, close to 80% of contacts are taking place within a fortnight.

This KPI was developed for the first time in 2003 and results indicate that the percent of contacts within seven days post discharge for 2004 has marginally increased since 2003.

301: Percent of contacts with community-based public mental health non-admitted services within seven and fourteen days post discharge from public mental health inpatient units (cont)

Table 21: Percent of contacts with community-based public mental health non-admitted services within seven and fourteen days post discharge from public mental health inpatient unit

Days to first contact	2003	2004
0 - 7 days	87.23%	68.75%
8 - 14 days	3.19%	11.25%
15 - 28 days	5.32%	5.00%
29 + days	1.06%	8.75%
No contact	3.19%	6.25%

Data source
Mental Health Information System, Information Collection and Management, Department of Health WA.

Note
As well as community-based clinical services clients have access to non-clinical support services (refer to Department of Health performance indicator R301).

Performance Indicators

304: Completed assessments as a proportion of accepted ACAT referrals

This indicator reports the completed outcomes against the total number of accepted referrals to an ACAT.

Referred ACAT Clients
An ACAT client is usually an older person who is experiencing difficulty managing at home and/or is considering admission to residential care. However on occasion a younger person may seek ACAT assessment due to long term disability where residential care or community support is considered appropriate.

ACATs receive referrals from any source including self-referral. The ACAT intake process determines the appropriateness of the referral as per the program guidelines. An ACAT comprehensive assessment will determine the older person's eligibility for services including Commonwealth subsidised aged care services. An ACAT client is not a person who requires acute medical services, post acute services or rehabilitation.

Rationale
An ACAT assessment will identify those clients who are at risk of experiencing a poorer quality of life because of frailty, chronic illness or disability reducing their capacity to manage their activities of daily living and whose needs fall within the capacity of subsidised aged care services.

The assessment is the first step in ensuring the ACAT clients gain access to the appropriate services and receive care either in the community or in an institutional setting. The range of services are available to people requiring support to improve or maintain their optimal quality of life. There are supports available to people living in their own homes as well as supported accommodation options.

A completed assessment is when a comprehensive assessment has been undertaken (and full information on the client is recorded) and has resulted in recommendations being made. This includes approvals to access Commonwealth funded programs (eg residential care, community aged care packages and some flexible care options).

If during an assessment the older person is found to require acute medical services, post acute services or rehabilitation services the assessment is recorded as incomplete. The record is also incomplete if during the process the person withdraws, moves to another services or dies before a comprehensive assessment has been completed and recommendations have been made.

Note
Commencing in 2003-04 the WA ACAT Program made significant amendments to how ACAT teams collect and report their minimum data set on their activities. As described in the 2003-04 annual report the minimum data set for calculating this performance indicator was revised. As a result of evaluation the operational definition of an accepted ACAT referral has been revised and now includes all referrals.

Previously only those referrals, which resulted in a comprehensive assessment, were included. This change in methodology now aligns WA with national reporting methodologies.

Table 22: Completed assessments as a proportion of accepted ACAT referrals

	2003	2004
Completed assessments as a proportion of accepted ACAT referrals	100%	98.5%

Data Source
Aged Care Assessment Program WA Evaluation Unit Minimum Data Set Reports, July to September 2003 and October to December 2004.

Note
As the data is based on ACAT team coverage rather than statistical local areas, this indicator includes ACAT assessment data from Rockingham and Peel.

303: Average cost per person receiving care from public community-based mental health services

This indicator reports the average cost per person with mental illness under community care.

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

Results
During the last four financial years, the increase in average cost has been statistically significant and may be attributed to an increase in Peel Mental Health FTE. This FTE includes liaison and non-direct clinical care positions that therefore would be costs not directly associated with clinical activity.

Psychiatric Services Online Information System (PSOLIS) implementation has resulted in the introduction of new business rules in defining an assessment, and this may also have had an impact.

However in benchmarking with other sites the average cost per person remains lower or is in keeping with similar services.

Table 23: Average cost per person with a mental illness under community care

	2000-01	2001-02	2002-03	2003-04	2004-05
Actual cost	$1629	$1849	$2504	$3010	$3305
CPI adjusted	$1733	$1909	$2504	$2946	$3157

Data Source
Local Health Service Data Systems.

Performance Indicators

311: Average cost per completed ACAT assessment

This indicator measures the average cost per completed ACAT assessment.

Rationale
People within targeted age groups are at risk of experiencing a poorer quality of life because of frailty, chronic illness or disability reducing their capacity to manage their activities of daily living.

A range of services are available to people requiring support to improve or maintain their optimal quality of life.

The Commonwealth funds the Aged Care Assessment Program based on state health service assessments which determine eligibility for and the level of care required by these aged care services.

Results
2004-05 activity is comparable with that of 2003, there has been a slight increase in FTE to manage increased demands, however not a significant increase to effect this increase in cost per completed assessment. 2004-05 average cost have been significantly affected by the addition of uncontrollable costs added to the Peel report, including depreciation and capital user charge.

Table 24: Average cost per completed ACAT assessment

	2003-04	2004-05
Actual cost	$299	$504
CPI adjusted	$293	$481

Data Sources
Local Health Service Financial System.
Aged Care Assessment Program WA Evaluation Unit Minimum Data Set Reports, July to September 2003 and October to December 2003.

Note
As the data is based on ACAT team coverage rather than statistical local areas, this indicator includes ACAT assessment data from Rockingham and Peel.

Financial Statements Certification

CERTIFICATION OF FINANCIAL STATEMENTS
for the year ended 30 June 2005

The accompanying financial statements of the Peel Health Services Board have been prepared in compliance with the provisions of the *Financial Administration and Audit Act 1985* from proper accounts and records to present fairly the financial transactions for the financial year ending 30 June 2005 and the financial position as at 30 June 2005.

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.

Dr Neale Fong
Acting Director General
Accountable Authority

30 August 2005

John Griffiths
Principal Accounting Officer

30 August 2005

Financial Statements Audit Opinion

AUDITOR **GENERAL**

INDEPENDENT AUDIT OPINION

To the Parliament of Western Australia

PEEL HEALTH SERVICE
FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2005

Audit Opinion
In my opinion,

(i) the controls exercised by the Peel Health Service provide reasonable assurance that the receipt and expenditure of moneys, the acquisition and disposal of property, and the incurring of liabilities have been in accordance with legislative provisions; and

(ii) the financial statements are based on proper accounts and present fairly in accordance with applicable Accounting Standards and other mandatory professional reporting requirements in Australia and the Treasurer's Instructions, the financial position of the Health Service at 30 June 2005 and its financial performance and cash flows for the year ended on that date.

Scope
The Director General, Department of Health's Role
The Director General, Department of Health is responsible for keeping proper accounts and maintaining adequate systems of internal control, preparing the financial statements, and complying with the Financial Administration and Audit Act 1985 (the Act) and other relevant written law.

The financial statements consist of the Statement of Financial Performance, Statement of Financial Position, Statement of Cash Flows and the Notes to the Financial Statements.

Summary of my Role
As required by the Act, I have independently audited the accounts and financial statements to express an opinion on the controls and financial statements. This was done by looking at a sample of the evidence.

An audit does not guarantee that every amount and disclosure in the financial statements is error free. The term "reasonable assurance" recognises that an audit does not examine all evidence and every transaction. However, my audit procedures should identify errors or omissions significant enough to adversely affect the decisions of users of the financial statements.

D D R PEARSON
AUDITOR GENERAL
9 November 2005

PEEL HEALTH SERVICE

Statement of Financial Performance

For the year ended 30th June 2005

	Note	2005 $000	2004 $000
COST OF SERVICES			
Expenses from Ordinary Activities			
Employee expenses	3	8,173	7,856
Fees for visiting medical practitioners		140	165
Patient support costs	4	910	888
Depreciation expense	5	216	197
Asset revaluation decrement	25	533	0
Capital user charge	7	337	413
Carrying amount of non-current assets disposed of		1	1
Other expenses from ordinary activities	8	926	936
Total cost of services		11,236	10,456
Revenues from Ordinary Activities			
Revenue from operating activities			
Patient charges	9	32	67
Grants and subsidies	10	207	199
Other revenues from operating activities	12(a)	160	572
Revenue from non-operating activities			
Donations revenue	11	56	54
Interest revenue		24	26
Other revenues from non-operating activities	12(b)	270	166
Total revenues from ordinary activities		749	1,084
NET COST OF SERVICES		**10,486**	**9,372**
Revenues from State Government			
Service appropriation	13	9,787	9,662
Liabilities assumed by the Treasurer	14	14	12
Total revenues from State Government		9,801	9,674
CHANGE IN NET ASSETS		**(686)**	**302**
Net increase / (decrease) in asset revaluation reserve	25	(61)	0
Total revenues, expenses and valuation adjustments recognised directly in equity		(61)	0
Total changes in equity other than those resulting from transactions with WA State Government as owners		**(748)**	**302**

The Statement of Financial Performance should be read in conjunction with the notes to the financial statements.

PEEL HEALTH SERVICE

Statement of Financial Position

As at 30th June 2005

	Note	2005 $000	2004 $000
CURRENT ASSETS			
Cash assets	15	83	16
Restricted cash assets	16	65	71
Receivables	17	71	77
Other assets	19	0	1
Total current assets		219	165
NON-CURRENT ASSETS			
Amounts receivable for services	18	968	728
Property, plant and equipment	20	5,472	4,273
Total non-current assets		6,440	5,001
Total assets		**6,659**	**5,166**
CURRENT LIABILITIES			
Payables	21	109	87
Provisions	22	1,358	1,242
Other liabilities	23	108	76
Total current liabilities		1,575	1,405
NON-CURRENT LIABILITIES			
Provisions	22	366	292
Total non-current liabilities		366	292
Total liabilities		**1,941**	**1,697**
NET ASSETS		**4,718**	**3,469**
EQUITY			
Contributed equity	24	561	(1,435)
Reserves	25	13	74
Accumulated surplus / (deficiency)	26	4,144	4,830
TOTAL EQUITY		**4,718**	**3,469**

The Statement of Financial Position should be read in conjunction with the notes to the financial statements.

PEEL HEALTH SERVICE

Statement of Cash Flows

For the year ended 30th June 2005

	Note	2005 $000 Inflows (Outflows)	2004 $000 Inflows (Outflows)
CASH FLOWS FROM STATE GOVERNMENT			
Service appropriation	27(c)	9,200	9,054
Capital contributions	27(c)	1,900	0
Net cash provided by State Government		11,100	9,054
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Supplies and services		(1,942)	(2,082)
Employee costs		(7,961)	(7,873)
Receipts			
Receipts from customers		52	22
Grants and subsidies		207	199
Interest received		24	26
GST receipts on sales		0	0
GST receipts from taxation authority		0	0
Other receipts		487	780
Net cash (used in) / provided by operating activities	27(b)	(9,133)	(8,928)
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments for purchase of non-current assets	20	(1,906)	(8)
Net cash (used in) / provided by investing activities		(1,906)	(8)
Net increase / (decrease) in cash held		61	118
Cash assets at the beginning of the financial year		87	(31)
CASH ASSETS AT THE END OF THE FINANCIAL YEAR	27(a)	148	87

The Statement of Cash Flows should be read in conjunction with the notes to the financial statements.

PEEL HEALTH SERVICE

Notes to the Financial Statements
For the year ended 30th June 2005

Note 1 Significant accounting policies

The following accounting policies have been adopted in the preparation of the financial statements. Unless otherwise stated these policies are consistent with those adopted in the previous year.

(a) General Statement

The financial statements constitute a general purpose financial report which has been prepared in accordance with Accounting Standards, Statements of Accounting Concepts and other authoritative pronouncements of the Australian Accounting Standards Board, and Urgent Issues Group (UIG) Consensus Views as applied by the Treasurer's Instructions. Several of these are modified by the Treasurer's Instructions to vary application, disclosure, format and wording. The Financial Administration and Audit Act and the Treasurer's Instructions are legislative provisions governing the preparation of financial statements and take precedence over Accounting Standards, Statements of Accounting Concepts and other authoritative pronouncements of the Australian Accounting Standards Board, and UIG Consensus Views. The modifications are intended to fulfil the requirements of general application to the public sector, together with the need for greater disclosure and also to satisfy accountability requirements.

If any such modification has a material or significant financial effect upon the reported results, details of that modification and where practicable, the resulting financial effect, are disclosed in individual notes to these financial statements.

(b) Basis of Accounting

The financial statements have been prepared on the accrual basis of accounting using the historical cost convention, except for certain assets and liabilities which, as noted, are measured at fair value.

(c) Service Appropriation

Service Appropriations are recognised as revenues in the period in which the Health Service gains control of the appropriated funds. The Health Service gains control of appropriated funds at the time those funds are deposited into the Health Service's bank account or credited to the holding account held at the Department of Treasury and Finance.

(d) Contributed Equity

Under UIG 38 "Contributions by Owners Made to Wholly-Owned Public Sector Entities", transfers in the nature of equity contributions must be designated by the Government (owners) as contributions by owners (at the time of, or prior to transfer) before such transfers can be recognised as equity contributions in the financial statements. Capital contributions (appropriations) have been designated as contributions by owners and have been credited directly to Contributed Equity in the Statement of Financial Position. Capital appropriations which are repayable to the Treasurer are recognised as liabilities.

(e) Acquisitions of Assets

The cost method of accounting is used for all acquisitions of assets. Cost is measured as the fair value of the assets given up or liabilities undertaken at the date of acquisition plus incidental costs directly attributable to the acquisition.

Assets acquired at no cost or for nominal consideration, are initially recognised at their fair value at the date of acquisition.

Assets costing less than $1,000 are expensed in the year of acquisition (other than where they form part of the group of similar items which are significant in total).

(f) Property, Plant and Equipment

Valuation of Land and Buildings

The Health Service has a policy of valuing land and buildings at fair value. The revaluations of the Health Service's land and buildings undertaken by the Department of Land Information (Valuation Services) are recognised in the financial statements.

i) Land and Non-Clinical Buildings

The revaluations of land and non-clinical buildings have been undertaken on the following bases:

Land (clinical site)	Market value for Current use
Land (non-clinical site)	Market value for Highest and best use
Buildings (non-clinical)	Market value for Highest and best use

Recent valuations on this basis are equivalent to fair value.

ii) Clinical Buildings

The clinical buildings are valued at "Replacement Capital Value", which is defined as the cost to replace buildings constructed at current building costs with current materials on a greenfield site. All building costs are Perth based and include elements of electrical, mechanical and plumbing services. Loose and free standing furniture and equipment together with specialised medical equipment are excluded from this valuation. Buildings are depreciated using a weighted average age to determine the net carrying values. Recent valuations on this basis are equivalent to fair value.

PEEL HEALTH SERVICE

Notes to the Financial Statements
For the year ended 30th June 2005

Note 1 Significant accounting policies (continued)

Depreciation of Non-Current Assets

All property, plant and equipment having a limited useful life are systematically depreciated over their estimated useful lives in a manner which reflects the consumption of their future economic benefits.

Land is not depreciated. Depreciation on buildings are calculated using the reducing balance method. Depreciation on other assets are calculated using the reducing balance with a straight-line switch method under which the cost amounts of the assets are allocated on a reducing balance basis over the first half of their useful lives and on a straight line basis for the second half of the useful lives.

The assets' useful lives are reviewed, and adjusted if appropriate, annually. Expected useful lives for each class of depreciable asset are:

Buildings	50 years
Computer equipment and software	5 to 15 years
Furniture and fittings	5 to 50 years
Motor vehicles	4 to 10 years
Medical Equipment	4 to 25 years
Other plant and equipment	5 to 50 years

(g) Leases

The Health Service has entered into a number of operating lease arrangements for the rent of buildings and equipment where the lessors effectively retain all of the risks and benefits incident to ownership of the items held under the operating leases. Equal instalments of the lease payments are charged to the Statement of Financial Performance over the lease term as this is representative of the pattern of benefits to be derived from the leased items.

(h) Cash

For the purpose of the Statement of Cash Flows, cash includes cash assets and restricted cash assets net of outstanding bank overdrafts. These include short-term deposits that are readily convertible to cash on hand and are subject to insignificant risk of changes in value.

(i) Receivables

Receivables are recognised at the amounts receivable as they are due for settlement no more than 30 days from the date of recognition.

Collectability of receivables is reviewed on an ongoing basis. Debts which are known to be uncollectable are written off. A provision for doubtful debts is raised where some doubts as to collection exists.

(j) Payables

Payables, including accruals not yet billed, are recognised when the Health Service becomes obliged to make future payments as a result of a purchase of assets or services. Payables are generally settled within 30 days.

(k) Accrued Salaries

Accrued salaries (refer note 23) represent the amount due to staff but unpaid at the end of the financial year, as the end of the last pay period for that financial year does not coincide with the end of the financial year. The Health Service considers the carrying amount approximates net fair value.

(l) Employee Benefits

Annual Leave

This benefit is recognised at the reporting date in respect to employees' services up to that date and is measured at the nominal amounts expected to be paid when the liabilities are settled.

Long Service Leave

The liability for long service leave expected to be settled within 12 months of the reporting date is recognised in the provisions for employee benefits, and is measured at the nominal amounts expected to be paid when the liability is settled. The liability for long service leave expected to be settled more than 12 months from the reporting date is recognised in the provisions for employee benefits and is measured at the present value of expected future payments to be made in respect of services provided by employees up to the reporting date. Consideration is given, when assessing expected future payments, to expected future wage and salary levels including relevant on costs, experience of employee departures and periods of service. Expected future payments are discounted using market yields at the reporting date on national government bonds with terms to maturity and currency that match, as closely as possible, the estimated future cash outflows.

This method of measurement of the liability is consistent with the requirements of Accounting Standard AASB 1028 "Employee Benefits".

PEEL HEALTH SERVICE

Notes to the Financial Statements
For the year ended 30th June 2005

Note 1 Significant accounting policies (continued)

Superannuation

Staff may contribute to the Pension Scheme, a defined benefits pension scheme now closed to new members, or to the Gold State Superannuation Scheme, a defined benefit lump sum scheme now also closed to new members. All staff who do not contribute to either of these schemes become non-contributory members of the West State Superannuation Scheme, an accumulation fund. The Health Service contributes to this accumulation fund in compliance with the Commonwealth Government's Superannuation Guarantee (Administration) Act 1992. All of these schemes are administered by the Government Employees Superannuation Board (GESB).

From 30 June 2004, the Treasurer has assumed the liability for pension and pre-transfer benefit superannuation liabilities. The assumption was designated as a contribution by owners under Treasurer's Instruction 955 (3)(iv) on 30 June 2004.

The superannuation expense comprises the following elements:

i) changes in the unfunded employer's liability in respect of current employees who are members of the Pension Scheme and current employees who accrued a benefit on transfer from that Scheme to the Gold State Superannuation Scheme; and

ii) employer contributions paid to the Gold State Superannuation Scheme and the West State Superannuation Scheme.

The superannuation expense does not include payment of pensions to retirees, as this does not constitute part of the cost of services provided by the Health Service in the current year.

A revenue "Liabilities assumed by the Treasurer" equivalent to (i) is recognised under Revenues from State Government in the Statement of Financial Performance as the unfunded liability is assumed by the Treasurer. The GESB makes the benefit payment and is recouped from the Treasurer.

The Health Service is funded for employer contributions in respect of the Gold State Superannuation Scheme and the West State Superannuation Scheme. The liabilities for superannuation charges under these schemes are extinguished by payment of employer contributions to the GESB.

Employee benefit on-costs

Employee benefit on-costs are recognised and included in employee benefit liabilities and costs when the employee benefits to which they relate are recognised as liabilities and expenses. (See notes 3 and 22)

(m) Revenue Recognition

Revenue from the sale of goods, disposal of other assets and the rendering of services, is recognised when the Health Service has passed control of the goods or other assets or has delivered the services to the customer.

(n) Grants and Other Contributions Revenue

Grants, donations, gifts and other non-reciprocal contributions are recognised as revenue when the Health Service obtains control over the assets comprising the contributions. Control is normally obtained upon their receipt.

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

(o) Comparative Figures

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

Note 2 Outputs of the Health Service

Information about the Health Service's outputs and, the expenses and revenues which are reliably attributable to those outputs is set out in Note 38. The three key outputs of the Health Service are:

Prevention and Promotion
Prevention and promotion services aim to improve the health of Western Australians by reducing the incidence of preventable disease, injury, disability and premature death. This output primarily focuses on the health and well being of populations, rather than on individuals. The programs define populations that are at-risk and ensure that appropriate interventions are delivered to a large proportion of these at-risk populations.

Diagnosis and Treatment
The objective for the diagnosis and treatment services is to improve the health of Western Australians by restoring the health of people with acute illness. The services provided to diagnose and treat patients include emergency services; ambulatory care or outpatient services and services for those people who are admitted to hospitals, oral health services and other supporting services such as patient transport and the supply of highly specialised drugs.

Continuing Care
Continuing care services are provided to people and their carers who require support with moderate to severe functional disabilities and/or a terminal illness to assist in the maintenance or improvement of their quality of life.

PEEL HEALTH SERVICE

Notes to the Financial Statements
For the year ended 30th June 2005

Note 3 Employee expenses

	2005 $000	2004 $000
Salaries and wages (i)	6,402	6,429
Superannuation	593	599
Annual leave	713	539
Long service leave	303	230
Other related expenses	162	59
	8,173	7,856

(i) These employee expenses include employment on-costs associated with the recognition of annual and long service leave liability.

The related on-costs liability is included in employee benefit liabilities at Note 22.

Note 4 Patient support costs

Medical supplies and services	258	270
Domestic charges	68	80
Fuel, light and power	147	157
Food supplies	231	161
Patient transport costs	93	96
Purchase of external services	113	124
	910	888

Note 5 Depreciation expense

Buildings	87	108
Computer equipment and software	49	34
Furniture and fittings	24	19
Motor vehicles	1	1
Medical Equpment	20	17
Other plant and equipment	35	18
	216	197

Note 6 Net gain / (loss) on disposal of non-current assets

a) Proceeds from disposal of non-current assets	0	0
b) Gain / (Loss) on disposal of non-current assets:		
Computer equipment and software	(1)	(1)
	(1)	(1)

Note 7 Capital user charge

	337	413

A capital user charge rate of 8% has been set by the Government for 2004/05 and represents the opportunity cost of capital invested in the net assets of the Health Service used in the provision of services. The charge is calculated on the net assets adjusted to take account of exempt assets. Payments are made to the Department of Treasury and Finance on a quarterly basis by the Department of Health on behalf of the Health Service.

PEEL HEALTH SERVICE

Notes to the Financial Statements
For the year ended 30th June 2005

	2005 $000	2004 $000
Note 8 Other expenses from ordinary activities		
Motor vehicle expenses	110	104
Insurance	54	66
Communications	164	138
Printing and stationery	50	62
Rental of property	20	10
Repairs, maintenance and consumable equipment expense	387	390
Administration - general	49	97
Purchase of external services	75	69
Other	17	0
	926	936
Note 9 Patient charges		
Inpatient charges	32	67
	32	67
Note 10 Grants and contributions		
Grant for aids and appliances	0	188
Grant for early intervention for childrens health matters	0	11
Other grants	207	0
	207	199
Note 11 Donations revenue		
General public contributions - Cash	56	42
General public contributions - Assets	0	12
	56	54
Note 12 Other revenues from ordinary activities		
a) Revenue from operating activities		
Recoveries	109	113
Use of hospital facilities	39	38
Other	12	421
	160	572
b) Revenue from non-operating activities		
Boarders' accommodation	243	141
Other	27	25
	270	166
	430	738
Note 13 Service appropriation		
Appropriation revenue received during the year:		
Service appropriation	9,787	9,662

Service appropriations are accrual amounts reflecting the full cost of services delivered. The appropriation revenue comprises a cash component and a receivable (asset). The receivable (holding account) comprises the estimated depreciation expense for the year and any agreed increase in leave liability during the year.

PEEL HEALTH SERVICE

Notes to the Financial Statements
For the year ended 30th June 2005

	2005 $000	2004 $000
Note 14 Liabilities assumed by the Treasurer		
The following liabilities have been assumed by the Treasurer during the financial year:		
- Superannuation	14	12

The assumption of the superannuation liability by the Treasurer is a notional revenue to match the notional superannuation expense reported in respect of current employees who are members of the Pension Scheme and current employees of who have a pre-transfer benefit entitlement under the Gold State Superannuation Scheme.

Note 15 Cash assets

Cash on hand	4	4
Cash at bank	79	12
	83	16

Note 16 Restricted cash assets

Cash assets held for specific purposes		
Cash at bank	65	71
	65	71

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

Note 17 Receivables

Patient fee debtors	7	18
Other receivables	65	60
	72	78
Less: Provision for doubtful debts	(1)	(1)
	71	77

Note 18 Amounts receivable for services

Current	0	0
Non-current	968	728
	968	728
Balance at beginning of year	728	542
Credit to holding account	250	192
Less holding account drawdowns	(10)	(6)
Balance at end of year	968	728

This asset represents the non-cash component of service appropriations which is held in a holding account at the Department of Treasury and Finance. It is restricted in that it can only be used for asset replacement or payment of leave liability.

Note 19 Other assets

Prepayments	0	1
	0	1

PEEL HEALTH SERVICE

Notes to the Financial Statements
For the year ended 30th June 2005

Note 20 Property, plant and equipment	2005 $000	2004 $000
Land		
At cost	0	1,026
At fair value	493	0
	493	1,026
Buildings		
Clinical:		
At cost	0	10,869
Accumulated Depreciation	0	(8,135)
	0	2,734
At fair value	4,563	0
Accumulated Depreciation	(11)	0
	4,552	0
Total of clinical buildings	4,552	2,734
Non-Clinical:		
At cost	0	113
Accumulated depreciation	0	(85)
	0	28
At fair value	64	0
Accumulated depreciation	0	0
	64	0
Total of non clinical buildings	64	28
Total of all land and buildings	5,109	3,788
Computer equipment and software		
At cost	375	383
Accumulated depreciation	(344)	(302)
	31	81
Furniture and fittings		
At cost	301	296
Accumulated depreciation	(146)	(122)
	155	174
Motor vehicles		
At cost	45	45
Accumulated depreciation	(45)	(44)
	0	1
Medical Equipment		
At cost	199	199
Accumulated depreciation	(126)	(106)
	73	93
Other plant and equipment		
At cost	349	344
Accumulated depreciation	(245)	(211)
	104	133
Works in progress	0	3
	0	3
Total of property, plant and equipment	5,472	4,273

The revaluation of land and buildings was performed in June 2005 in accordance with an independent valuation by the Department of Land Information (Valuation Services). Fair value has been determined on the basis of current market buying values for land and non-clinical buildings and replacement capital values for clinical buildings.

PEEL HEALTH SERVICE

Notes to the Financial Statements

For the year ended 30th June 2005

	2005 $000	2004 $000
Payments for non-current assets		
Payments were made for purchases of non-current assets during the reporting period as follows:		
Paid as cash by the Health Service from capital contributions	1,907	8
Gross payments for purchases of non-current assets	1,907	8

Reconciliations

Reconciliations of the carrying amounts of property, plant and equipment at the beginning and end of the current financial year are set out below.

	2005 $000
Land	
Carrying amount at start of year	1,026
Revaluation increments / (decrements)	(533)
Carrying amount at end of year	493
Buildings	
Carrying amount at start of year	2,762
Other additions	1,999
Transfers from work in progress	3
Revaluation increments / (decrements)	(61)
Depreciation	(87)
Carrying amount at end of year	4,616
Computer equipment and software	
Carrying amount at start of year	81
Disposals	(1)
Depreciation	(49)
Carrying amount at end of year	31
Furniture and fittings	
Carrying amount at start of year	174
Additions	5
Depreciation	(24)
Carrying amount at end of year	155
Motor vehicles	
Carrying amount at start of year	1
Depreciation	(1)
Carrying amount at end of year	0
Medical Equipment	
Carrying amount at start of year	93
Depreciation	(20)
Carrying amount at end of year	73
Other plant and equipment	
Carrying amount at start of year	133
Other additions	6
Depreciation	(35)
Carrying amount at end of year	104
Works in progress	
Carrying amount at start of year	3
Transfers to other asset classes	(3)
Carrying amount at end of year	0
Total property, plant and equipment	
Carrying amount at start of year	4,273
Additions	2,010
Disposals	(1)
Revaluation increments / (decrements)	(595)
Depreciation	(216)
Carrying amount at end of year	5,472

PEEL HEALTH SERVICE

Notes to the Financial Statements
For the year ended 30th June 2005

	2005 $000	2004 $000
Note 21 Payables		
Trade creditors	29	34
Other creditors	7	5
Accrued expenses	73	49
	109	87
Note 22 Provisions		
Current liabilities:		
Annual leave	685	572
Time off in lieu leave	126	127
Long service leave	539	537
Superannuation	8	6
	1,358	1,242
Non-current liabilities:		
Long service leave	366	292
	366	292
Total employee benefit liabilities	1,724	1,534

The settlement of annual and long service leave liabilities give rise to the payment of superannuation and other employment on-costs. The liability for such on-costs is included here. The associated expense is included under Employee expenses at Note 3.

The Health Service considers the carrying amount of employee benefits approximates the net fair value.

Note 23 Other liabilities		
Accrued salaries	108	76
Note 24 Contributed equity		
Balance at beginning of the year	(1,435)	370
Capital contributions (i)	1,996	0
Contributions by owners		
Transfer of pension liabilities to the Treasurer	0	611
Distribution to owners	0	(2,416)
Balance at end of the year	561	(1,435)

(i) Capital Contributions have been designated as contributions by owners and are credited directly to equity in the Statement of Financial Position.

Note 25 Reserves		
Asset revaluation reserve (i):		
Balance at beginning of the year	74	74
Net revaluation increments / (decrements) :		
- Buildings	(61)	0
Balance at end of the year	13	74
Asset revaluation decrements recognised as an expense (iii):		
Land	533	0
	533	0

(i) The asset revaluation reserve is used to record increments and decrements on the revaluation of non-current assets. Revaluation increments and decrements are offset against one another within the same class of non-current assets.

(ii) Any net 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.

(iii) Any net decrement is recognised as an expense in the Statement of Financial Performance, except to the extent that any decrement reverses a revaluation increment previously credited to the asset revaluation reserve.

PEEL HEALTH SERVICE

Notes to the Financial Statements
For the year ended 30th June 2005

Note 26 Accumulated surplus / (deficiency)	2005 $000	2004 $000
Balance at beginning of the year	4,830	4,528
Change in net assets	(686)	302
Balance at end of the year	4,144	4,830

Note 27 Notes to the statement of cash flows

a) **Reconciliation of cash**

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

Cash assets (Refer note 15)	83	16
Restricted cash assets (Refer note 16)	65	71
	148	87

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

Net cash used in operating activities (Statement of Cash Flows)	(9,133)	(8,928)
Increase / (decrease) in assets:		
Receivables	(6)	45
Prepayments	(1)	(2)
Other assets	0	(42)
Decrease / (increase) in liabilities:		
Payables	(22)	116
Accrued salaries	(32)	(33)
Provisions	(190)	83
Non-cash items:		
Depreciation expense	(216)	(197)
Net gain / (loss) from disposal of non-current assets	(1)	(1)
Capital user charge paid by Department of Health	(337)	(413)
Donation of non-current assets	0	12
Asset revaluation decrements	(533)	0
Superannuation liabilities assumed by the Treasurer	(14)	(12)
Other	(2)	(0)
Net cost of services (Statement of Financial Performance)	(10,486)	(9,372)

c) **Notional cash flows**

Service appropriations as per Statement of Financial Performance	9,787	9,662
Capital appropriations credited directly to Contributed Equity (Refer Note 24)	1,996	0
Holding account drawdowns credited to Amounts Receivable for Outputs (Refer Note 18)	10	6
	11,793	9,668
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:		
Capital user charge	(337)	(413)
Accrual appropriations	(250)	(192)
Capital works expenditure	(105)	0
Other non cash adjustments to output appropriations	(1)	(9)
	(693)	(614)
Cash Flows from State Government as per Statement of Cash Flows	11,100	9,054

PEEL HEALTH SERVICE

Notes to the Financial Statements
For the year ended 30th June 2005

Note 28 Remuneration of members of the accountable authority and senior officers

Remuneration of members of the accountable authority
The Acting Director General of Health is the Accountable Authority for Peel Health Service and is also the Executive Chairman of the Health Reform Implementation Taskforce. The remuneration of the Acting Director General of Health is paid by the Metropolitan Health Services.

Remuneration of senior officers
The Chief Executive (Peel Health Service) is the senior officer for Peel Health Service. The Chief Executive (Peel Health Service) is paid by the South Metropolitan Health Service.

Note 29 Remuneration of Auditor	**2005 $000**	**2004 $000**
Remuneration to the Auditor General for the financial year is as follows:		
Auditing the accounts, financial statements and performance indicators	18	17

Note 30 Commitments for Expenditure

a) **Capital expenditure commitments**
Capital expenditure commitments, being contracted capital expenditure additional to the amounts reported in the financial statements, are payable as follows:

Within one year	1,000	0
Later than one year, and not later than five years	1,600	0
	2,600	0

b) **Operating lease commitments:**
Commitments in relation to leases contracted for at the reporting date but not recognised as liabilities, are payable as follows:

Within one year	159	144
Later than one year, and not later than five years	93	125
	252	269

Note 31 Contingent liabilities and contingent assets

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

Note 32 Events occurring after reporting date

International Financial Reporting Standards
For reporting periods beginning on or after 1 July 2005, the Health Service must comply with Australian equivalents to International Financial Reporting Standards (AIFRS) as issued by the Australian Accounting Standards Board. The potential impact of adopting AIFRS are detailed in Note 35 to the financial statements.

The Health Service is not aware of any other events occurring after reporting date which have significant financial effects on these financial statements.

Note 33 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. Related bodies are generally government agencies which have no financial administration responsibilities.

The Health Service had no related bodies during the reporting period.

Note 34 Affiliated bodies

An affiliated body is a body which receives more than half its funding and resources from the Health Service and is not subject to operational control by the Health Service. Affiliated bodies are generally non-government agencies, such as charitable, welfare and community interest groups which receive financial support from government.

The Health Service had no affiliated bodies during the reporting period.

PEEL HEALTH SERVICE

Notes to the Financial Statements
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Note 35 Impact of Adopting Australian Equivalents to International Financial Reporting Standards

For reporting periods beginning on or after 1 July 2005, the Health Service must comply with the Australian equivalents to International Financial Reporting Standards (AIFRS) as issued by the Australian Accounting Standard Board.

This financial report has been prepared in accordance with Australian accounting standards and other financial reporting requirements (Australian GAAP) applicable for the reporting periods ended 30 June 2005.

The impact of transition to AIFRS, including the transitional adjustments disclosed in the reconciliations from current Australian GAAP and AIFRS, are based on AIFRS standards that the Health Service expects to be in place, when preparing the first complete AIFRS financial report (being the year ending 30 June 2006). Only a complete set of financial statements and notes together with comparative balances can provide a true and fair presentation of the Health Service's financial position, financial performance and cash flows in accordance with AIFRS. This note provides only a summary, therefore, further disclosure and explanations will be required in the first complete AIFRS financial report for a true and fair view to be presented under AIFRS.

Revisions to the selection and application of the AIFRS accounting policies may be required as a result of:

(i) changes in financial reporting requirements that are relevant to the Health Service's first complete AIFRS financial report arising from new or revised accounting standards or interpretations issued by the Australian Accounting Standards Board subsequent to the preparation of the 30 June 2005 financial report;

(ii) additional guidance on the application of AIFRS in a particular industry or to a particular transaction.

The rules for the first time adoption of AIFRS are set out in AASB 1 "First Time Adoption of Australian Equivalents to International Financial Reporting Standards". In general, AIFRS accounting policies must be applied retrospectively to determine the opening AIFRS balance sheet as at transition date, being 1 July 2004. The Standard allows a number of exemptions to this general principle to assist in the transition to reporting under AIFRS.

Reconciliation of Equity

The following table sets out the expected adjustments to the statement of financial position for the AIFRS comparative period balance sheet as at 30 June 2005.

	AGAAP 30 June 2005	*Transition Impact*	*AIFRS 30 June 2005*
Statement of Financial Position	$000	$000	$000
Cash assets	83	0	83
Restricted cash assets	65	0	65
Receivables	71	0	71
Total current assets	219	0	219
Amounts receivable for services	968	0	968
Property, plant and equipment	5,472	0	5,472
Total non-current assets	6,440	0	6,440
Total assets	6,659	0	6,659
Payables	109	0	109
Provisions	1,358	(48)	1,310
Other liabilities	108	0	108
Total current liabilities	1,575	(48)	1,527
Provisions	366	0	366
Total non-current liabilities	366	0	366
Total liabilities	1,941	(48)	1,893
NET ASSETS	4,718	48	4,766
Contributed equity	561	0	561
Reserves	13	81	94
Accumulated surplus / (deficiency)	4,144	(33)	4,111
TOTAL EQUITY	4,718	48	4,766

PEEL HEALTH SERVICE

Notes to the Financial Statements
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Note 35 Impact of Adopting Australian Equivalents to International Financial Reporting Standards (continued)

Reconciliation of net cost of services for the financial year ended 30 June 2005

The following table sets out the expected adjustments to the statement of financial performance for the year ended 30 June 2005.

	AGAAP 30 June 2005	*Transition Impact*	*AIFRS 30 June 2005*
Statement of Financial Performance	$000	$000	$000
Employee expenses	8,173	(26)	8,147
Fees for visiting medical practitioners	140	0	140
Patient support costs	910	0	910
Depreciation expense	216	37	253
Asset revaluation decrement	533	(533)	0
Capital user charge	337	0	337
Carrying amount of non-current assets disposed of	1	0	1
Other expenses from ordinary activities	926	0	926
Total Cost of Services	11,236	(522)	10,714
Total revenues from ordinary activities	749	0	749
NET COST OF SERVICES	10,486	(522)	9,965

Summary of impact on transition to AIFRS on accumulated surplus/(deficiency)

The impact of the transition to AIFRS on accumulated surplus/(deficiency) as at 1 July 2004 is summarised below:

Accumulated surplus/(deficiency) as at 1 July 2004 under AGAAP	4,830
AIFRS reconciliation	
Adjustments in respect of the Employee benefits provisions	22
Accumulated surplus/(deficiency) as at 1 July 2004 under AIFRS	4,853

The significant changes in accounting policies expected to be adopted in preparing the AIFRS reconciliations are set out below:

(a) Property, Plant and Equipment
The measurement of land and buildings was changed from the cost basis to the fair value basis in June 2005 under current Australian GAAP. Under AIFRS, the Health Service is required to apply the same accounting policy relating to the measurement of land and buildings at the fair value basis throughout all periods presented in the first IFRS financial statements. The adjustment to recognise the land and buildings at fair values from the date of transition is expected to increase the depreciation expense by $37k and reduce the asset revaluation decrement expense by $533k for the financial year ended 30 June 2005, and increase the asset revaluation reserve by $81k as at 30 June 2005.

(b) Employee Benefits
Under current Australian GAAP, all annual leave and vesting long service leave are measured at nominal amounts. Under AIFRS, all employee benefits that fall due after 12 months are measured at the present value.

The adjustment to recognise the long-term employee benefits at present value is expected to reduce the liability by $22k as at 1 July 2004 and $26k as at 30 June 2005 and increase the accumulated surplus by $22k as at 1 July 2004. For the financial year ended 30 June 2005, employee benefits expense is expected to decrease by $26k.

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Notes to the Financial Statements

For the year ended 30th June 2005

Note 36 Explanatory Statement

(A) Significant variations between actual revenues and expenditures for the financial year and revenues and expenditures for the immediately preceding financial year.

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

	Note	2005 Actual $000	2004 Actual $000	Variance $000
Statement of Financial Performance - Expenses				
Employee expenses		8,173	7,856	316
Fees for visiting medical practitioners	(a)	140	165	(25)
Patient support costs		910	888	22
Depreciation expense		216	197	20
Asset revaluation decrement		533	0	533
Capital user charge	(b)	337	413	(76)
Carrying amount of non-current assets disposed of		1	1	1
Other expenses from ordinary activities		926	938	(12)
Statement of Financial Performance - Revenues				
Patient charges		32	67	(35)
Grants and subsidies		207	199	8
Other revenues from operating activities	(c)	160	572	(412)
Donations revenue		56	54	2
Interest revenue		24	26	(2)
Other revenues from non-operating activities	(d)	270	166	105
Service appropriation		9,787	9,662	125
Liabilities assumed by the Treasurer		14	12	2

(a) Fees for visiting medical practitioners
There was a re-negotiation of the fee arrangement with visiting medical practitioners during the year resulting in an increase in fees charged.

(b) Capital user charge
The charge is calculated on the net assets adjusted to take account of exempt assets. Reduction in capital user charge in 2004-05 due to the lower level of non-exempted net assets.

(c) Other revenues from operating activities
There was a one-off adjustment of $377k in 2003/04 financial year to correct an accounting error made in 2002/03 when the accounting system was re-structured.

(d) Other revenues from non-operating activities
Meals on wheels contract commenced in March 2004 which provided revenue inflow of about $20k per month.

(B) Significant variations between estimates and actual results for the financial year

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

	Note	2005 Actual $000	2005 Estimates $000	Variance $000
Operating expenses				
Employee expenses	(a)	8,173	7,167	1,006
Other goods and services		3,063	3,155	(92)
Total expenses from ordinary activities		11,236	10,322	914
Less: Revenues from ordinary activities	(b)	(749)	(685)	(64)
Net cost of services		10,486	9,637	849

(a) Employee expenses
Employee expenses were greater than those estimated mainly due to greater than expected increase in wages and salaries rates.

(b) Revenues from ordinary activities
Revenue from ordinary activities increased mainly due to the commencement of the Meals on wheels contract in March 2004.

PEEL HEALTH SERVICE

Notes to the Financial Statements
For the year ended 30th June 2005

Note 37 Financial instruments

a) **Interest rate risk exposure**

The following table details the Health Service's exposure to interest rate risk as at the reporting date:

	Weighted average effective interest rate %	Variable interest rate $000	Fixed interest rate maturities: Less than 1 year $000	1 to 5 years $000	Over 5 years $000	Non interest bearing $000	Total $000
As at 30th June 2005							
Financial Assets							
Cash assets	4.8%	83	0	0	0	0	83
Restricted cash assets	4.8%	65	0	0	0	0	65
Receivables						71	71
		148	0	0	0	71	219
Financial Liabilities							
Payables						109	109
		0	0	0	0	109	109
Net financial assets / (liabilities)		148	0	0	0	(38)	110
As at 30th June 2004							
Financial Assets	4.8%	87	0	0	0	77	164
Financial Liabilities	0.0%	0	0	0	0	87	87

b) **Credit risk exposure**

All financial assets are unsecured. Amounts owing by other government agencies are guaranteed and therefore no credit risk exists in respect of those amounts. The carrying amounts of financial assets recorded in the financial statements, net of any provisions or losses, represent the Health Service's maximum exposure to credit risk.

c) **Net fair values**

The carrying amounts of financial assets and financial liabilities recorded in the financial statements are not materially different from their net fair values, determined in accordance with the accounting policies disclosed in note 1 to the financial statements.

PEEL HEALTH SERVICE

Notes to the Financial Statements

For the year ended 30th June 2005

Note 38 Schedule of Services Delivered

	Prevention & Promotion		Diagnosis & Treatment		Continuing Care		Total	
	2005 $000	2004 $000	2005 $000	2004 $000	2005 $000	2004 $000	2005 $000	2004 $000
COST OF SERVICES								
Expenses from Ordinary Activities								
Employee expenses	360	392	7,164	7,228	649	236	8,173	7,856
Fees for visiting medical practitioners	6	8	123	152	11	5	140	165
Patient support costs	40	44	798	817	72	27	910	888
Depreciation expense	10	10	189	181	17	6	216	197
Asset revaluation decrement	24	0	467	0	42	0	533	0
Capital user charge	15	21	295	380	27	12	337	413
Carrying amount of non-current assets disposed of	0	0	1	1	0	0	1	1
Other expenses from ordinary activities	41	47	811	861	74	28	926	936
Total cost of services	496	522	9,848	9,620	892	314	11,236	10,456
Revenues from Ordinary Activities								
Revenue from operating activities								
Patient charges	1	3	28	62	3	2	32	67
Grants and subsidies	9	10	182	183	16	6	207	199
Other revenues from operating activities	7	29	140	526	13	17	160	572
Revenue from non-operating activities						0		
Donations revenue	3	2	49	50	4	2	56	54
Interest revenue	1	1	21	24	2	1	24	26
Other revenues from non-operating activities	12	8	237	153	21	5	270	166
Total revenues from ordinary activities	33	53	657	998	59	32	749	1,084
NET COST OF SERVICES	**462**	**469**	**9,191**	**8,622**	**834**	**281**	**10,486**	**9,372**
Revenues from State Government								
Service appropriation	432	483	8,578	8,889	777	290	9,787	9,662
Liabilities assumed by the Treasurer	(0)	1	13	11	1	0	14	12
Total revenues from State Government	431	484	8,591	8,900	778	290	9,801	9,674
CHANGE IN NET ASSETS	**(30)**	**15**	**(601)**	**278**	**(55)**	**9**	**(686)**	**302**

Abbreviations

ABS	Australian Bureau of Statistics
ACAT	Aged Care Assessment Team
ACHS	Australian Council of HealthCare Standards
ACIR	Australian Childhood Immunisation Register
CPI	Consumer Price Index
DOH	Department of Health
EEO	Equal Employment Opportunity
FOI	Freedom of Information
FTE	Full Time Equivalent
GP	General Practitioner
HACC	Home and Community Care
HMDS	Hospital Morbidity Data System
IT	Information Technology
KPI	Key Performance Indicator
NAATI	National Accreditation Authority for Translators and Interpreters
MDH	Murray District Hospital
NHMRC	National Health Medical Research Council
NHTP	Nursing Home Type Patient
PARK	Peel and Rockingham Kwinana
PATS	Patient Assisted Travel Scheme
PHS	Peel Health Service
PID	Public Interest Disclosure
PSOLIS	Psychiatric Services Online Information System
SLA	Statistical Local Area
SMAHS	South Metropolitan Area Health Service
TTY	Teletypewriter