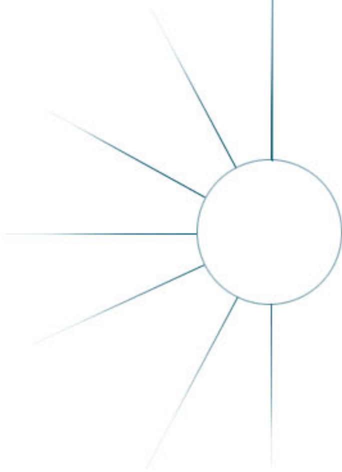


Annual Report 2001/2002

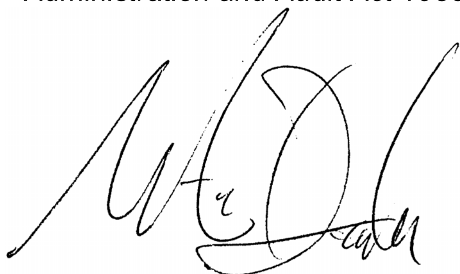
Department of Health
Government of Western Australia

To the Hon Bob Kucera 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 Boddington District Hospital Board for the year ended 30 June 2002.

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



Mike Daube
DIRECTOR GENERAL
DEPARTMENT OF HEALTH
ACCOUNTABLE AUTHORITY
14 March 2003

ANNUAL REPORT

The past year has seen significant changes in the WA health system, in the context of an increasing recognition of its place in to our national health system.

The State Government health system does not exist in isolation. We work alongside other Government and non-Government services in the context of a national health system that remains fragmented and at times competitive. Much of our work and many of our challenges are informed by national and international trends, and decisions taken elsewhere. Nowhere is this clearer than in areas that tend to attract most public attention and place the greatest stresses for our system, such as workforce issues and the pressures on our teaching hospitals. These are understandably seen locally as local problems for local solution, but the reality is that they are significantly influenced by international trends and national policy and funding decisions.

We in Western Australia face all the challenges of contemporary health systems, together with high community expectations and often optimistic or disingenuous expectations that long-standing problems faced by all health systems can be resolved overnight in our State.

Against this backdrop have been steadily implementing change to ensure that the WA Government health system is as well placed as possible to face the challenges of the future. While ever more conscious of the size and complexity of our system and the challenges we face, remain optimistic that with good support and community understanding we can move well towards achieving our common objectives.

Our community enjoys outstanding health and health care by any standards. When we see and hear about problems we face, it is tempting to imagine that our system is failing us overall or that we are doing badly by national or international standards.

Of course there are areas of deficit, but Western Australians enjoy some of the best health and health care in the world. We live longer than people in almost all other countries, and even within Australia some parts of Western Australia are notable for the longevity of their populations.

Our health professionals are as well trained and qualified as those anywhere around the world, and we rightly adopt the most stringent standards in relation to their training and practice.

Those in the system will be more aware than any others of areas in which we can do better, but above all our community should be aware and rightly proud that we have a system in which first class professionals deliver high quality health care to a community with health outcomes that would be envied in almost any other country.

The world of health and health care has changed dramatically in recent years, and especially in the last decade. Around Australia, Governments and health systems are faced with identical problems and pressures including increasing costs of labour, equipment and pharmaceutical products, the changing roles of health professionals, a

very proper emphasis on quality (and the inevitable costs and changes that this will impose on us), the needs of ageing populations and more.

The Department of Health is a vast and complex organisation, employing some 30,000 staff operating from more than 650 sites around the State. It is not a simple agency. We deliver some services ourselves; we work collaboratively with Commonwealth and local Governments; and we fund several hundred non-Government organisations, ranging in size from those such as St John Ambulance Association and the Royal Flying Doctor Service to small groups providing equally important local services.

During 2001/2002 we restructured the Department so that it is now a single unified health system. We now have a State Health Management Team, which works as a single Departmental Executive Committee. The four Metropolitan Areas have been established. Our Country Health Services have been rationalised; and an enormous amount of work has been carried out to move away from silo mentalities and towards a recognition that we must indeed work as a unified system.

During the year, the Department has recognised its responsibilities arising out of matters such as the Douglas Report on King Edward Memorial Hospital, as well as resolving some important industrial negotiations.

As the work of consolidation, always slower than one would hope, develops, my hope is that during the coming year we will be able to address further some of the high profile priorities for both Government and the community – for example coping with winter pressures, reduce waiting lists and valuing and supporting our workforce; that we will be able to demonstrate our values as a health system committed to quality, prevention and remedying disadvantage; that we will be able to focus on the medium and long term planning that are crucial if the needs of the next generation are to be well serviced; and that we will be able to engender an understanding in the community of the national and international context within which our system works. In the latter regard, negotiations on the next phase of the Australian Health Care Agreements will be of fundamental importance.

I would like to convey special appreciation to all the staff and volunteers working within the Department of Health. They know as well as anyone else the pressures we all face, but also the excellent service they provide and the commitment they display on a daily basis.

Mike Daube
DIRECTOR GENERAL

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Address and Location

Boddington District Hospital
46–53 Hotham Ave
BODDINGTON WA 6390

c/o Post Office
BODDINGTON WA 6390

☎ *(08) 9883 8008*
℡ *(08) 9883 9187*
✉ paul.seats@health.wa.gov.au

Mission Statement

Our Mission
To improve the health of the community in the Boddington District region by:

- Reducing the incidence of preventable disease, injury, disability and premature death.
- Restoring the health of people who have an acute illness.
- Improving the quality of life for people who have a chronic illness or disability.

Broad Objectives

The objectives of the Boddington District Hospital are:

- To strive for excellence in the delivery of health services to the Boddington District region.
- To actively involve the community in the administration of health services.
- To be responsive to the values and choices of individual patients.
- To be a competitive and financially successful agency.
- To enhance community health through the provision of educational courses and information.

Enabling Legislation

The Boddington District Hospital is incorporated under the *Hospitals and Health Services Act 1927*, which provides for the establishment, maintenance and management of public hospitals, and for incidental and other purposes.

The Hospital is directed and controlled by a Board of Management constituted under Section 15 of the *Hospitals and Health Services Act 1927*.

As the Accountable Authority for the Boddington District Hospital, the Board of Management is responsible to the Minister for Health, Hon. R. C. Kucera APM MLA, for the general administration of the Hospital.

The Hospital does not operate in coordination with any subsidiary, related or affiliated bodies.

Ministerial Directives

The Minister for Health did not issue any directives on Hospital operations during 2001/2002.

Submission of Annual Report

Approval was sought under the *Financial Administration and Audit Act 1985* to extend the Boddington District Hospital's deadline for submission of key performance indicators and financial statements to the Auditor General to 14 October 2002.

Statement of Compliance with Public Sector Standards

In the administration of the Boddington District Hospital, I have complied with the *Public Sector Standards in Human Resource 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.

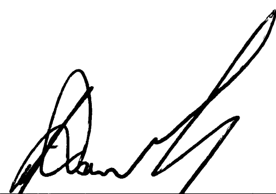
Such processes include:

- Adopting the policy and procedures documented in the Upper Great Southern Health Service's administration manual, with regards to public sector standards and the *Code of Ethics*.

The applications made to report a breach in standards, and the corresponding outcomes for the reporting period are:

- Number of applications lodged None
- Number of material breaches found None
- Applications under review None

The Boddington District Hospital has not been investigated or audited by the Office of the Public Sector Standards Commissioner for the period to 30 June 2002.



Kim Darby
ACTING REGIONAL DIRECTOR
WHEATBELT REGION
December 2002

Advertising and Sponsorship — Electoral Act 1907

The following table lists the expenditure on advertising and sponsorship made by the Boddington District Hospital published in accordance with Section 175ZE of the *Electoral Act 1907*:

CLASS OF EXPENDITURE	1999/2000 $	2000/2001 $	2001/2002 $
Advertising Agencies	–	–	–
Market Research Organisations	–	–	–
Polling Organisations	–	–	–
Direct Mail Organisations — Australia Post	–	60.00	–
Media Advertising Organisations	–	–	–
TOTAL	**$0.00**	**$60.00**	**$0.00**

Freedom of Information Act 1992

The Boddington District Hospital received and dealt with no formal applications under the Freedom of Information guidelines during 2001/2002.

Formal applications are defined as requests which:

- Are in writing.
- Give enough information to enable the requested documents to be identified.
- Give an address in Australia to which notices under the *Freedom of Information Act 1992* can be sent.
- Give any other information or details required under FOI regulations.
- Are lodged at an office of the agency with any application fee required under FOI regulations.

Applications are usually received from existing or former patients wanting to read or have a copy of their medical record, while others are from lawyers, authorised next of kin or authorised agencies.

The types of documents held by the Hospital include:

- Patient medical records.
- Staff employment records.
- Department of Health reports, plans and guidelines.
- Other health-related agency reports.
- Agreements with the Department of Health.
- Statistical data and reports.
- Books relating to health planning and management.
- Books relating to the treatment of illness and disease.
- General administrative correspondence.

In accordance with Part Five of the *Freedom of Information Act 1992*, an information statement detailing the nature and types of documents held by the organisation is available from:

Marlene Waldock
Information Coordinator
46–53 Hotham Ave
BODDINGTON WA 6390

☎ *(08) 9883 8008*

Boddington District Hospital

Key Operations and Achievements

- The Hospital now provides weekly day care activities through its Home and Community Care Department.
- The Hospital recorded no workers' compensation claims for the fourth consecutive year.
- The Hospital continued to maintain a high retention rate amongst nursing staff with no contract agency personnel being used.
- The Men's Health Program continued to grow in popularity, and is now in its third year of operation.

Major Capital Projects

Projects Completed during the Year

PROJECT DESCRIPTION	Actual Total Cost	Estimated Total Cost
Purchase of House for Staff Accommodation	$178,463.00	$178,463.00
Hospital Car Park Upgrade	$26,310.00	$30,000.00

A house was purchased to assist the Boddington District Hospital with staff retention, particularly in the area of nursing services. There are currently not enough nurses living in Boddington to support the Hospital's staffing requirements.

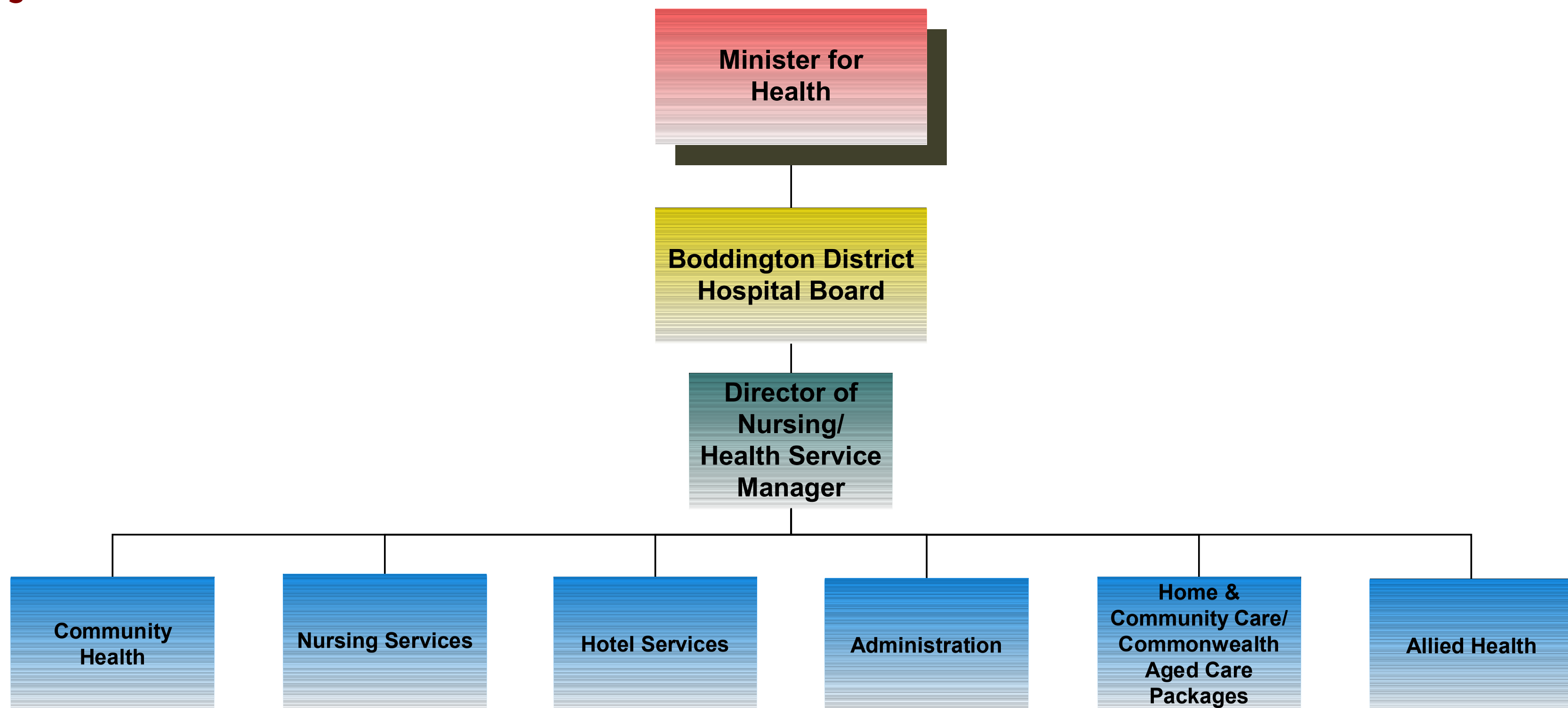
The surface of the Hospital car park was upgraded from gravel to bitumen to improve safety, and to reduce the cost of ongoing maintenance.

Projects in Progress

The Boddington District Hospital does not have any major capital projects in progress as at 30 June 2002.

Management Structure

Organisational Chart



Accountable Authority

The Boddington District Hospital Board represents the Accountable Authority for the Hospital. The board is comprised of the following members:

Name	Position	Term of Office Expires
Jeff Gibbs	Chairperson	30 June 2002
Denise Hardie	Deputy Chairperson	30 June 2002
Wayne English	Member	30 June 2002
Jim Nelson	Member	30 June 2002
Sandy Salmerie	Member	30 June 2002
Deb Schorer	Member	30 June 2002

Note: The Governor in Executive Council approved the amalgamation of several hospital boards including the Boddington District Hosptial Board to form one board, with the assigned name WA Country Health Service, with effect from 1 July 2002. Notice to this effect was published in the Government Gazette on 28 June 2002.

Senior Officers

The senior officers of the Boddington District Hospital and their areas of responsibility are listed below:

Area of Responsibility	Title	Name	Basis of Appointment
Health Unit and Clinical Management	Director of Nursing/Health Service Manager	Paul Seats	Permanent
Business Support Services	Business Support Coordinator	Stan Sherry	Permanent
Medical Services	GP	Dr R Hames	Visiting Medical Officer

Pecuniary Interests

Senior officers at the Boddington District Hospital have declared no pecuniary interests other than those reported in the Financial Statements section of this report.

Demography

The Boddington District Hospital delivers services to communities covered by the following local authorities:

- Boddington Shire
- Wandering Shire

The following table shows population figures for each local authority within the Boddington District region:

LOCAL AUTHORITY	Population as at 1996*	Population as at 2001*	Projected Population as at 2006*
Boddington Shire	1540	1421	2101
Wandering Shire	364	336	352

*Data sources:

Australian Bureau of Statistics 1996, *Estimated Resident Population by Age and Sex in Statistical Local Areas, WA*, Cat. No. 3203.5.

ABS 2001, *Population Estimates by Age, Sex and Statistical Local Area, WA*, Cat. No. 3235.5.

Ministry of Planning 2000, *Population Projections by Age, Sex and Local Government Area, WA*.

The Boddington Shire is a mining and agricultural area, while the Wandering Shire is supported by an agriculture-based economy.

No significant changes to the demography of the Boddington or Wandering Shires occurred between 1996 and 2001.

Available Services

The following is a list of health services and facilities available to the community:

Direct Patient Services	Medical Support Services
Accident and Emergency	Pharmacy
Acute Medical	Physiotherapy
Aged Care Services	Podiatry
Domiciliary Nursing	Respite Care
Obstetrics (Postnatal Care Only)	X-ray
Occupational Health	
Paediatric	
Palliative Care Services	
Community Services	**Other Support Services**
Aboriginal Liaison	Day Centre
Child and School health	Hotel Services
Health Promotion	Medical Records
Home Care	
Meals on Wheels	
Occupational Health Services	
Postnatal Early Discharge	
Primary Health Care	

Specialist Services
Visiting specialist services are provided in the areas of:

Occupational Therapy	Speech Pathology

Other Services
None

Disability Services

Our Policy
The Boddington District Hospital is committed to ensuring all people with disabilities can access the facilities provided by and within the Hospital.

Programs and Initiatives
The Hospital has aimed to improve its disability services plan during 2001/2002, 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.

- All car parks and internal laneways have been resurfaced to remove potholes and loose stones.
- Kerbing in the vicinity of the Hospital has been modified to allow better wheelchair access to footpaths.

Outcome 2: Access to buildings and facilities is improved.

- A disabled parking bay has been allocated next to the ramp used to access the day centre.
- A covered parking bay allowing for all-weather access to both the day centre and the Hospital has been installed at the rear of the facility.

Outcome 3: Information about services is provided in formats which meet the communication requirements of people with disabilities.

- A Disability Services Commission officer held six sessions at the Hospital to provide advice to members of the public regarding disability services. A combined total of 48 people attended.

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

- Both Home and Community Care, and Aged Care Packages staff — who deliver the majority of services to people with disabilities in the region — received training during 2001/2002 on how to identify potential and existing disabilities.

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

- The majority of people with disabilities in the community access the HACC and ACP services provided by the Hospital. A community survey was conducted during 2001/2002 to assess patient satisfaction with these services, and to help identify means of improvement for the future. Sixty-five individual responses were received. The Hospital will use these responses to assess the changes needed to meet service requirements, and to gauge the level of funding needed for HACC and ACP services.

Future Direction
The Hospital will continue to review and amend its policies, practices and procedures to identify possible barriers experienced by people with disabilities.

Cultural Diversity and Language Services

Our Policy
The Boddington District Hospital strives to ensure there is no discrimination against members of the public based upon race, ethnicity, religion, language or culture.

Programs and Initiatives
The Hospital operates in conjunction with the *Western Australian Government Language Services 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:

- The Hospital has access to a telephone interpreter service when it is required.
- A member of the local Aboriginal community has been employed through the Hospital's Home and Community Care Department. The employee assists with the provision of health services to the Indigenous community, and helps communicate health service needs to Aboriginal people.

Youth Services

Our Policy
The Boddington District Hospital acknowledges the rights and special needs of youth, and endeavours to provide appropriate services, supportive environments and opportunities for young people.

The Hospital is committed to the following objectives as outlined in *Action: A State Government Plan for Young People, 2000–2003*:

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

Programs and Initiatives
The Boddington District Hospital has run numerous programs targeting youth groups and introduced a number of innovations such as:

- Encouraging young people to participate in extended periods of work experience at the Hospital. Students from the local high school rotate through the Hospital over a 12-week period in a department of their choice.
- Seeking to employ graduate nurses from WA universities. The Hospital currently employs one full-time graduate nurse.
- Coordinating a Graduate Nurse Program aimed at developing the leadership skills of young employees within the Hospital.

The Hospital's Health Service Manager is also a member of the judging panel for the Australia Day Citizen and Young Citizen Awards. This role includes reviewing nominations for the Australia Day Young Citizen of the Year Award.

Employee Profile

The following table shows the number of full-time equivalent staff employed by the Boddington District Hospital:

CATEGORY	1999/2000	2000/2001	2001/2002
Nursing Services*	7.99	10.81	11.34
Administration and Clerical*	1.80	1.82	1.40
Medical Support*	–	0.50	0.20
Hotel Services*	5.24	6.54	6.98
Maintenance	–	–	–
Medical (salaried)	–	–	–
Other	–	–	–
TOTAL	**15.03**	**19.67**	**19.92**

*Note these categories include the following:

- **Nursing Services** — School and Child Health nursing staff (not reported in previous years).
- **Administration and Clerical** — health project officers, ward clerks, receptionists and clerical staff.
- **Medical Support** — physiotherapists, speech pathologists, medical imaging technologists, pharmacists, occupational therapists, dietitians and social workers.
- **Hotel Services** — cleaners, caterers, patient service assistants, Home and Community Care staff, and Aged Care Packages staff.

It is important to note FTE staffing figures for the Hospital were incorrectly reported by the Human Resource Information System in 1999/2000.

Recruitment Practices

The Boddington District Hospital Board has followed the guidelines set out in the *Public Sector Standards in Human Resource Management* regarding recruitment and selection practices for the employment of staff.

These guidelines state the minimum standard of merit, equity and probity is met for recruitment, selection and appointment of staff if:

- A proper assessment matches a candidate's skills, knowledge and abilities with the work-related requirements of the job and the outcomes sought by the public sector body, which may include diversity.
- The process is open, competitive, and free of bias, unlawful discrimination, nepotism or patronage.
- Decisions are transparent and capable of review.

Staff Development

The Boddington District Hospital Board supports and encourages staff to attend internal and external training courses relevant to their duties. The types of staff training courses available though the Hospital include:

- Accident and emergency courses for nursing staff.
- Development courses for graduate nurses.
- A financial management and organisational development course.
- Food handling courses for hotel staff.
- Financial system training for clerical staff.
- Patient service assistant training for Home and Community Care workers.
- Registration for nurses wishing to re-enter the workforce.

Industrial Relations Issues

The following wage adjustments have been made at the Boddington District Hospital during 2001/2002, according to the relevant Enterprise Bargaining Agreement or organisation as shown in the table below:

EBA	Date Implemented	Wage Adjustment
Australian Nursing Federation	2 May 2002	4.5%
Health and Disabilities Support Workers Award	9 July 2001 1 April 2002	2.0% 6.0%
Hospital Salaried Officers Association of WA	19 July 2001 12 November 2001	3.0% 2.8%
Enrolled Nurses and Nursing Assistants Enterprise Agreement 1999	9 July 2001 6 January 2002	2.0% 3.0%

Workers' Compensation and Rehabilitation

The following table shows the number of workers' compensation claims made through the Boddington District Hospital:

CATEGORY	1999/2000	2000/2001	2001/2002
Nursing Services	0	0	0
Administration and Clerical*	0	0	0
Medical Support*	0	0	0
Hotel Services*	0	0	0
Maintenance	0	0	0
Medical (salaried)	0	0	0
Other	0	0	0
TOTAL	**0**	**0**	**0**

*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, dietitians and social workers.
- **Hotel Services** — cleaners, caterers and patient service assistants.

The Risk Management Committee continues to play an important role in identifying and managing risks, particularly those hazards arising from manual handling practices. All injuries, incidents and hazards were reported to the Boddington District Hospital Board on a monthly basis during 2001/2002.

Equity and Diversity Outcomes

Our Policy

The ability of an organisation to provide high quality health services to the general public is closely related to workforce diversity. That diversity needs to be tapped for planning, decision-making and service delivery.

The Boddington District Hospital aims to achieve equity and diversity in the workplace by eliminating any discrimination in employment based upon grounds of sex, marital status, pregnancy, family status, race, religious or political conviction, or age, and by promoting equal opportunity for all people.

Programs and Initiatives

The Hospital 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 Hospital employs staff ranging in age from 19 to 65 years. The majority of these employees are women.
- The Hospital has one employee from a non-English speaking background, and one employee from the Aboriginal community.
- There have been no applications lodged for breaches in EEO equity standards.

Outcome 2 — Workplaces are free from employment practices that are biased or discriminate unlawfully against employees or potential employees.

- The Hospital coordinates flexible rostering arrangements to assist employees who need to care for children or parents.
- Encouragement and assistance is provided to allow less skilled workers to improve their qualifications.

Outcome 3 — Employment programs and practices recognise and include strategies for EEO groups to achieve workforce diversity.

- A confidential EEO questionnaire is made available to ensure all employee needs are met.

EEO Indicators

The following table indicates strategic plans or processes the Department of Health aims to have in place across the health system to achieve equity and diversity in the workplace, and the level to which the Boddington District Hospital has been able to meet these goals:

Plan or Process	Level of Achievement
EEO Management Plan	District-wide plan developed
Organisational plans reflect EEO	Implemented
Policies and procedures encompass EEO requirements	Implemented
Established EEO contact officers	Officers appointed
Training and staff awareness programs	Implemented
Diversity	Implemented

Marketing

Community awareness of the Boddington District Hospital's services was raised through the following marketing activities:

- Running health promotions at local public events, such as administering more than 100 one-on-one health checks with community members at the Boddington Rodeo.
- Placing regular public notices in the local community newsletter.
- Running mailbox drops of Hospital pamphlets and brochures.
- Coordinating more than 120 individual health assessments in the Boddington District region as part of Men's Health Week.
- Providing on-site flu vaccinations to workers at the Boddington bauxite and gold mines.
- Running interactive Hospital tours for Boddington Primary School students.
- Running two women's health clinics and the Positive Parenting Program.
- Managing an op shop at the Hospital.

Publications

The Boddington District Hospital produced no external publications during 2001/2002.

Research and Development

The Boddington District Hospital carried out no major research and development programs during 2001/2002.

Evaluations

Future Needs Survey
The Boddington District Hospital carried out a future needs survey across the surrounding region. The purpose of the survey was to identify specific patient needs for Home and Community Care and Meals on Wheels services. Sixty-five individual responses were received. It has become apparent — given the survey's results and the ageing population within the district — that funding for HACC and Meals on Wheels services will need to be increased over the next three to five years to meet service delivery requirements.

Risk Management

Our Policy

The Boddington District Hospital aims to achieve the best possible practice in the management of all risks that threaten to adversely impact upon the Hospital itself, its patients, staff, assets, functions, objectives, operations, or upon members of the public.

Strategies and Initiatives

The Risk Management Committee meets on a quarterly basis and has addressed hazards such as:

- Identifying public liability risks. As a result, an application was sent to the Department of Health requesting resurfacing and kerbing of car parks and driveways at the Hospital. These improvements have since been completed.
- Identifying the need to extend the fire detection system to the old cottage hospital currently used by community groups and allied health staff. This recommendation has been completed.
- Identifying unauthorised phone use as a risk in the area of fraud detection and management. A Windows-based software program has been installed in the Hospital's administration office, and all phone calls and costs are now monitored.

Future Direction

The Hospital will continue to review its risk management and quality improvement processes in keeping with the above policy.

Internal Audit Controls

The Boddington District Hospital has established a system of internal controls as a means of providing reasonable assurance that assets are safeguarded, proper accounting records are maintained and financial information is reliable. An audit committee oversees the operation of internal audit functions, and ensures management addresses any findings arising from internal and external audit reports.

There were no significant audit findings identified during 2001/2002.

Waste Paper Recycling

The Boddington Shire began to supply some recycling facilities at a nearby landfill site during 2001/2002. The Boddington District Hospital's staff also began to recycle all cardboard boxes on a monthly basis.

No records were kept of the amount of waste paper recycled during 2001/2002 with recycling practices still under development.

Pricing Policy

The Boddington District Hospital raises a number of fees and charges to recover the estimated cost of providing certain services, except where a public service obligation exists.

A daily bed fee is raised against all patients other than those treated under the public health system. These fees contribute towards the cost of services required to treat patients. The only exception to this is professional medical services, which are provided privately by medical practitioners.

No fees are raised against registered public and private outpatients of the Hospital.

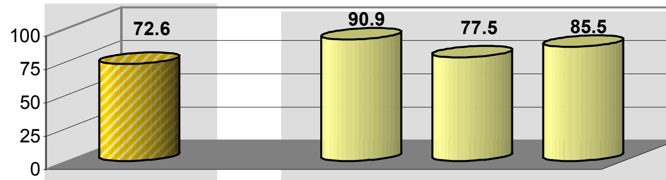
Client Satisfaction Surveys

Favourable satisfaction ratings have been associated with favourable health outcomes. In addition, if a patient's perception of health service provision is favourable they will be more likely to seek timely help, assistance or treatment. The Department of Health has produced Client Satisfaction Survey Questionnaires for various health service client groups with special forms for parents to answer on behalf of their children. The questionnaires have been standardised and have demonstrated valid and reliable results over time.

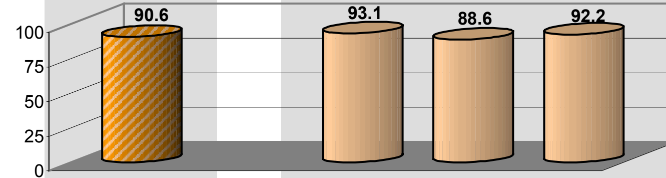
Each year a number of client groups are selected to answer questions about their experiences within the health system. The survey process is managed by the Department of Health with questionnaires being posted to patients during a specified survey period. Details of the responses to individual questions are shown below and audited aggregate results of these surveys are shown in the Key Performance Indicator section (page 41) of this report.

KPI 2.2: EMERGENCY PATIENTS — RURAL

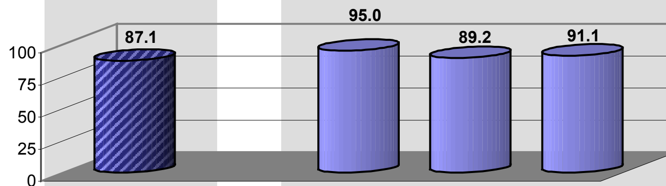
GETTING TO THE HOSPITAL



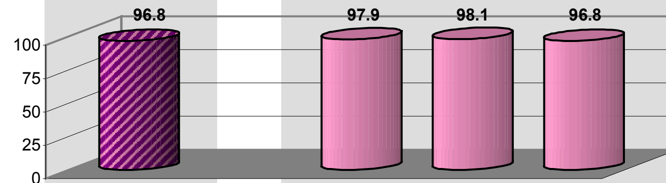
ATTENTION FROM DOCTORS AND NURSING STAFF



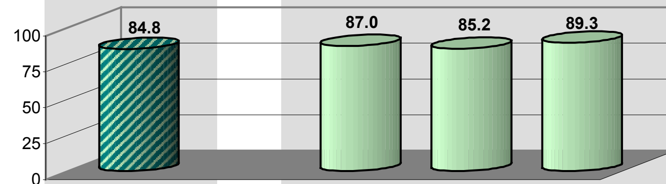
INFORMATION AND COMMUNICATION



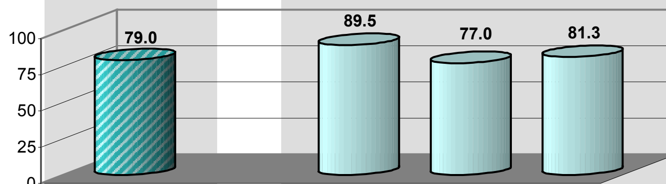
MEETING PERSONAL NEEDS



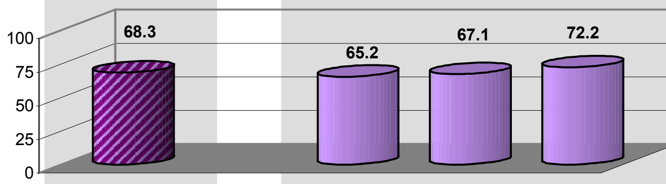
CONTINUITY OF CARE



RESIDENTIAL ASPECTS OF THE HOSPITAL



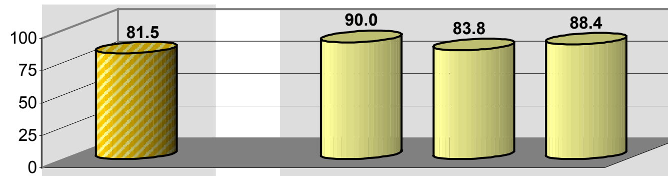
YOUR RIGHTS AS A PATIENT



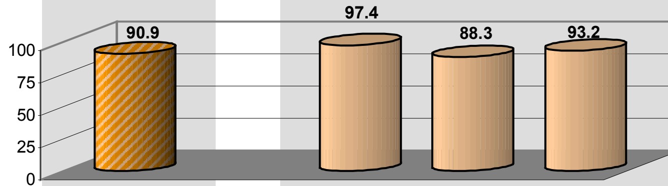
BODDINGTON | Upper Great Southern | Central Great Southern | Western

KPI 2.2: OUTPATIENTS — RURAL

GETTING TO THE HOSPITAL



ATTENTION FROM DOCTORS AND NURSING STAFF



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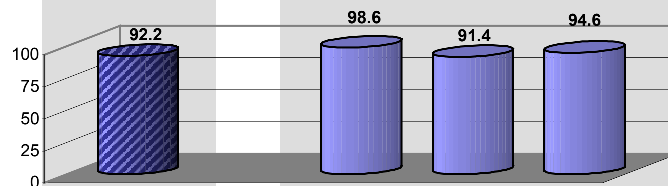
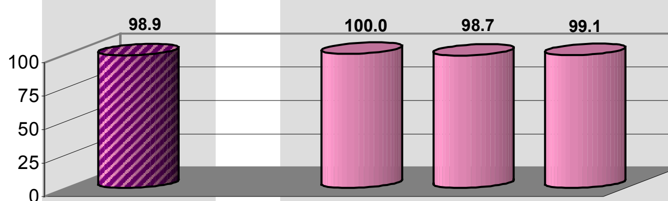


MEETING PERSONAL NEEDS



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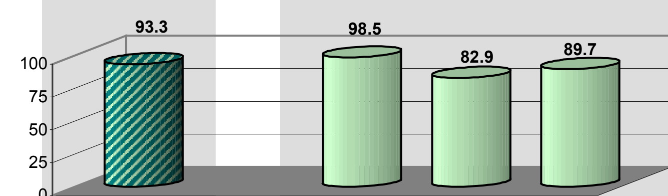
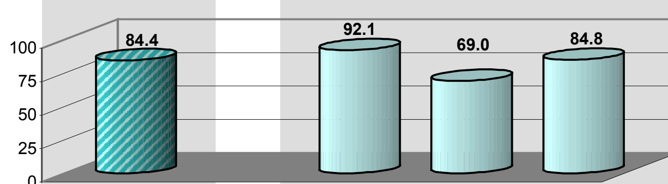
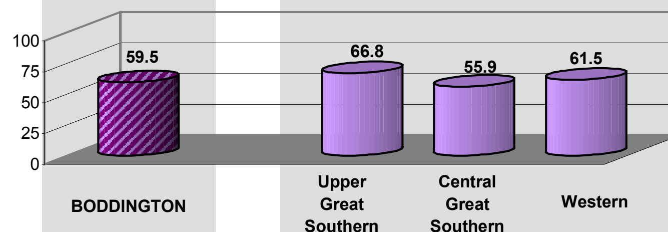


RESIDENTIAL ASPECTS OF THE HOSPITAL



YOUR RIGHTS AS A PATIENT



AUDITOR GENERAL

To the Parliament of Western Australia

BODDINGTON DISTRICT HOSPITAL BOARD
PERFORMANCE INDICATORS FOR THE YEAR ENDED JUNE 30, 2002

Scope
I have audited the key effectiveness and efficiency performance indicators of the Boddington District Hospital Board for the year ended June 30, 2002 under the provisions of the Financial Administration and Audit Act 1985.

The Board was responsible for developing and maintaining proper records and systems for preparing and presenting performance indicators. I have conducted an audit of the key performance indicators in order to express an opinion on them to the Parliament as required by the Act. The key performance indicators reflect the progress made to date as part of the staged process to develop more enhanced measurement of the performance of the Boddington District Hospital Board.

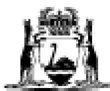
My audit was performed in accordance with section 79 of the Act to form an opinion based on a reasonable level of assurance. The audit procedures included examining, on a test basis, evidence supporting the amounts and other disclosures in the performance indicators, and assessing the relevance and appropriateness of the performance indicators in assisting users to assess the Hospital's performance. These procedures have been undertaken to form an opinion as to whether, in all material respects, the performance indicators are relevant and appropriate having regard to their purpose and fairly represent the indicated performance.

The audit opinion expressed below has been formed on the above basis taking into account the ongoing development of the key performance indicators.

Audit Opinion
In my opinion, the key effectiveness and efficiency performance indicators of the Boddington District Hospital Board are relevant and appropriate for assisting users to assess the Hospital's performance and fairly represent the indicated performance for the year ended June 30, 2002.

D D R PEARSON
AUDITOR GENERAL
March 7, 2003

4th Floor Dumas House 2 Havelock Street West Perth 6005 Western Australia Tel: 08 9222 7500 Fax: 08 9322 5664



AUDITOR GENERAL

INTERIM REPORT

To the Parliament of Western Australia

BODDINGTON DISTRICT HOSPITAL BOARD

Under the provisions of section 94 of the Financial Administration and Audit Act 1985, I advise that it will not be possible to complete the audit of the financial statements and performance indicators of the Boddington District Hospital Board for the year ended June 30, 2002 by February 28, 2003.

Whilst the Minister for Health granted the Boddington District Hospital Board an extension to October 14, 2002 to prepare and submit performance indicators, my Office did not receive these until November 29, 2002. The indicators submitted were not of an appropriate standard and were returned for further revision. These were resubmitted to my Office on January 28, 2003 in a form adequate to enable my staff and audit contractors to undertake audit testing against the supporting documentation held at the Health Service site. Audit testing and a review of the results of that work is currently in course to enable the forming of an audit opinion.

It is anticipated that the opinions will be issued by March 31, 2003.

D D R PEARSON
AUDITOR GENERAL
February 28, 2003

4th Floor Dumas House 2 Havelock Street West Perth 6005 Western Australia Tel: 08 9222 7500 Fax: 08 9322 5664

BODDINGTON DISTRICT HOSPITAL BOARD
CERTIFICATION OF PERFORMANCE INDICATORS
FOR THE YEAR ENDED 30 JUNE 2002

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 Boddington District Hospital Board and fairly represent the performance of the Hospital Board for the financial year ending 30 June 2002.

Mike Daube
ACCOUNTABLE AUTHORITY
Director General of Health

November 2002

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Background

The Performance Indicators reported in the following pages address the extent to which the strategies and activities of the Health Service have contributed to the required health outcomes and outputs, viz.,

OUTCOME 1 - Improvement in health by a reduction in the incidence of preventable disease, injury, disability, premature death and the extent and impact of drug abuse.

Output 1 - Prevention and promotion services aim to improve the health of Western Australians by reducing the incidence of preventable disease, injury, disability, premature death and the extent and impact of drug abuse.

OUTCOME 2 - Restoration of the health of people with acute illness.

Output 2 - Diagnosis and treatment services aim to improve the health of Western Australians by restoring the health of people with acute illness.

OUTCOME 3 - Improvement in the quality of life for people with chronic illness and disability.

Output 3 - Continuing care services are provided to improve the quality of life for those who need continuing care.

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

Output 1: *Prevention and Promotion*

- Community and Public health services
- Mental health services
- Drug abuse strategy coordination, treatment and prevention services

Output 2: *Diagnosis and Treatment*

- Hospital services (emergency, outpatient & in-patient)
- Nursing posts
- Community health services (post discharge care)
- Mental health services

Output 3: *Continuing Care*

- Services for frail aged and disabled people (eg, Aged Care Assessments, in-patient respite, outpatient services for chronic pain and disability, Nursing Home Type hospital care)
- Services for the terminally ill (eg, in-patient palliative care)
- Mental health services

There are some services, such as Community Health, which address all three of the outputs. Current information systems do not easily allow the distinction to be made between the three and this is therefore an important area for future development. To assure consistency in reporting and evaluation the Health Service has, during the year, continued to develop clear guidelines for the collection and interpretation of data for performance reporting. Whilst steps have been taken to minimise inconsistencies, some still exist.

General Approach

One of the aims of the Health Service has been to deliver activity, equitably distributed to, and accessible by, all sectors of the community.

For most of those performance indicators of health service delivery which target the
- reduction of the incidence of preventable disease, injury, disability and premature death and
- the improvement of the quality of life of people with chronic illness and disability,

the graphs used indicate performance for those who live in each catchment area irrespective of where service is provided and whether service is delivered in private or public hospitals.

For most services restoring the health of those with acute illness, performance is graphed according to where the service has been provided, irrespective of where people live and only includes service delivered by the public sector.

The indicators for these intervention strategies are the first step in a staged process leading to more comprehensive and meaningful measurement and reporting of performance in the above. Further indicators are being developed to assist in measurement, management and reporting.

Comparative Results

In certain cases results for other Health Services are assessed as being helpful in illustrating the performance of the Health Service being principally reported, ie the subject matter of the Report.

In the labelling of graphs, the technique has been used in which the results of the principally reported Health Service is always placed first (on the left), using UPPER CASE lettering.

After leaving a space, those results for comparative Health Services are shown to the right of this and use Lower Case identification to differentiate clearly between principal and comparative Health Services.

Output Measures

The four output measures are of quantity, quality, timeliness and cost. These are direct measures of performance, but are not to be confused with Key Performance Indicators of Efficiency and Effectiveness.

Quantity measures describe outputs in terms of how much, or how many are performed and require a unit of measurement to be defined.

Quality measures usually reflect service standards based on customer needs. The dimensions of quality as an output measure include: accuracy; completeness; accessibility; continuity; and a customer acceptability of the output.

Timeliness measures provide parameters for how often, or within what time frame, outputs will be produced.

Cost measures reflect the full accrual cost to an agency of producing each output.

Hospitals and Health Services are required to report output measures of quantity, quality, timeliness and cost together with a comparison between actual and target performance.

Assessing the Performance of the Health Service

It is not only the KPIs and Output Measures which readers of this report should examine when assessing the performance of the Health Service. The Key Performance Indicators, Financial Statements and Hospitals/Health Services reports, all provide information relevant to assessment of Health Service performance for 2001/02.

Glossary of Terms

Performance Indicator – *information about output performance or outcome achievement, usually expressed as a unit, index or ratio.*
Efficiency Indicator – *a performance indicator that relates an output to the level of resource input required to produce it.*
Effectiveness Indicator – *a performance indicator which provides information on the extent to which a government desired outcome has been achieved through the funding and production of an agreed output.*

RATE OF SCREENING IN CHILDREN	KPI 1.2

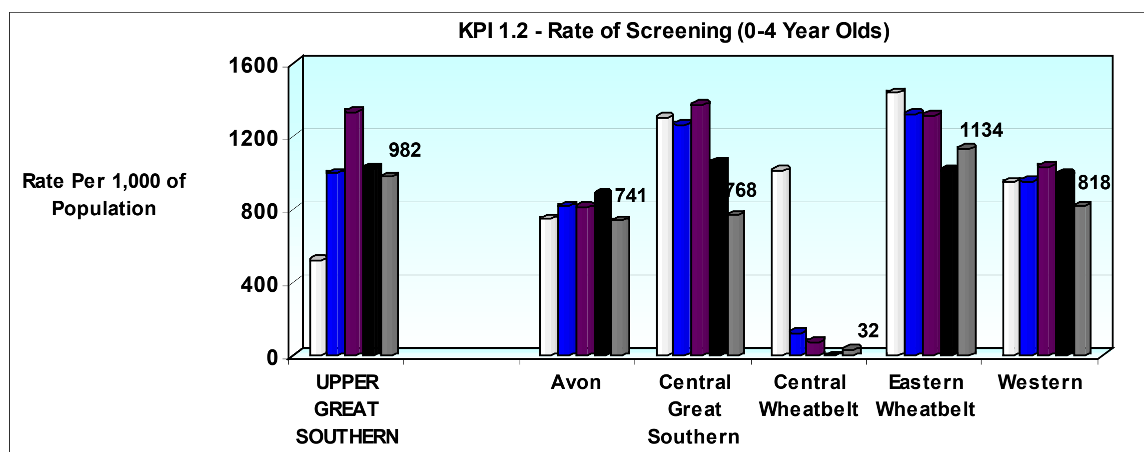
The community sets a very high priority on ensuring that the health and well being of children are safeguarded. Screening programs designed to detect disability and disease in the early stages of childhood development can prevent long-term disability. These programs not only restore children to good health when they become ill, but also help to maintain a state of 'wellness' that allows them to develop to their full potential. The State promotes a program of health monitoring at specific intervals in the period from birth to adolescence in accordance with the National Health and Medical Research Council's (NH&MRC) Minimum Screening Schedule.

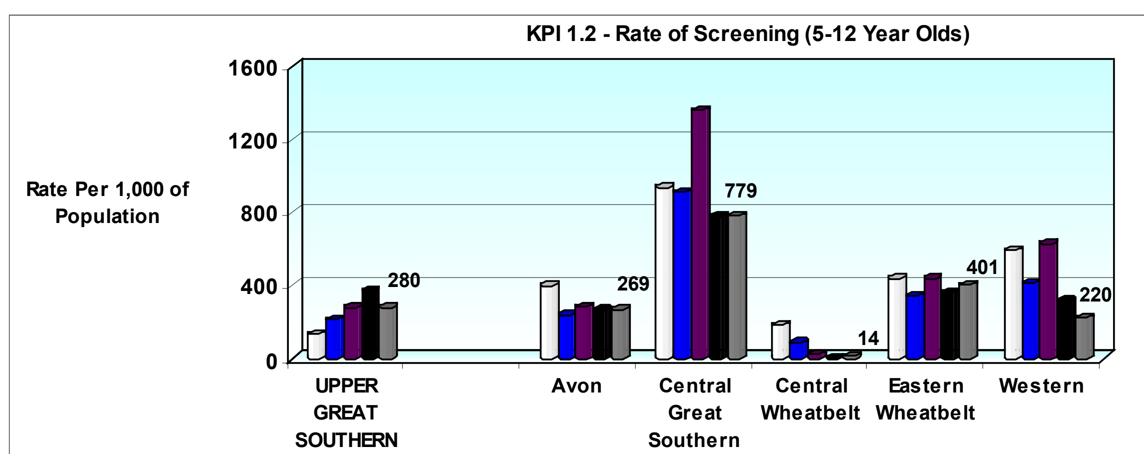
The consequences of any illness or disability not detected by routine screening programs for children are more likely to be permanently disabling or even contribute to their premature death.

This indicator measures the rate of NH&MRC screening, by 0-4 and 5-12 year age groups of the resident child population in the catchment for the health service.

This year's results are comparable to last years.

Note: A rate in excess of 1,000 per thousand can occur due to the same child attending more than once a year.





Calendar Year
1997 1998 1999 2000 2001

RATE OF CHILDHOOD IMMUNISATION — KPI 1.5

Vaccine preventable diseases are associated with considerable morbidity and mortality, and vaccination is effective in reducing the incidence of these diseases in the community. Through this adoption of the National Immunisation Schedule, health system effectiveness in providing vaccination coverage at key milestones (12 and 24 months of age) can be assessed.

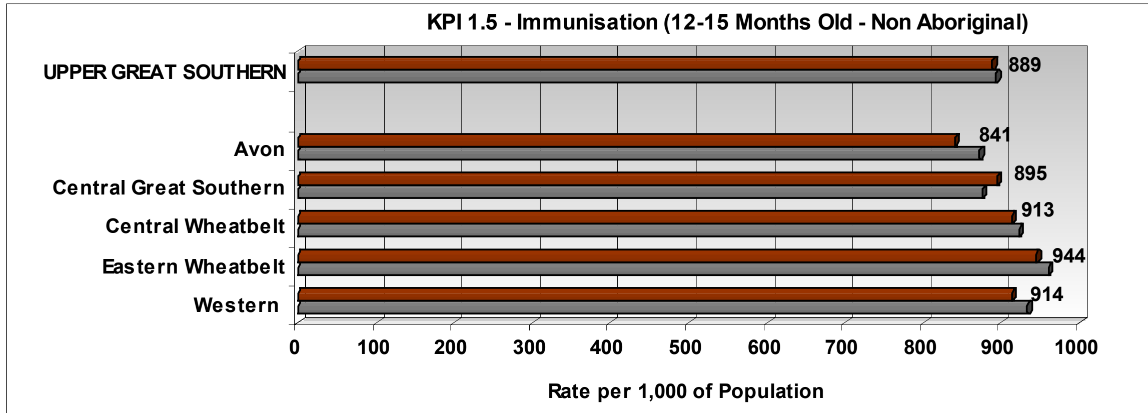
Without access to immunisation for children the consequences of any illness or disability are likely to be more disabling and more likely to contribute to a premature death.

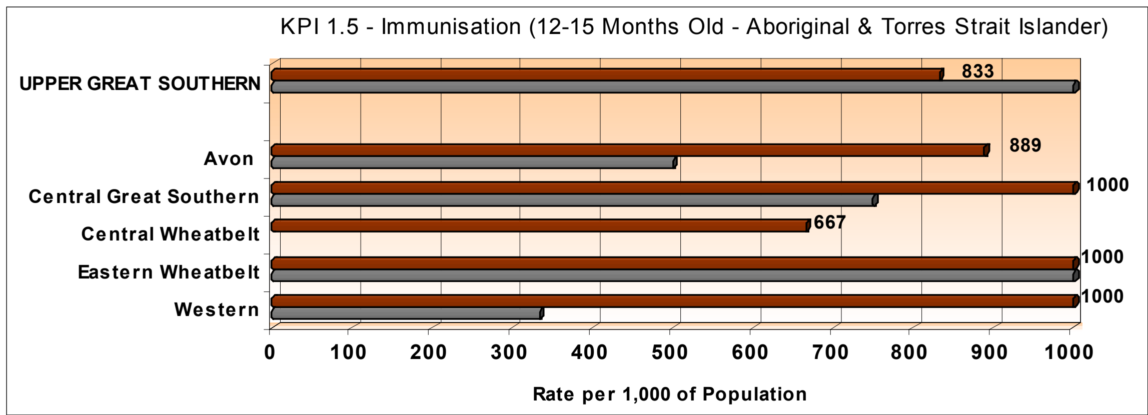
This indicator measures the rate of immunisation against particular diseases, by age group, of the resident child population in the catchment for the Health Service.

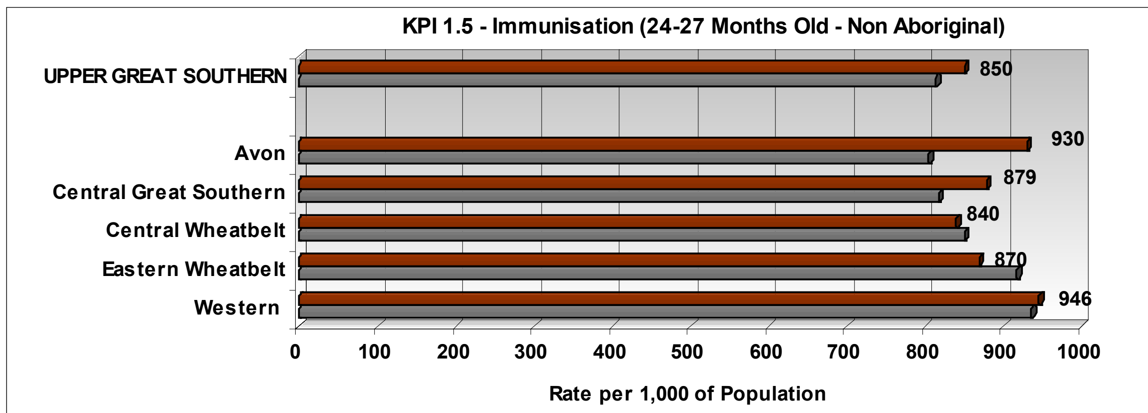
In calculating the rate of Immunisation, the number of Immunisations refer to the number of children who were fully vaccinated in accordance with the National Health and Medical Research Council (NH&MRC) standard vaccination schedule.

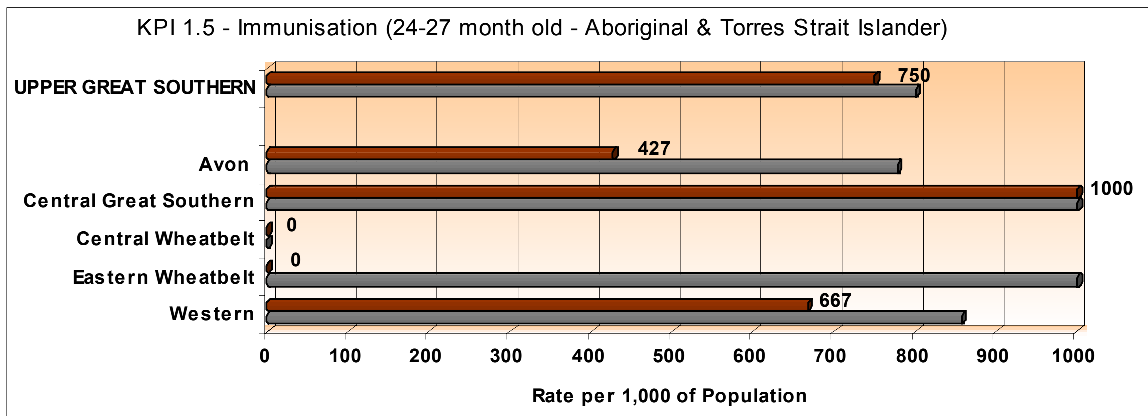
All infants born after May 2000 (but not before) were to be vaccinated against Hepatitis B at birth and again at 12 months. This effectively created 2 classes of immunised infants in that age group (12-15 months). It also means that there will be some discrepancies with the 24-27 month age group of the children shown even up to the calendar year 2002. The data shown for calendar year 2002 is from the first six months of the 2001/02 financial year and is therefore appropriate for this Report.

Year comparison with the state average would indicate continued commitment to the immunisation program within the Boddington District Hospital.









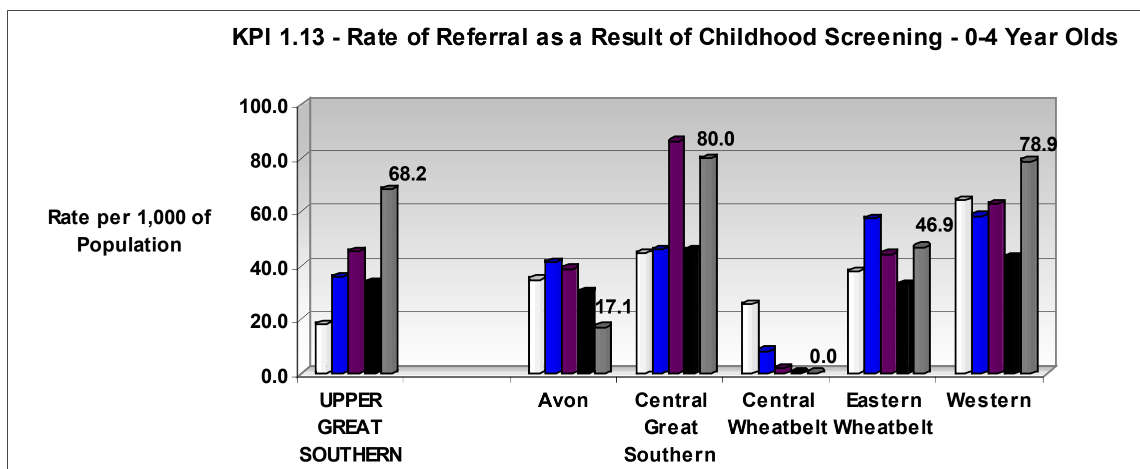
Calendar Year 2001 2002

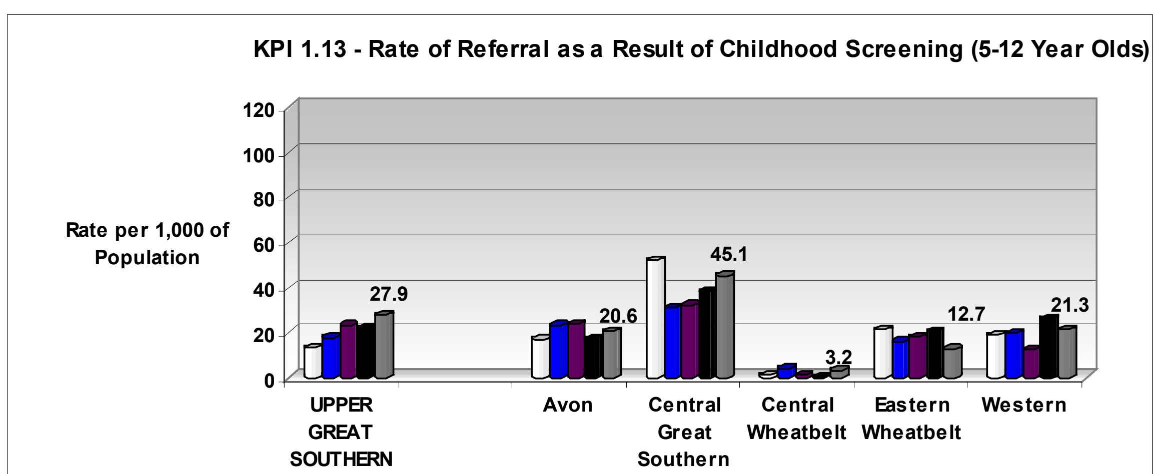
RATE OF REFERRAL AS A RESULT OF CHILDHOOD SCREENING SCHEDULE	KPI 1.13

The community sets a very high priority on ensuring that the health and well being of children are safeguarded. Screening programs designed to detect disability and disease in the early stages of childhood development can prevent long-term disability. These programs not only to restore children to good health when they become ill, but also help to maintain a state of 'wellness' that allows them to develop to their full potential.

The State promotes a program of health monitoring at specific intervals in the period from birth to adolescence in accordance with the National Health and Medical Research Council's (NH&MRC) Minimum Screening Schedule. This program includes appropriate referral for children needing further assessment and treatment. Timely referral can improve health outcomes for children in preventing disease or disability in later years.

This indicator measures the rate of referral after NH&MRC screening, by 0-4 and 5-12 year age groups of the resident child population in the catchment for the health service.





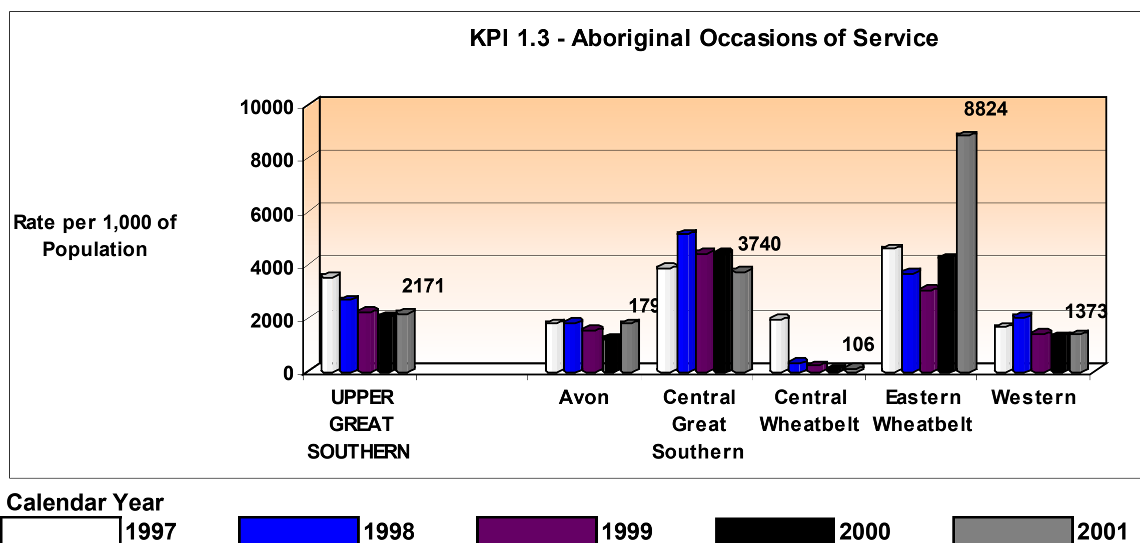
Calendar Year
1997 1998 1999 2000 2001

RATE OF SERVICE PROVISION BY COMMUNITY HEALTH STAFF TO ABORIGINAL PEOPLE	KPI 1.3

The lower level of health experienced by Aboriginal people has been of ongoing concern not just to the local community but to the world at large. National and State policies focus attention and resources on the area in an attempt to bring the health of Aboriginal people to a state that is comparable to the rest of Australia.

It is assumed that with poorer health, Aboriginal people will need to access health services at least as frequently as non-Aboriginal people. However, it must be noted that cultural differences which make them reluctant or unable to access available services and the inconsistent reporting of Aboriginality could mean that the number of services credited to the population may display inconsistent patterns.

A rate in excess of 1,000 occurs when individuals attend more than once in a year.



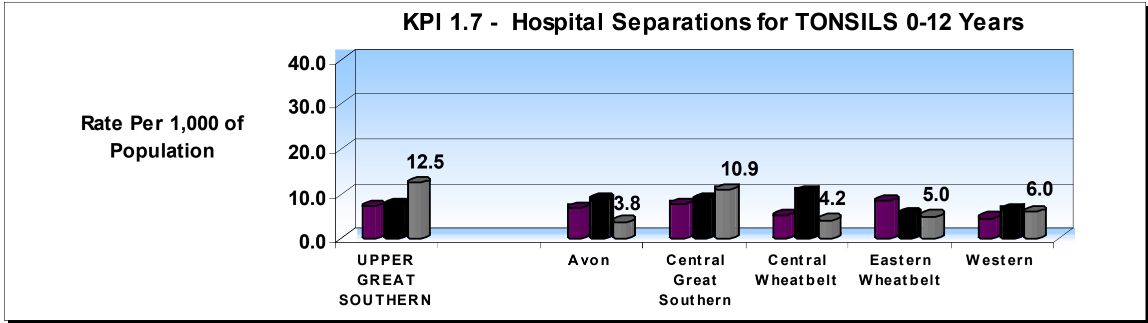
HOSPITAL SEPARATIONS FOR TONSILLECTOMIES & GROMMETS — KPI 1.7

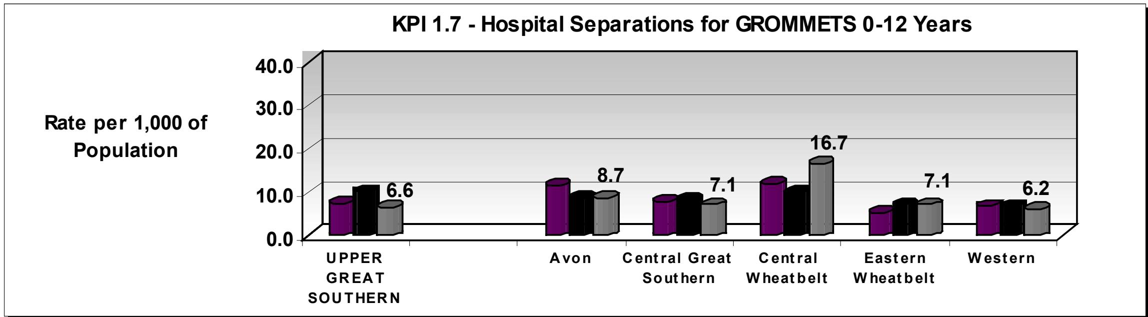
Current evidence suggests many tonsillectomies and grommet insertions are unnecessary and 'watchful waiting' and presurgery testing may be effective in reducing inappropriate surgery.

Successful management and treatment of children with chronic infections by community health staff could be anticipated to reduce the level of surgical intervention. As the success of this intervention program cannot be measured directly, an indirect measure of its success can be estimated by determining the rate of hospitalisation for these procedures.

Comparison of the rate of hospitalisation for tonsillectomies and grommet insertions with other comparable areas can help identify those areas where improvements in primary care could be necessary.

Both of the conditions for which these procedures are performed, are ones which have a high number of patients treated either in hospital or the community. It would be expected that hospital admissions would decrease as performances and quality of service in the many different health areas increases.





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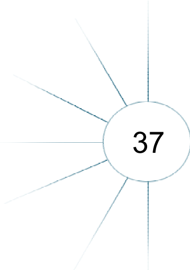


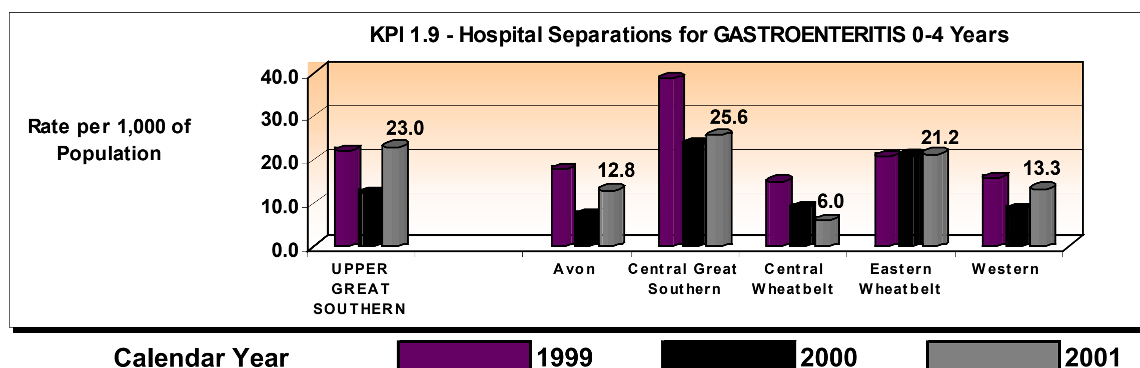
HOSPITAL SEPARATIONS FOR GASTROENTERITIS IN CHILDREN — KPI 1.9

Public health and environmental health programs are aimed at maintaining safe water and sewerage disposal systems, and establishing and enforcing effective food processing and handling practices.

Effective delivery of these programs reduces the rate of transmissible disease like gastroenteritis, of which severe cases can result in hospitalisation.

An indirect measure of the success of community and public health prevention strategies is the rate of hospitalisation due to gastroenteritis. Improved primary management will reflect a decrease in the number of admissions for this condition.

Comparison of the rate of hospitalisation for gastroenteritis with other comparable areas can help identify those areas where improvements in primary care could be necessary.



HOSPITAL SEPARATIONS FOR RESPIRATORY CONDITIONS	KPI 1.10

Respiratory illness is one of the most common reasons for hospital admission in children and young adults. Improved primary health and community health strategies, such as health monitoring, education and risk prevention can assist in reducing the incidence and prevalence of conditions such as acute asthma, acute bronchitis, bronchiolitis and croup.

Improved primary management will reflect a decrease in the number of admissions for these conditions. Comparison of the rate of hospitalisation for respiratory illness with other comparable areas can help identify those areas where improvements in primary care could be necessary.

Bronchiolitis

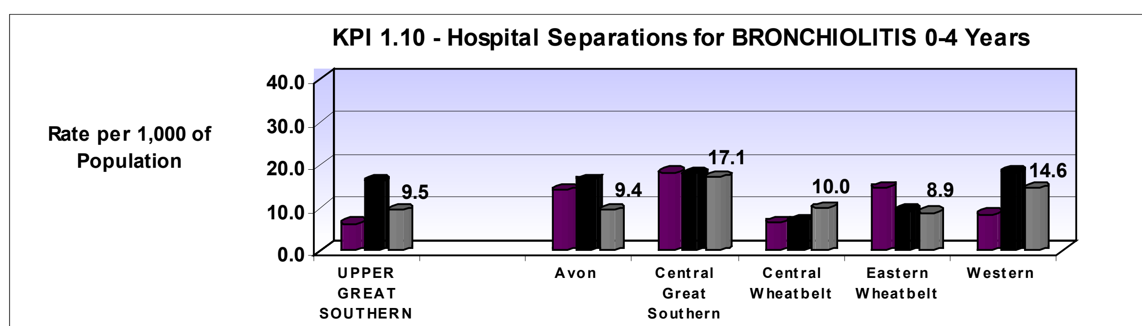
The graph shows individuals aged 0-4. Of those individuals aged 5-12, only 1 was hospitalised this year at a rate of 0.4 per thousand and of those individuals aged 13-18, none were hospitalised this year.

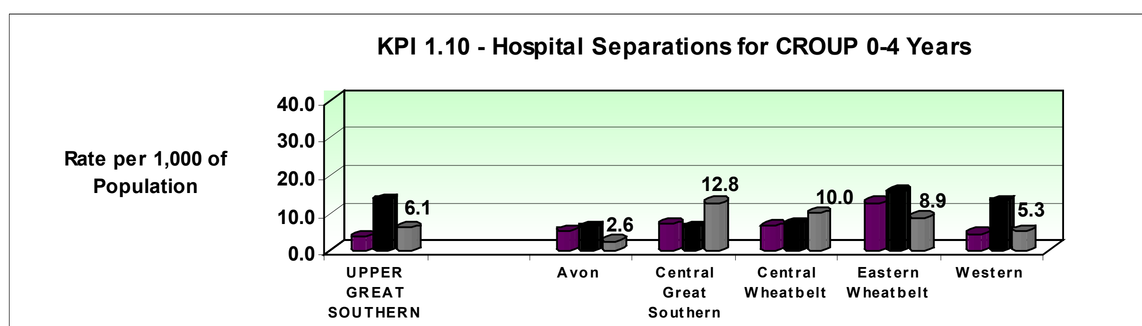
Croup

The graph shows individuals aged 0-4. Of those individuals aged 5-12, only 2 were hospitalised this year, a rate of 0.8 per thousand and of those aged 13-18, none were hospitalised this year.

Acute Bronchitis

Only 3 individuals aged 0-4 at a rate of 2 per thousand were hospitalised this year, with 1 individual being admitted aged 5-12 at a rate of 0.4 per thousand with 1 individual aged 13-18 years being admitted at a rate of 0.7 per thousand.





Calendar Year 1999 2000 2001

HOSPITAL ADMISSIONS FOR ASTHMA	KPI 3.7

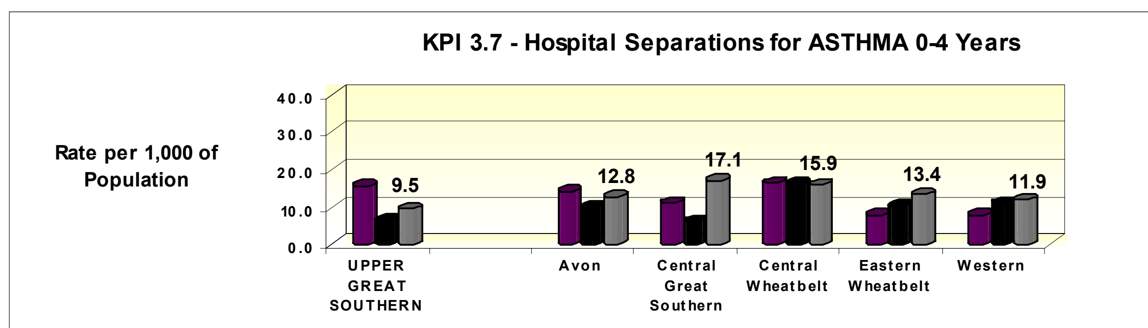
Hospitalisation for Respiratory Conditions like Bronchitis, Croup would generally include patients who have asthma. However, because of its importance as a condition in WA, hospitalisation for acute Asthma also reported separately to provide a more exact view of Asthma hospitalisation.

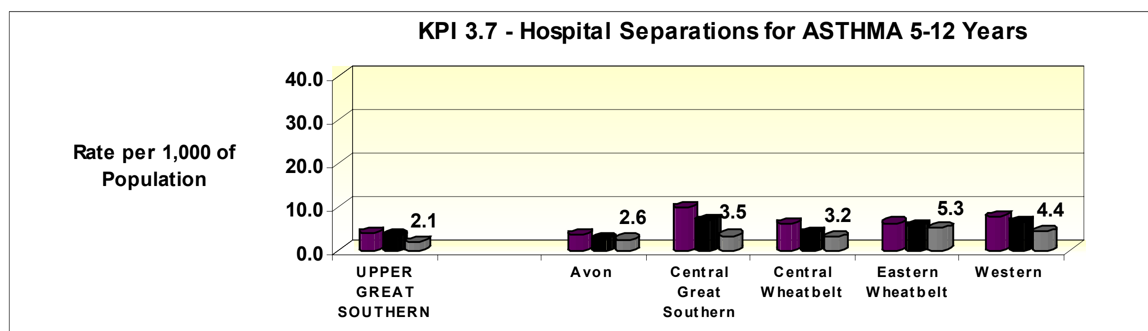
Hospitalisation for Asthma is part of managing this chronic condition. It is being reported in Output 1, instead of Output 3, in order to highlight the focus on measuring the effectiveness of Prevention and Promotion services for the condition.

The number of patients who are admitted to hospital per 1,000 population for treatment of Asthma may be an indication of improved primary care or community health strategies - for example, health education.

It is important to note however, that other factors - such as allergic and climatic responses for example - may influence the number of people hospitalised with Asthma. This condition is one which has a high number of patients treated either in hospital or in the community. It would be expected that hospital admissions for Asthma may decrease as performance and quality of service increases thus indicating an improvement in the quality of life of people with a chronic illness.

The graphs show individuals aged 0-4 and 5-12. 7 individuals aged 13-18 at a rate of 4.7 per thousand were hospitalised this year, with 5 individuals being admitted aged 19-34 at a rate of 1.4 per thousand and 29 individuals aged 35 years and over at a rate of 3 per thousand.





Calendar Year 1999 2000 2001

CLIENT SATISFACTION	KPI 2.2

This indicator is a measurement of how clients have rated the personal care and the way services are provided by hospitals and other health services.

Favourable satisfaction ratings have been associated with favourable health outcomes. In addition, if patients' perception of health service provision are favourable they will be more likely to seek timely help, assistance or treatment.

The Boddington District Hospital reports an overall satisfaction score of 83 for emergency patients and 86 for outpatients for this financial year with standard errors of 2.62 and 2.47 respectively on a confidence interval of 95%. The estimated population of individuals surveyed were 714 Emergency Services patients.

The table below shows the response rate by patient type.

SURVEY QUESTIONNAIRES			
PATIENT TYPE	**NUMBER SENT**	**NUMBER RETURNED**	**RESPONSE RATE**
Emergency Patients – Centrally Administered	52	17	33%
Emergency Patients – Hospital Administered	60	6	10%
Outpatients – Centrally Administered	46	18	39%
Outpatients – Hospital Administered	45	5	11%

EMERGENCY DEPARTMENT WAITING TIMES — KPI 2.18

Access to health services must be provided on the basis of clinical need and if a hospital has large numbers of patients waiting longer than the accepted standards, or transfers a significant percentage of those patients to another facility, it may be that there are "gaps" in its ability to provide emergency services. This may reflect sub-optimal practices, under-resourcing and/or poor recognition of the need for hospital and community services.

In smaller rural communities in Western Australia, medical services are predominantly provided by solo or small group medical practices. In these areas standards for availability and provision of services applicable to larger towns and cities may not be met due to the heavy demand for services and due to periods of time when the GP is not in the town.

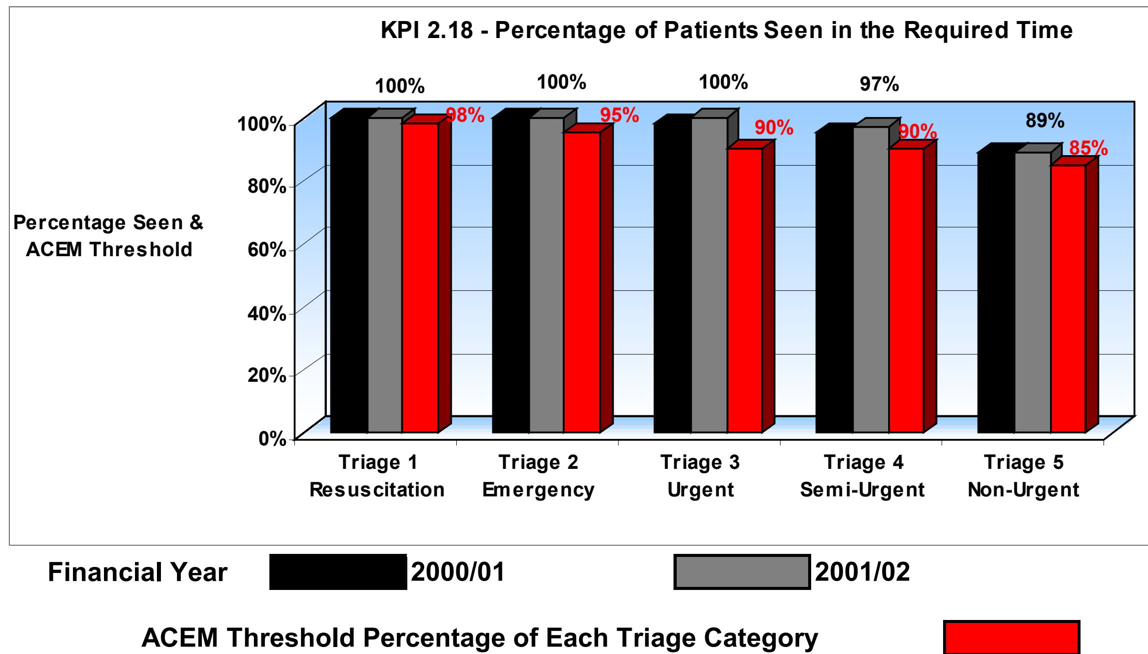
Furthermore, in small health care units, measuring waiting times has either not been regularly performed or the information systems in place collectively pool the data for all health care professionals attending patients in each of the triage categories.

When patients first enter an Emergency Department, they are assessed by nursing staff and allocated a triage code between 1 and 5 that indicates their urgency. This code provides an indication of how quickly patients should be reviewed by medical staff. In rural areas however, where a medical practitioner is not available (eg; GP out of town etc), timely review by Nursing staff should be measured (and clearly documented in the explanatory notes).

Data relevant to this indicator should be linked to data on the transfer of patients to other health care units, for example, larger hospitals and tertiary metropolitan centres.

This indicator assesses what percentage of patients in each triage category were seen within the time periods recommended by the Australasian College for Emergency Medicine (ACEM) – in rural areas, this may include for example, telephone advice given by GP.

TRIAGE CATEGORY	TYPE OF PATIENT	REQUIRED TIME TO BE FIRST SEEN (By Practitioner)	ACEM THRESHOLD FOR PERCENTAGE SEEN WITHIN REQUIRED TIME
Triage 1	Resuscitation	Immediately	98%
Triage 2	Emergency	Within 10 Minutes	95%
Triage 3	Urgent	Within 30 Minutes	90%
Triage 4	Semi-Urgent	Within 60 Minutes	90%
Triage 5	Non-Urgent	Within 120 Minutes	85%

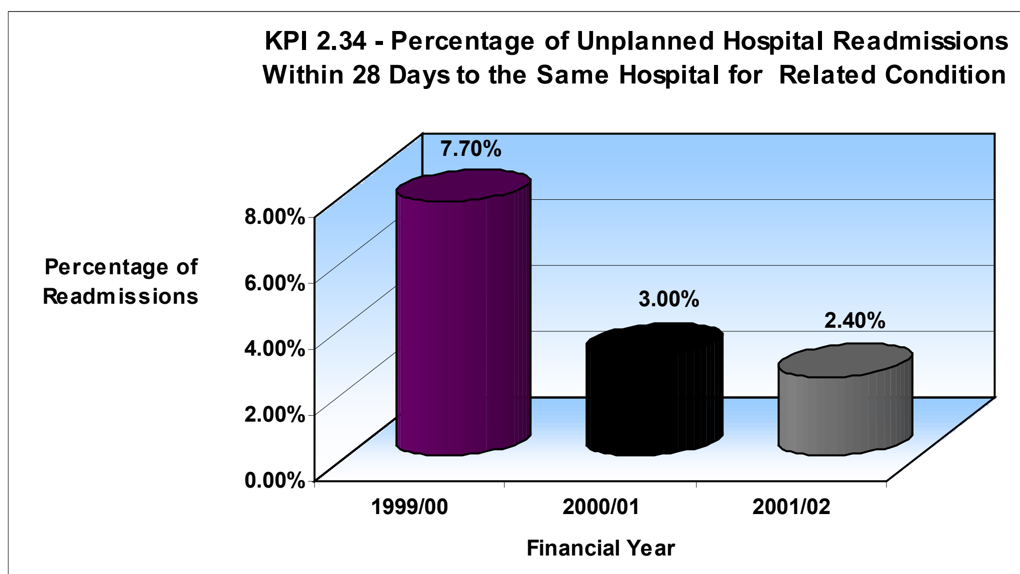


KPI 2.18 - Percentage of Patients Seen in the Required Time
Percentage Seen & ACEM Threshold
100%
80%
60%
40%
20%
0%
100%
98%
100%
95%
100%
90%
97%
90%
89%
85%
Triage 1 Resuscitation
Triage 2 Emergency
Triage 3 Urgent
Triage 4 Semi-Urgent
Triage 5 Non-Urgent
Financial Year
2000/01
2001/02
ACEM Threshold Percentage of Each Triage Category

UNPLANNED HOSPITAL READMISSIONS WITHIN 28 DAYS TO THE SAME HOSPITAL FOR A RELATED CONDITION	KPI 2.34

Good medical and/or surgical intervention 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.

A low unplanned readmission rate suggests that good clinical practice is in operation. Although there are some conditions which 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.

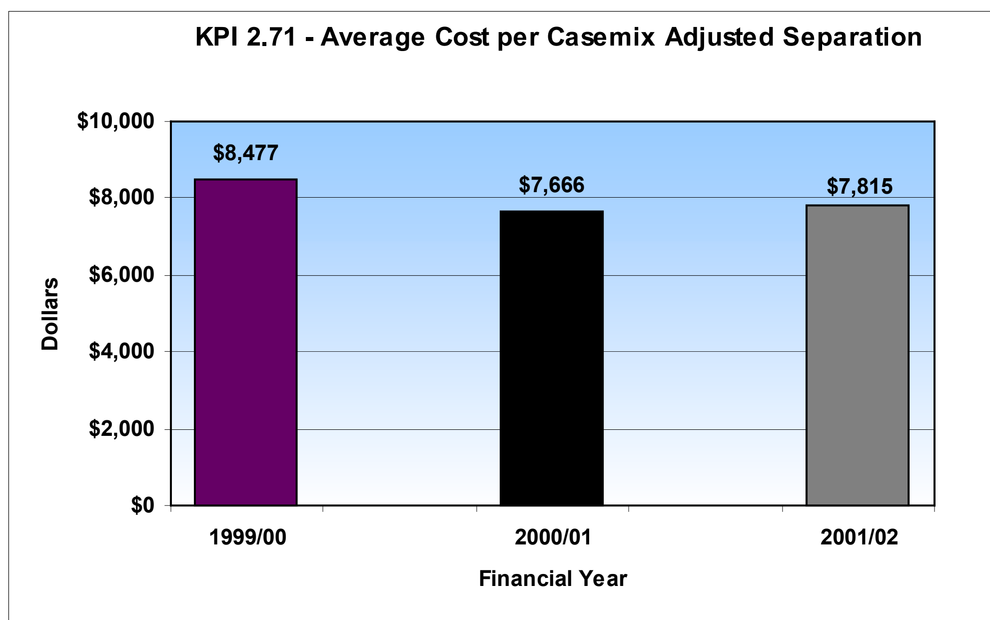


AVERAGE COST PER CASEMIX ADJUSTED SEPARATION FOR RURAL NON-TEACHING HOSPITALS	KPI 2.71

The use of casemix in hospitals is a recognised methodology for adjusting actual activity data to reflect the complexity of service provision and the use of resources. Hence the number of separations in a hospital may be adjusted from an actual number of 50,000 to 60,000 by a casemix index of 1.2 to reflect that very complex services have been provided. In Australia, hospitals utilise the Australian Diagnostic Related Groups (AN-DRGs) Version 4.2 to which cost weights are allocated. In Western Australia, cost weight allocations utilise scaled central episodes.

The use of a casemix index together with expenditure data allows a reasonable comparison between hospitals on the efficient use of resources in providing inpatient services.

This indicator measures the average cost of a casemix-adjusted separation.

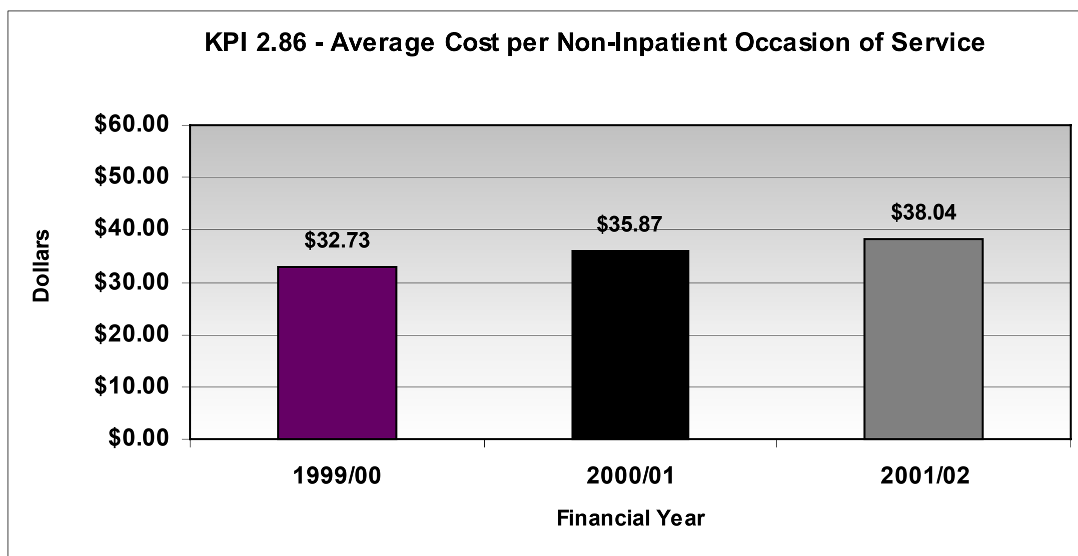


AVERAGE COST PER NON-INPATIENT OCCASION OF SERVICE — KPI 2.86

The effective use of hospital resources can help minimise the overall costs of providing health care or can provide for more patients to be treated for the same cost.

Excessive costs in providing non-inpatient services compared to other hospitals may indicate the inefficient use of resources.

This indicator measures the average cost per non-inpatient occasion of service.



KPI 3.7 : Hospital separations for Asthma

Hospitalisation for acute Asthma is part of managing chronic conditions. The indicator has been moved to Output 1 from Output 3 in order to highlight the focus on measuring the effectiveness of Prevention and Promotion services for the condition.

NUMBER OF INDIVIDUALS WITHIN TARGETED AGE GROUPS ADMITTED AS A NURSING HOME TYPE PATIENT	KPI 3.5
AVERAGE COST PER NURSING HOME TYPE PATIENT BED DAY	KPI 3.10

Number of Individuals Admitted as a Nursing Home Type Patient

Some people with chronic illness and disability who are not able to be cared for at home even with regular respite care and/or with the support services provided by Home and Community Care (HACC), may need long-term residential care. This care is provided in an acute hospital where beds/funds have been allocated for this type of long-term residential care.

A Nursing Home Type Patient (NHTP) is an individual who because of a need for 24-hour medical and nursing supervision and/or services, requires long-term residential care. The aim of the services and care is not only to allow the individual to maintain the greatest possible level of independence at the best possible level of health that can be practically achieved, but that these services and care are provided in a home-like environment.

This indicator measures the extent to which people within the targeted age groups are admitted as a Nursing Home Type Patient. The number of individuals within the targeted age group, i.e. over 70 years for non Aboriginal patients and over 50 years for Aboriginal patients, is measured against the total population in the catchment area. This shows the proportion of the eligible population that receives Nursing Home Type care in the Health Service.

At Boddington District Hospital there were a total of two Nursing Home Type Patients with an average bed day of 2.4.

Average Cost per Nursing Home Type Patient Bed Day

A Nursing Home Type Patient (NHTP) is an individual who because of a need for 24-hour medical and nursing supervision and/or services, requires long-term residential care. This indicator measures the cost per NHTP bed day.

The effective use of hospital resources can help to minimise the overall cost of providing health care or can provide for more patients to be treated at the same cost. Higher costs in providing care for NHTPs compared to providing the same service in another health service may indicate the inefficient use of resources.

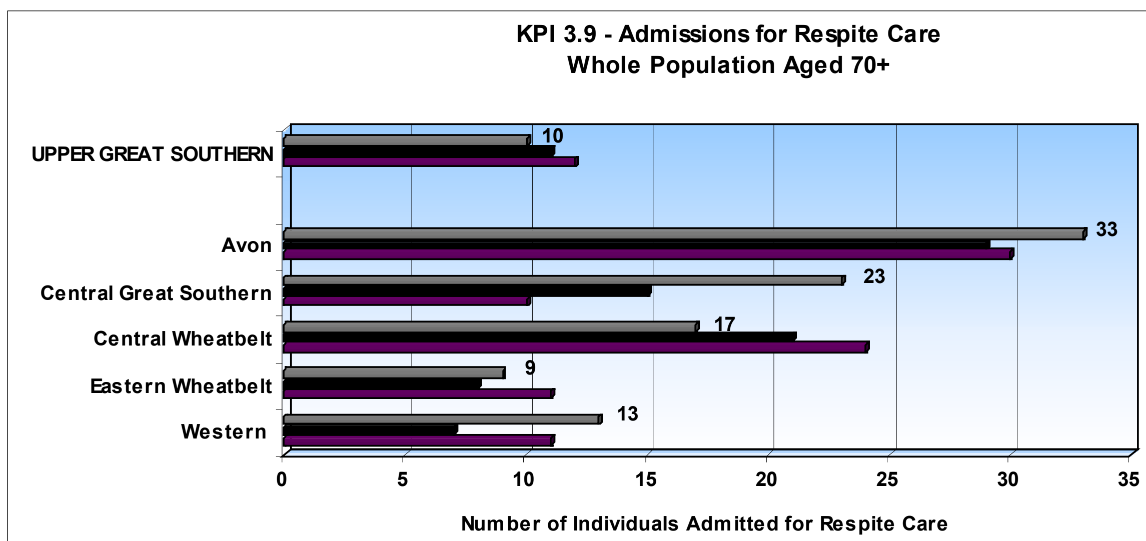
The average cost per Nursing Home Type Patient for Boddington District Hospital Board for the year 2001/02 is $312.68. N.B. This figure is not CPI Adjusted.

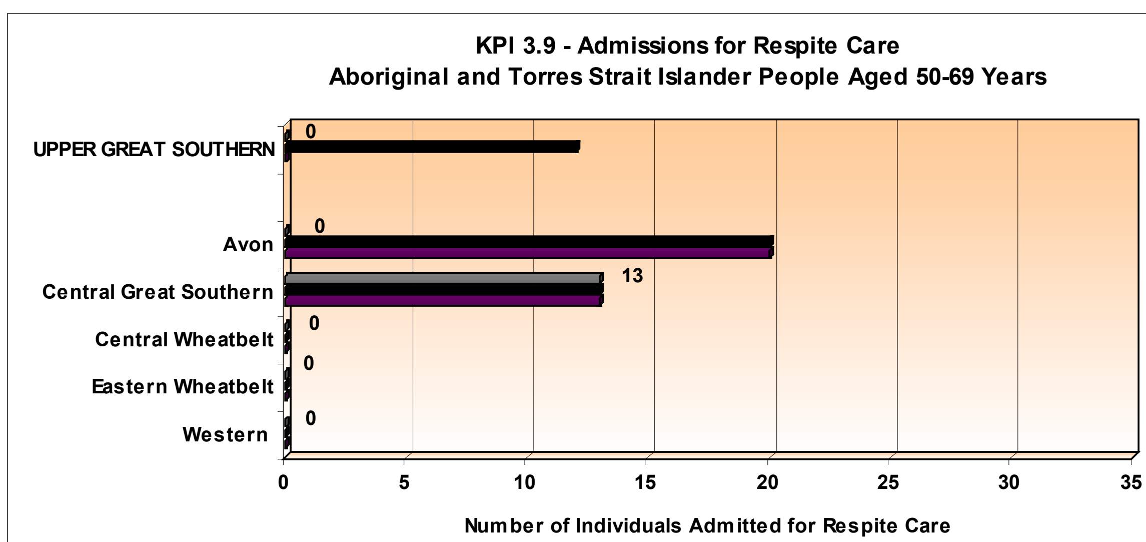
NB: This is the first year this KPI has been reported. Over time, the indicator will be refined so that there is clearer differentiation between the cost of the different care types treated within hospitals.

NUMBER OF INDIVIDUALS WITHIN TARGETED AGE GROUP ADMITTED FOR RESPITE CARE	KPI 3.9

Some people with chronic illness and disability are cared for at home or in a family member's home with the support of local community services including Home & Community Care (HACC). To enable the carer to have a break from the continual carer role, short-term care may be provided in country facilities. This short-term (or Respite) care may be provided on a planned (and sometimes on an emergency) basis for day(s) or night(s) to enable the carer to have a break. Without access to this type of service more people with chronic illness may require permanent Nursing Home Type Care earlier.

The number of individuals within the targeted age group, ie. over 70 years for non Aboriginal patients and between 50 and 69 years for Aboriginal patients, is measured against the total population in the catchment area. This shows the proportion of the eligible population that receives Respite Care in the Health Service.





Financial Year 1999/00 2000/01 2001/02

AUDITOR GENERAL

To the Parliament of Western Australia

BODDINGTON DISTRICT HOSPITAL BOARD
FINANCIAL STATEMENTS FOR THE YEAR ENDED JUNE 30, 2002

Scope
I have audited the accounts and financial statements of the Boddington District Hospital Board for the year ended June 30, 2002 under the provisions of the Financial Administration and Audit Act 1985.

The Board is responsible for keeping proper accounts and maintaining adequate systems of internal control, preparing and presenting the financial statements, and complying with the Act and other relevant written law. The primary responsibility for the detection, investigation and prevention of irregularities rests with the Board.

My audit was performed in accordance with section 79 of the Act to form an opinion based on a reasonable level of assurance. The audit procedures included examining, on a test basis, the controls exercised by the Hospital to ensure financial regularity in accordance with legislative provisions, evidence to provide reasonable assurance that the amounts and other disclosures in the financial statements are free of material misstatement and the evaluation of accounting policies and significant accounting estimates. These procedures have been undertaken to form an opinion as to whether, in all material respects, the financial statements are presented fairly in accordance with Accounting Standards and other mandatory professional reporting requirements in Australia and the Treasurer's Instructions so as to present a view which is consistent with my understanding of the Hospital's financial position, its financial performance and its cash flows.

The audit opinion expressed below has been formed on the above basis.

4th Floor Dumas House 2 Havelock Street West Perth 6005 Western Australia Tel: 08 9222 7500 Fax: 08 9322 5664

Boddington District Hospital Board
Financial Statements for the year ended June 30, 2002

Audit Opinion
In my opinion,

(i) the controls exercised by the Boddington District Hospital Board provide reasonable assurance that the receipt, expenditure and investment of moneys and the acquisition and disposal of property and the incurring of liabilities have been in accordance with legislative provisions; and

(ii) the Statement of Financial Performance, Statement of Financial Position and Statement of Cash Flows and the Notes to and forming part of 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 Hospital at June 30, 2002 and its financial performance and its cash flows for the year then ended.

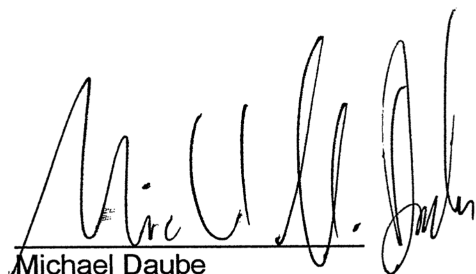
D D R PEARSON
AUDITOR GENERAL
March 7, 2003

4th Floor Dumas House 2 Havelock Street West Perth 6005 Western Australia Tel: 08 9222 7500 Fax: 08 9322 5664

CERTIFICATION OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2002

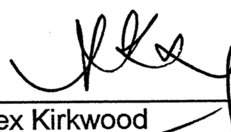
The accompanying financial statements of the Boddington District Hospital Board have been prepared in compliance with the provisions of the *Financial Administration and Audit Act 1985* from proper accounts and records to present fairly the financial transactions for the twelve months ending 30 June 2002 and the financial position as at 30 June 2002.

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.



Michael Daube
Director General of Health
Accountable Authority for
Boddington District
Hospital Board

30 August 2002



Alex Kirkwood
Principal Accounting Officer
Boddington District
Hospital Board

30 August 2002

	Note	2001/02 $	2000/01 $
COST OF SERVICES			
Expenses from Ordinary Activities			
Employee expenses		967,833	843,784
Fees for visiting medical practitioners		32,678	18,579
Superannuation expense		70,506	65,217
Patient support costs	3	131,461	163,909
Patient transport costs		21,568	27,547
Repairs, maintenance and consumable equipment expense		105,496	113,142
Depreciation expense	4	65,577	42,815
Net loss on disposal of non-current assets	5	9,230	0
Capital user charge	6	90,665	0
Other expenses from ordinary activities	7	101,525	106,200
Total cost of services		1,596,539	1,381,193
Revenues from Ordinary Activities			
Patient charges	8	136,285	154,300
Commonwealth grants and contributions	9	84,101	68,391
Donations revenue	10	5,919	200
Interest revenue		1,845	4,949
Other revenues from ordinary activities	11	17,906	21,973
Total revenues from ordinary activities		246,056	249,813
NET COST OF SERVICES		**1,350,483**	**1,131,380**
Revenues from Government			
Output appropriations	12	1,389,579	901,047
Capital appropriations	12	0	77,977
Liabilities assumed by the Treasurer	13	0	63,734
Resources received free of charge	14	19,519	8,000
Total revenues from government		1,409,098	1,050,758
Change in net assets		**58,615**	**(80,622)**
Total changes in equity other than those resulting from transactions with WA State Government as owners		**58,615**	**(80,622)**

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

	Note	2001/02 $	2000/01 $
CURRENT ASSETS			
Cash assets	15	116,289	54,510
Receivables	16	38,875	16,869
Prepayments		592	453
Total current assets		155,756	71,835
NON-CURRENT ASSETS			
Amounts receivable for outputs	17	45,000	0
Property, plant and equipment	18	1,273,962	1,041,905
Total non-current assets		1,318,962	1,041,905
Total assets		**1,474,718**	**1,113,740**
CURRENT LIABILITIES			
Payables		32,645	34,754
Accrued salaries	19	107,692	15,805
Provisions	20	87,720	104,799
Total current liabilities		228,057	155,358
NON-CURRENT LIABILITIES			
Provisions	20	42,303	33,000
Total non-current liabilities		42,303	33,000
Total liabilities		**270,360**	**188,358**
Net Assets		**1,204,358**	**925,382**
EQUITY			
Contributed equity	21	220,361	0
Asset revaluation reserve	22	55,108	55,108
Accumulated surplus / (deficiency)	23	928,889	870,274
Total Equity		**1,204,358**	**925,382**

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

	Note	2001/02 $ Inflows (Outflows)	2000/01 $ Inflows (Outflows)
CASH FLOWS FROM GOVERNMENT			
Output appropriations	24(c)	1,283,914	901,047
Capital contributions (2000/01 appropriation)	24(c)	0	45,942
Net cash provided by Government		1,283,914	946,989
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Supplies and services		(464,549)	(391,001)
Employee costs		(873,197)	(819,286)
GST payments on purchases		(42,414)	(33,323)
Receipts			
Receipts from customers		126,706	158,272
Commonwealth grants and contributions		84,101	68,391
Donations		5,919	200
Interest received		1,845	4,949
GST receipts on sales		3,095	1,912
GST receipts from taxation authority		39,320	31,093
Other receipts		17,884	20,743
Net cash (used in) / provided by operating activities	24(b)	(1,101,290)	(958,050)
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments for purchase of non-current assets	18	(121,209)	(66,444)
Proceeds from sale of non-current assets	5	364	0
Net cash (used in) / provided by investing activities		(120,845)	(66,444)
Net increase / (decrease) in cash held		61,779	(77,505)
Cash assets at the beginning of the reporting period		54,510	132,015
Cash assets at the end of the reporting period	24(a)	116,289	54,510

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

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 Australian 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 Australian 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.

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 valuation.

(b) Output Appropriations

Output 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.

(c) 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. All other transfers have been recognised in the Statement of Financial Performance. Prior to the current reporting period, capital appropriations were recognised as revenue in the Statement of Financial Performance. Capital appropriations which are repayable to the Treasurer are recognised as liabilities.

(d) Acquisition 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.

(e) Valuation of Non-Current Assets

The Health Service has applied the transitional provisions in AASB 1041 "Revaluation of Non-Current Assets" for land and buildings, and as a consequence assets are reported at cost, valuation and fair value. Fair value is the amount for which an asset could be exchanged, between knowledgeable, willing parties in an arm's length transaction.

i) Land and Non-Clinical Buildings

The revaluations of land and non-clinical buildings have been undertaken by the Valuer General's Office in Western Australia, 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 valuations of clinical buildings (eg hospitals) have been carried out at five yearly intervals by the Department of Health in conjunction with the Department of Housing and Works using "as constructed" drawings. 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 weighted average age to determine the net carrying values. Recent valuations on this basis are equivalent to fair value.

(f) Depreciation of Non-current Assets

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

Depreciation is calculated on the reducing balance basis, using rates which are reviewed annually. Useful lives for each class of depreciable assets are:

Buildings	50 years
Computer equipment	5 to 15 years
Furniture and fittings	5 to 50 years
Motor vehicles	4 to 10 years
Other mobile plant	10 to 20 years
Other plant and equipment	4 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.

The Health Service has no contractual obligations under finance leases.

(h) Cash

For the purpose of the Statement of Cash Flows, cash includes cash assets and restricted cash assets. 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) Inventories

Inventories are not valued as Boddington District Hospital Board is on an imprest system from Royal Perth and Narrogin Hospitals.

(k) 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.

(l) Accrued Salaries

Accrued salaries 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.

(m) Provisions

Employee Entitlements

i) Annual and Long Service Leave

The liability for annual leave represents the amount which the Health Service has a present obligation to pay resulting from employees' services up to the reporting date. The liability has been calculated on current remuneration rates and includes related on-costs.

The liability for long service leave is recognised, and is measured as 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 related on-costs, experience of employee departures and periods of service. Expected future payments are discounted using interest rates on national government securities to obtain the estimated future cash outflows.

The methods of measurement of the liabilities are consistent with the requirements of Australian Accounting Standard AAS 30 "Accounting for Employee Entitlements".

ii) 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 complying with the Commonwealth Government's Superannuation Guarantee (Administration) Act 1992. All of these schemes are administered by the Government Employees Superannuation Board (GESB).

The liability for future payments under the Pension Scheme are provided for at reporting date.

The unfunded employer's liability in respect of the pre-transfer benefit for employees who transferred from the Pension Scheme to the Gold State Superannuation Scheme is assumed by the Treasurer. A revenue "Liabilities assumed by the Treasurer" equivalent to the change in this unfunded liability is recognised in the Statement of Financial Performance.

From 1 July 2001 employer contributions were paid to the GESB in respect of the Gold State Superannuation Scheme and West State Superannuation Scheme. Prior to 1 July 2001, the unfunded liability in respect of these schemes was assumed by the Treasurer. An amount equivalent to the employer contributions which would have been paid to the Gold State Superannuation Scheme and the West State Superannuation Scheme if the Health Service had made concurrent employer contributions to those schemes, was included in superannuation expense. This amount was also included in the revenue item "Liabilities assumed by the Treasurer".

The note disclosure required by paragraph 51(e) of AAS30 (being the employer's share of the difference between employees' accrued superannuation benefits and the attributable net market value of plan assets) has not been provided. State scheme deficiencies are recognised by the State in its whole of government reporting. The GESB's records are not structured to provide the information for the Health Service. Accordingly, deriving the information for the Health Service is impractical under current arrangements, and thus any benefits thereof would be exceeded by the cost of obtaining the information.

iii) Deferred Salary Scheme

With the written agreement of the Health Service, an employee may elect to receive, over a four-year period, 80% of the salary they would otherwise be entitled to receive. On completion of the fourth year, an employee will be entitled to 12 months leave and will receive an amount equal to 80% of the salary they were otherwise entitled to in the fourth year of deferment. An employee may withdraw from this scheme prior to completing a four-year period by written notice. The employee will receive a lump sum payment of salary forgone to that time.

The liability for deferred salary scheme represents the amount which the Health Service is obliged to pay to the employees participating in the deferred salary scheme. The liability has been calculated on current remuneration rates in respect of services provided by the employees up to the reporting date and includes related on-costs.

(n) 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.

(o) 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.

(p) Resources Received Free of Charge or For Nominal Value

Resources received free of charge or for nominal value which can be reliably measured are recognised as revenues and as assets or expenses as appropriate at fair value.

(q) Comparative Figures

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

	2001/02 $	2000/01 $
Note 2 Administered trust accounts		
Funds held in these trust accounts are not controlled by the Health Service and are therefore not recognised in the financial statements.		
a) The Health Service administers a trust account for the purpose of holding patients' private moneys.		
A summary of the transactions for this trust account is as follows:		
Opening Balance	17	0
Add Receipts		
- Patient Deposits	554	17
- Interest	0	0
	571	17
Less Payments		
- Patient Withdrawals	0	0
- Interest / Charges	10	0
Closing Balance	561	17
Note 3 Patient support costs		
Medical supplies and services	30,212	32,979
Domestic charges	7,981	11,135
Fuel, light and power	25,563	33,010
Food supplies	33,494	34,237
Purchase of external services	34,212	52,548
	131,461	163,909
Note 4 Depreciation expense		
Buildings	27,946	27,322
Computer equipment and software	6,027	3,901
Furniture and fittings	5,391	2,599
Motor vehicles	14,289	0
Other mobile plant	31	0
Other plant and equipment	11,893	8,993
	65,577	42,815
Note 5 Net profit / (loss) on disposal of non-current assets		
a) **Proceeds from sale of non-current assets**		
Proceeds were received for the sale of non-current assets during the reporting period as follows:		
Received as cash by the Health Service	364	0
Gross proceeds from sale of non-current assets	364	0
b) **Profit / (Loss) on disposal of non-current assets:**		
Computer equipment and software	(2,869)	0
Furniture and fittings	(3,167)	0
Other plant and equipment	(3,194)	0
	(9,230)	0
Note 6 Capital user charge		
	90,665	0

A capital user charge rate of 8% has been set by the Government for 2001/02 and represents the opportunity cost of capital invested in the net assets of the Health Service used in the provision of outputs. 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.

	2001/02 $	2000/01 $
Note 7 Other expenses from ordinary activities		
Workers compensation insurance	19,125	17,089
Other employee expenses	6,010	1,454
Motor vehicle expenses	17,586	11,981
Insurance	8,044	7,307
Communications	13,384	19,308
Printing and stationery	3,746	6,854
Rental of property	0	1,387
Audit fees - external	8,500	8,000
Bad and doubtful debts expense	599	271
Other	24,532	32,549
	101,525	106,200

Note 8 Patient charges

	2001/02 $	2000/01 $
Inpatient charges	126,501	145,473
Outpatient charges	9,784	8,827
	136,285	154,300

Note 9 Commonwealth grants and contributions

	2001/02 $	2000/01 $
Grant for Community Aids & Appliances Program	84,101	68,391
	84,101	68,391

Note 10 Donations revenue

	2001/02 $	2000/01 $
General public contributions	5,919	200
	5,919	200

Note 11 Other revenues from ordinary activities

	2001/02 $	2000/01 $
Rent from properties	0	433
Recoveries	17,460	13,986
Other	446	7,554
	17,906	21,973

Note 12 Government appropriations

	2001/02 $	2000/01 $
Output appropriations (I)	1,389,579	901,047
Capital appropriations (II)	0	77,977
	1,389,579	979,024

(I) Output appropriations are accrual amounts as from 1 July 2001, reflecting the full price paid for outputs purchased by the Government. 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.

(II) Capital appropriations were revenue in 2000/01 (year ended 30 June 2001). From 1 July 2001, capital appropriations, termed Capital Contributions, have been designated as contributions by owners and are credited directly to equity in the Statement of Financial Position.

Note 13 Liabilities assumed by the Treasurer

	2001/02 $	2000/01 $
Superannuation	0	63,734

The change in funding arrangement for the Gold State Superannuation Scheme and the West State Superannuation Scheme has resulted in the decrease in Liabilities
assumed by the Treasurer. (Refer note 1(m) (ii)).

	2001/02 $	2000/01 $
Note 14 Resources received free of charge		
Resources received free of charge has been determined on the basis of the following estimates provided by agencies.		
Office of the Auditor General		
- Audit services	8,500	8,000
Other		
- 3 x electric beds donated by the Ladies Auxillary	11,019	0
	19,519	8,000

Where assets or services have been received free of charge or for nominal consideration, the Health Service recognises revenues equivalent to the fair value of the assets and/or the fair value of those services that can be reliably determined and which would have been purchased if not donated, and those fair values shall be recognised as assets or expenses, as applicable.

Note 15 Cash assets

	2001/02 $	2000/01 $
Cash on hand	400	400
Cash at bank - general	115,078	50,011
Cash at bank - donations	811	4,099
	116,289	54,510

Note 16 Receivables

	2001/02 $	2000/01 $
Patient fee debtors	24,730	12,766
GST receivable	95	191
Other receivables	14,920	4,184
	39,745	17,141
Less: Provision for doubtful debts	(870)	(271)
	38,875	16,869

Note 17 Amounts receivable for outputs

	2001/02 $	2000/01 $
Non-current	45,000	0

This asset represents the non-cash component of output appropriations. It is restricted in that it can only be used for asset replacement or payment of leave liability.

Note 18 Property, plant and equipment

	2001/02 $	2000/01 $
Land		
At cost (i)	28,000	0
At valuation - 30 June 2000 (ii)	29,000	29,000
	57,000	29,000
Buildings		
Clinical:		
At cost (i)	17,720	6,100
Accumulated depreciation	(262)	(2)
	17,458	6,098
At valuation - 30 June 2000 (ii)	3,175,000	3,175,000
Accumulated depreciation	(2,318,103)	(2,291,601)
	856,897	883,399
Non-Clinical:		
At cost (i)	147,000	0
Accumulated depreciation	(1,184)	0
	145,816	0
Computer equipment and software		
At cost	29,134	28,594
Accumulated depreciation	(11,785)	(15,944)
	17,349	12,650
Furniture and fittings		
At cost	87,250	113,058
Accumulated depreciation	(42,520)	(73,362)
	44,730	39,696
Motor vehicles		
At cost	55,856	0
Accumulated depreciation	(14,289)	0
	41,567	0
Other mobile plant		
At cost	1,873	0
Accumulated depreciation	(31)	0
	1,842	0
Other plant and equipment		
At cost	181,683	178,315
Accumulated depreciation	(90,380)	(107,253)
	91,303	71,062
Total of property, plant and equipment	1,273,962	1,041,905

Land and buildings

(i) Land, clinical buildings and non-clinical buildings that are yet to revalued are carried at their cost of acquisition.

(ii) Land, clinical buildings and non-clinical buildings are yet to be revalued at fair value.

Payments for non-current assets

Payments were made for purchases of non-current assets during the reporting period as follows:

	2001/02 $	2000/01 $
Paid as cash by the Health Service from output appropriations	94,899	66,444
Paid as cash by the Health Service from capital contributions	26,310	0
Paid by the Department of Health	175,000	20,390
Gross payments for purchases of non-current assets	296,209	86,834

Note 18 Property, plant and equipment - continued

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.

	2001/02 $
Land	
Carrying amount at start of year	29,000
Additions	28,000
Carrying amount at end of year	57,000
Buildings	
Carrying amount at start of year	889,497
Additions	158,620
Depreciation	(27,946)
Carrying amount at end of year	1,020,171
Computer equipment and software	
Carrying amount at start of year	12,650
Additions	13,959
Disposals	(3,233)
Depreciation	(6,027)
Carrying amount at end of year	17,349
Furniture and fittings	
Carrying amount at start of year	39,696
Additions	13,592
Disposals	(3,167)
Depreciation	(5,391)
Carrying amount at end of year	44,730
Motor vehicles	
Carrying amount at start of year	0
Additions	55,856
Depreciation	(14,289)
Carrying amount at end of year	41,567
Other mobile plant	
Carrying amount at start of year	0
Additions	1,873
Depreciation	(31)
Carrying amount at end of year	1,842
Other plant and equipment	
Carrying amount at start of year	71,062
Additions	35,328
Disposals	(3,194)
Depreciation	(11,893)
Carrying amount at end of year	91,303

Note 19 Accrued salaries

	2001/02 $	2000/01 $
Amounts owing for:	107,692	15,805

Nursing staff
7 days from 24 June to 30 June 2002
(2001: 6 days from 25 June to 30 June 2001)
Non-nursing staff
7 days from 24 June to 30 June 2002
(2001: 5 days from 25 June to 29 June 2001)

Note 20 Provisions

	2001/02 $	2000/01 $
Current liabilities:		
Annual leave	74,318	74,863
Long service leave	13,402	29,935
	87,720	104,799
Non-current liabilities:		
Long service leave	42,303	33,000
	42,303	33,000
Total employee entitlements	130,023	137,799

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

Note 21 Contributed equity

	2001/02 $	2000/01 $
Balance at beginning of the year	0	0
Capital contributions (i)	220,361	0
Balance at end of the year	220,361	0

(i) From 1 July 2001, capital appropriations, termed Capital Contributions, have been designated as contributions by owners and are credited directly to equity in the Statement of Financial Position.

Note 22 Asset revaluation reserve

	2001/02 $	2000/01 $
Balance at beginning of the year	55,108	55,108
Net revaluation increments / (decrements) :		
Land	0	0
Buildings	0	0
Balance at end of the year	55,108	55,108

(i) 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.

Note 23 Accumulated surplus / (deficiency)

	2001/02 $	2000/01 $
Balance at beginning of the year	870,274	950,896
Change in net assets	58,615	(80,622)
Balance at end of the year	928,889	870,274

Note 24 Notes to the statement of cash flows

	2001/02 $	2000/01 $
a) Reconciliation of cash		
Cash assets at the end of the reporting period 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)	116,289	54,510
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)	(1,101,290)	(958,050)
Increase / (decrease) in assets:		
GST receivable	(96)	175
Other receivables	22,701	(2,549)
Prepayments	139	290
Decrease / (increase) in liabilities:		
Doubtful debts provision	(599)	(271)
Payables	2,109	(24,056)
Accrued salaries	(91,887)	(2,352)
Provisions	7,776	(18,373)
Non-cash items:		
Depreciation expense	(65,577)	(42,815)
Profit / (loss) from disposal of non-current assets	(9,230)	0
Capital user charge paid by Department of Health	(90,665)	0
Superannuation liabilities assumed by the Treasurer	0	(63,734)
Resources received free of charge	(19,519)	(8,000)
Other	(4,346)	(11,645)
Net cost of services (Statement of Financial Performance)	(1,350,483)	(1,131,380)
c) Notional cash flows		
Output appropriations as per Statement of Financial Performance	1,389,579	901,047
Capital appropriations as per Statement of Financial Performance	0	77,977
Capital appropriations credited directly to Contributed Equity	220,361	0
	1,609,940	979,023
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	(90,665)	0
Other non cash adjustments to output appropriations	(235,361)	(32,034)
	(326,026)	(32,034)
Output appropriations as per Statement of Cash Flows	1,283,914	946,989

Note 25 Revenue, public and other property written off or presented as gifts

	2001/02 $	2000/01 $
a) Revenue and debts written off.	2,019	262

All of the amounts above were written off under the authority of the Accountable Authority.

Note 26 Remuneration of members of the accountable authority and senior officers

Remuneration of senior officers
The number of Senior Officers (other than members of the Accountable Authority), whose total of fees, salaries, superannuation and other benefits for the reporting period, fall within the following bands are:

	2001/02	2000/01
$60,001 - $70,000	0	1
$80,001 - $90,000	1	0
Total	1	1

	$	$
The total remuneration of senior officers is:	81,739	73,893

The superannuation included here represents the superannuation expense incurred by the Health Service in respect of Senior Officers (other than members of the Accountable Authority).

No Senior Officers presently employed are members of the Pension Scheme:

Note 27 Explanatory statement

a) **Significant variations between actual revenues and expenditures for the financial year and revenues and expenditures for the immediately preceding financial year.**
Details and reasons for significant variations between actual results and the corresponding items of the preceding year are detailed below. Significant variations are considered to be those greater than 10% and $10,000.

	2001/02 $	2000/01 $	Variation $
Expenses from Ordinary Activities			
Employee expenses Increase is mainly due to a voluntary severance scheme payment of $91,000, a community health nurse being previously paid by UGSHS and various pay increases.	967,833	843,784	124,049
Fees for visiting medical practitioners Increase is due to an increase in the public patient / private patient mix and the VMO being on a fixed price contract.	32,678	18,579	14,099
Patient support costs Decrease is mainly due to good management practice focussing on reducing costs in this area.	131,461	163,909	(32,448)
Depreciation expense $307,000 of fixed assets added in the current financial year, resulting in increased depreciation charges.	65,577	42,815	22,762
Capital user charge A capital user charge rate of 8% has been set by the government for 2001/2002 and represents the opportunity cost of capital invested in the net assets of the health service used in the provision of outputs.	90,665	0	90,665
Revenues from Ordinary Activities			
Patient charges Revenue collection decrease is due mainly to a decrease in private patient / public patient mix.	136,285	154,300	(18,015)
Commonwealth grants and contributions An increase in CACP funding for the current financial year.	84,101	68,391	15,710

Note 27 Explanatory statement (Continued)

b) **Significant variations between estimates and actual results for the financial year.**
Section 42 of the Financial Administration and Audit Act requires the Health Service to prepare annual budget estimates. Details and reasons for significant variations between these estimates and actual results are detailed below. Significant variations are considered to be those greater than 10% of budget.

	2001/02 Actual $000's	2001/02 Estimate $000's	Variation $000's
COST OF SERVICES			
Expenses from Ordinary Activities			
Employee expenses Increase is mainly due to a voluntary severance scheme payment of $91,000, a community health nurse being previously paid by UGSHS and various pay increases.	967.8	850.0	117.8
Capital user charge A capital user charge rate of 8% has been set by the government for 2001/2002 and represents the opportunity cost of capital invested in the net assets of the health service used in the provision of outputs.	90.7	0.0	90.7
Revenues from Government			
Output appropriations Unanticipated capital injection funding received included amounts for purchase of house ($175,000) and new bus ($55,856).	1,389.6	1,020.0	369.6
Capital appropriations Capital appropriations are now classified as equity in this current financial year, in the prior year capital appropriations were classified as revenue.	0.0	70.0	(70.0)

Note 28 Commitments for Expenditure

Operating lease commitments:
Commitments in relation to non-cancellable operating leases are payable as follows:

	2001/02 $	2000/01 $
Not later than one year	10,994	10,823
Later than one year, and not later than five years	8,879	19,350
	19,873	30,173

Note 29 Contingent liabilities

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

Note 30 Events occurring after reporting date

The Boddington District Hospital Board will cease to exist as a legal entity as at 1 July 2002. The health service will be amalgamated with other health services to form the WA Country Health Service on 1 July 2002. The amalgamation was gazetted on 28 June 2002.

Note 31 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 32 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.

Note 33 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 2002							
Financial Assets							
Cash assets	0.8%	115.9	0.0	0.0	0.0	0.4	116.3
Receivables		0.0	0.0	0.0	0.0	38.9	38.9
		115.9	0.0	0.0	0.0	39.3	155.2
Financial Liabilities							
Payables		0.0	0.0	0.0	0.0	33.0	33.0
Net financial assets / (liabilities)		115.9	0.0	0.0	0.0	6.3	122.2
As at 30th June 2001							
Financial Assets							
Cash assets	2.4%	54.1	0.0	0.0	0.0	0.4	54.5
Receivables		0.0	0.0	0.0	0.0	16.9	16.9
		54.1	0.0	0.0	0.0	17.3	71.4
Financial Liabilities							
Payables		0.0	0.0	0.0	0.0	34.8	34.8
Net financial assets / (liabilities)		54.1	0.0	0.0	0.0	(17.5)	36.6

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. In respect of other financial assets, the carrying amounts represent the Health Service's maximum exposure to credit risk in relation to those assets.

c) **Net fair values**
The carrying amount 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.

Note 34 Output information

	Prevention & Promotion		Diagnosis & Treatment		Continuing Care		Total	
	2001/02	2000/01	2001/02	2000/01	2001/02	2000/01	2001/02	2000/01
COST OF SERVICES	$000	$000	$000	$000	$000	$000	$000	$000
Expenses from Ordinary Activities								
Employee expenses	178.5	70.6	698.4	694.1	91.0	79.1	967.9	843.8
Fees for visiting medical practitioners	6.0	1.6	23.6	15.3	3.1	1.7	32.7	18.6
Superannuation expense	13.0	5.6	50.9	54.9	6.6	6.2	70.5	66.7
Patient support costs	24.2	13.7	94.9	134.8	12.4	15.4	131.5	163.9
Patient transport costs	4.0	2.3	15.6	22.7	2.0	2.6	21.6	27.5
Repairs, maintenance and consumable equipment expense	18.5	9.5	72.5	93.1	9.4	10.6	100.4	113.2
Depreciation expense	12.1	3.3	47.3	34.4	6.2	3.7	65.6	41.4
Net loss on disposal of non-current assets	1.7	0.0	6.7	0.0	0.8	0.0	9.2	0.0
Capital user charge	16.7	0.0	65.4	0.0	8.5	0.0	90.6	0.0
Other expenses from ordinary activities	19.7	8.9	76.9	87.1	10.0	9.9	106.6	105.9
Total cost of services	294.4	115.5	1,152.2	1,136.6	150.0	129.1	1,596.6	1,381.2
Revenues from Ordinary Activities								
Patient charges	25.1	12.9	98.3	126.9	12.9	14.5	136.3	154.3
Commonwealth grants and contributions	15.5	5.7	60.7	56.3	7.9	6.4	84.1	68.4
Donations revenue	1.1	0.0	4.3	0.2	0.6	0.0	6.0	0.2
Net profit on disposal of non-current assets	0.0	0.0	0.0	0.0	0.0	0.5	0.0	0.5
Interest revenue	0.3	0.4	1.3	4.1	0.2	0.0	1.8	4.9
Other revenues from ordinary activities	3.3	1.8	12.9	18.1	1.7	2.1	17.9	22.0
Total revenues from ordinary activities	45.3	20.9	177.5	205.5	23.3	23.4	246.1	249.8
NET COST OF SERVICES	**249.1**	**94.6**	**974.7**	**931.1**	**126.7**	**105.7**	**1,350.5**	**1,131.4**
Revenues from Government								
Output appropriations	256.3	76.2	1,002.7	739.6	130.6	85.3	1,389.6	901.1
Capital appropriations	0.0	5.8	0.0	65.7	0.0	6.5	0.0	78.0
Liabilities assumed by the Treasurer	0.0	5.5	0.0	52.1	0.0	6.1	0.0	63.7
Resources received free of charge	3.6	0.7	14.1	6.6	1.8	0.7	19.5	8.0
Total revenues from government	259.9	88.2	1,016.8	864.0	132.4	98.6	1,409.1	1,050.8
Change in net assets	**10.8**	**(6.4)**	**42.1**	**(67.1)**	**5.7**	**(7.1)**	**58.6**	**(80.6)**

Note 34 Output information (continued)

Output groups as defined in the budget papers are as follows:

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. Services provided in this output include community health services; screening services; communicable disease management; health regulation and control; and community information and education.

* **Community Health Services**
  Community health services include a range of community based services with the focus on improving the overall health of Western Australians. This is achieved by developing health promotion and prevention activities, supporting early child development, enhancing and ensuring universal access to community services, building capacity and assessing determinants of health as they relate to inequality.

* **Screening Services**
  Screening services assist in the early identification and intervention of disease or conditions that can lead to long-term disability or premature death.

* **Communicable Disease Management**
  Communicable disease management includes a range of strategies which aim to reduce the incidence and effects of communicable diseases.

* **Health Regulation and Control**
  Health regulation and control is used to prevent and/or reduce the risk of disease, injury or premature death in those areas where health risk factors can be managed.

* **Community Information and Education**
  A key strategy to prevent disease, injury or premature death is the provision of community information and education. The purpose of these services is to promote a healthy lifestyle and educate Western Australians about appropriate preventive health behaviours.

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 or outpatient services and services for those people who are admitted to hospitals. Services provided in this output include admitted care, ambulatory care and emergency services.

* **Admitted Care**
  The types of services admitted patients may receive include obstetric care, services to cure illness or provide definitive treatment of injury, surgery, relief of symptoms or a reduction of severity of injury or illness (excluding palliative care), protection against exacerbation and/or complication of an illness and/or injury which could threaten life or normal functions, and diagnostic or therapeutic procedures.

* **Ambulatory Care**
  Ambulatory care includes same day procedures, outpatient attendance, pre-admission assessments and home-based treatment and care. With these services patients do not undergo the formal hospital admission process.

* **Emergency Services**
  Emergency services are provided to treat people with sudden onset of illness or injury of such severity and urgency that they need immediate medical help which is either, not available from their General Practitioner, or for which their General Practitioner has referred them for treatment. Emergency departments provide a range of services from immediate resuscitation to urgent medical advice. An emergency department patient may subsequently undergo a formal admission process and would then be classified as an admitted patient, or be treated and discharged directly from the Emergency department without admission.

Continuing Care
Services provided to improve the quality of life for those who need continuing care. Services provided in this output include home care and residential services.

* **Home Care**
  Community based care and support to maintain and enhance, as far as possible, people's quality of life (eg home nursing, home help, transport service, home maintenance, delivered meals, respite care); care and support for terminally ill people and their families and carers (eg hospice services and palliative care); and care and support for people with long term disabilities to ensure an optimal quality of life.

* **Residential Care**
  Residential aged care services are for people assessed as being no longer able to live in their own home (eg nursing home services, nursing home type services in public hospitals and hostel services).