Bruce Rock Memorial Hospital Board

Annual Report 2001/2002

Department of Health
Government of Western Australia

Statement of Compliance

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 Bruce Rock Memorial 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

Bruce Rock Memorial Hospital
Dunstall St
BRUCE ROCK WA 6418

☎ *(08) 9061 1311*
℻ *(08) 9061 1075*
✉ brock.hospital@health.wa.gov.au

Mission Statement

Our Mission
To provide the Bruce Rock community with effective and efficient health services delivered within available financial, physical and human resources with excellence, care and compassion.

In line with this commitment, the Hospital:

- Recognises the worth, dignity and uniqueness of all individuals regardless of age, sex, race or creed.
- Recognises a responsibility to provide accessible and equitable services that aim to reduce health inequalities and disadvantages.
- Acknowledges a responsibility to encourage total health care, and to promote the concept of quality of life for all individuals.
- Acknowledges a responsibility to be accountable for the efficient and effective use of resources, both human and financial.

Broad Objectives

The objectives of the Bruce Rock Memorial Hospital are:

- To maintain high standards of care with a view towards keeping people as independent as possible within the limitations of each person's physical, emotional and social capacities.
- To adopt educational and support policies that will promote awareness and involvement in the health and wellbeing of the community.
- To use resources effectively and efficiently within the financial constraints of the Hospital.
- To promote and encourage voluntary community participation in the provision of health care services.
- To implement quality improvement policies that ensure high standards of care are maintained by the Hospital.
- To cooperate with other health care agencies and organisations in assessing and dealing with the socioeconomic and environmental issues impacting upon the health status of the Bruce Rock community.

Enabling Legislation

The Bruce Rock Memorial 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 Bruce Rock Memorial 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 Bruce Rock Memorial 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 Bruce Rock Memorial 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*.

Following an audit by the Office of the Public Sector Standards Commissioner in March 2000, I have put in place procedures designed to ensure such compliance and have undertaken appropriate internal processes to satisfy myself the statement made above is correct.

Such processes include:

- The updating of health policy and procedure manuals.
- Coordinating regular managerial meetings to ensure best practice and compliance is achieved at all times.

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 Bruce Rock Memorial 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 Bruce Rock Memorial 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	–	–	–
Media Advertising Organisations	–	–	–
TOTAL	**$0.00**	**$0.00**	**$0.00**

Freedom of Information Act 1992

The Bruce Rock Memorial Hospital received and dealt with four 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 the:

Health Service Manager
Bruce Rock Memorial Hospital
Dunstall St
BRUCE ROCK WA 6418

☎ *(08) 9061 1311*

Bruce Rock Memorial Hospital

Key Operations and Achievements

- Taking part in the Australian Council on HealthCare Standards Evaluation and Quality Improvement Program survey.
- Receiving support from hospital volunteers.
- Conducting a maintenance program.
- Progress towards achieving Multi Purpose Service status.
- Hosting the Trauma Weekend.
- Conducting a benchmarking exercise.

Taking Part in the ACHS EQuIP Survey

The Bruce Rock Memorial Hospital took part in the ACHS EQuIP survey in April 2002 and received a further four years accreditation. The Hospital's current accreditation status will expire in June 2006.

Receiving Support from Hospital Volunteers

The efforts of hospital volunteers, including board members, Hospital Auxiliary, St John Ambulance officers, Meals on Wheels drivers and other volunteers, have been greatly appreciated by both staff and patients at the Hospital. The volunteers have made a significant contribution towards providing health services to the local community during 2001/2002.

Conducting a Maintenance Program

An extensive maintenance program was conducted during 2001/2002, which included painting the interior and exterior of the Hospital.

Multi Purpose Service Scheme

Focus groups representing different sections of the community are meeting to provide input into a new MPS agreement, with the hope the Bruce Rock Memorial Hospital will become a MPS site in early 2002/2003.

A needs survey was also circulated to all homes in the Bruce Rock Shire as part of the process of seeking MPS status. The aim was to obtain information from the local community regarding ways of improving Hospital activities.

Hosting the Trauma Weekend

The Bruce Rock Memorial Hospital hosted the annual Trauma Weekend where trainee doctors participate in a large-scale mock trauma exercise. The activity was held over a weekend in March. The experience is considered to be a valuable training exercise for those involved.

Conducting a Benchmarking Exercise

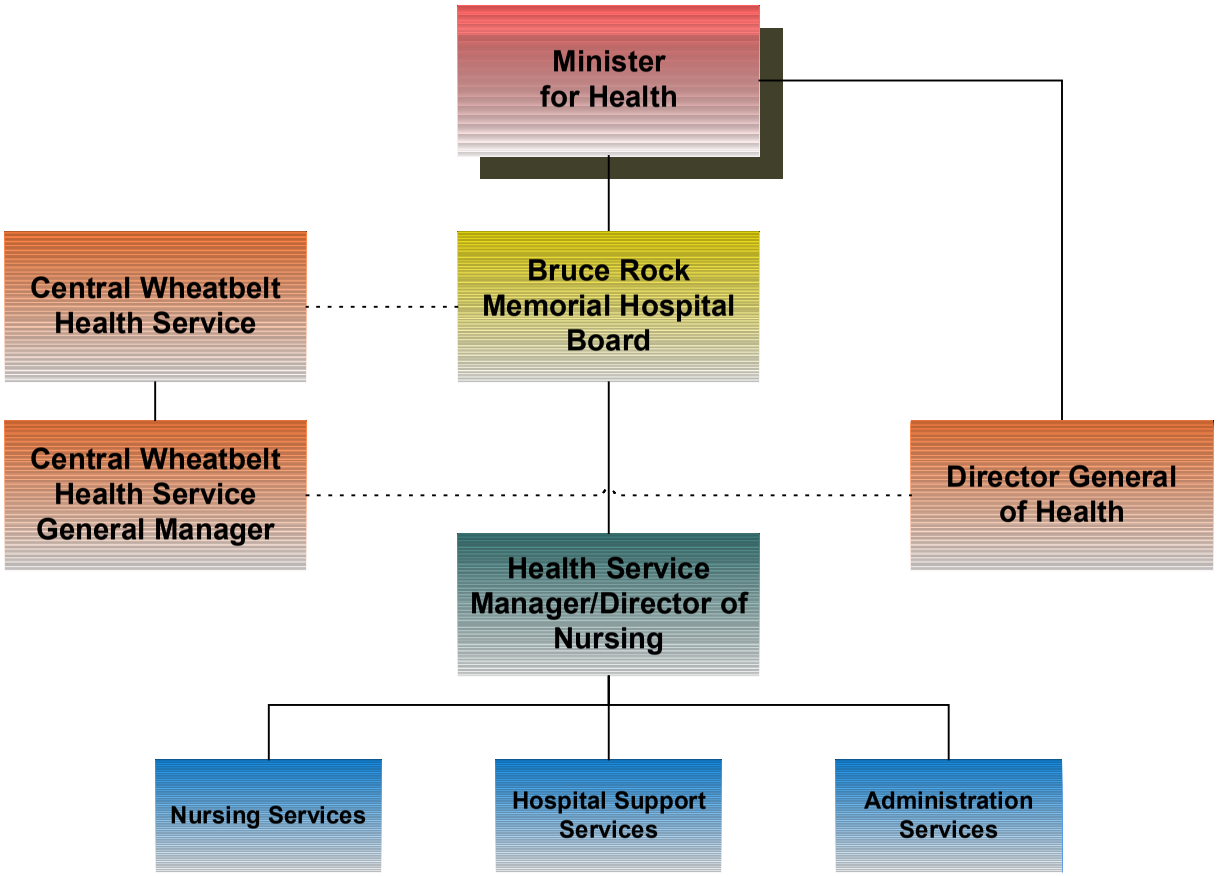
A benchmarking exercise was conducted during 2001/2002 to ensure the Hospital's support service areas were meeting industry standards. It was confirmed the Hospital was performing very close to the benchmark as a result.

Major Capital Projects

The Bruce Rock Memorial Hospital did not complete or make progress on any major capital projects during 2001/2002.

Management Structure

Organisational Chart



Accountable Authority

The Bruce Rock Memorial Hospital Board represents the Accountable Authority for the Hospital. The board is made up of community-elected representatives each appointed for a three-year term. The members of the board are as follows:

Name	Position	Term of Office Expires
Murray Arnold	Chairperson	30 June 2002
Cecily Aurisch	Member	30 June 2002
Kingsley Barber	Member	30 June 2002
Bruce Brown	Member	30 June 2002
Barrie Butler	Member	30 June 2002
Robyn Goldsmith	Member	30 June 2002
Janis Kilminster	Member	30 June 2002
Phillip Negri	Member	30 June 2002
Graeme Shearing	Member	30 June 2002

Note: The Governor in Executive Council approved the amalgamation of several hospital boards including the Bruce Rock Memorial Hospital 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 Bruce Rock Memorial Hospital Board and their areas of responsibility are listed below:

Area of Responsibility	Title	Name	Basis of Appointment
District and Corporate Management	General Manager	Graeme Leverington	Permanent
Health Service Management	Health Service Manager/Director of Nursing	Anne Dunlop	Permanent

Pecuniary Interests

Members of the Bruce Rock Memorial Hospital Board and senior officers at the Hospital have declared no pecuniary interests other than those reported in the Financial Statements section of this report.

Demography

The Bruce Rock Memorial Hospital delivers services to communities covered by the following local authority:

- Bruce Rock Shire

The following table shows population figures for the local authority covered by the Hospital:

LOCAL AUTHORITY	Population as at 1996*	Population as at 2001*	Projected Population as at 2006*
Bruce Rock Shire	1174	1126	1319

*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*.

Available Services

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

Direct Patient Services
Accident and Emergency
Acute Medical
Aged Care Accommodation
Extended Care Services
Mental Health Services
Minor Surgical
Paediatric
Postnatal Care

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

Community Services
Child Development
Home Care
Meals on Wheels
Primary Health Care

Other Support Services
Health Promotion
Hotel Services
Medical Records

Specialist Services
None

Other Services
None

Disability Services

Our Policy
The Bruce Rock Memorial 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.

- Extended Care services were expanded through methods such as increasing available staffing hours to meet the demands of the growing aged population in the district.

Outcome 2: Access to buildings and facilities is improved.

- The therapy consulting area was relocated to allow easier access for people with disabilities.

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

- Hospital facilities and services are advertised in local newspapers and through pamphlets using clear and concise language.
- Additional Hospital information has been made available in a variety of accessible formats, such as on posters, message boards and in local shire newsletters.

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

- Resources such as videos, and access to check lists to determine specific training needs were made available to all staff.

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

- A needs survey was circulated to all homes in the Bruce Rock Shire as part of the process of seeking Multi Purpose Service status. The aim was to obtain information from the local community regarding ways of improving Hospital activities.

Future Direction
The Bruce Rock Memorial 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 Bruce Rock Memorial 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:

- Although the Hospital does not offer an on-site interpreter service, access to an interpreter is available via phone link 24 hours a day.
- Staff and community members who speak a language other than English are used as interpreters where it is appropriate to do so.

Youth Services

Our Policy
The Bruce Rock Memorial 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
New health initiatives are being developed with community consultation — particularly in relation to youth — as a result of the Hospital's progression towards attaining Multi Purpose Service status. These initiatives are as follows:

- Early detection and treatment of speech and/or language disabilities in the paediatric population.
- Delivery of the Kidsafe Program. Kidsafe — otherwise known as the Child Accident Prevention Foundation of Australia — initiates programs aimed at raising public awareness of child safety issues and injury prevention.
- Organising HomeSafe parties. These parties use the successful home party plan model — along the lines of tupperware parties — to provide people with simple strategies for dealing with hazards in the home that frequently lead to injuries, accidents or sometimes death.
- Working cooperatively with youth organisations and police to provide workshops and activities aimed at improving the practical and social skills of young people. These workshops have covered topics such as mental health, healthy eating, drug and alcohol awareness, smoking effects, exercise, sexual health and youth relationships.
- Running driver awareness programs for young people.
- Improving the Look After Your Mate Program to educate participants on first aid, and to raise young people's awareness of the consequences of binge drinking.

The Bruce Rock Memorial Hospital also provides a broad range of services incorporating youth into wider community programs. Some examples of this include running a broad range of promotional health activities, including quit smoking and healthy eating programs.

Employee Profile

The following table shows the number of full-time equivalent staff employed by the Bruce Rock Memorial Hospital:

CATEGORY	1999/2000	2000/2001	2001/2002
Nursing Services	14.41	12.39	13.75
Administration and Clerical*	3.63	3.14	2.75
Medical Support*	–	0.01	0.01
Hotel Services*	9.73	8.40	9.23
Maintenance	–	–	–
Medical (salaried)	–	–	–
Other	–	–	–
TOTAL	**27.77**	**23.94**	**25.74**

*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.

Recruitment Practices

All recruitment activities undertaken by the Bruce Rock Memorial Hospital during 2001/2002 were conducted according to the *Department of Health Recruitment and Selection Manual*, and were implemented according to EEO principles.

Staff Development

The Bruce Rock Memorial Hospital has implemented a Staff Training Policy that ensures all employees have equal access to appropriate training and development services, relevant to the role and function of the organisation.

Staff development and education programs were provided during 2001/2002, and employees were given the opportunity to attend programs at metropolitan and regional hospitals.

Industrial Relations Issues

The Bruce Rock Memorial Hospital is guided by the *Department of Health Industrial Relations Policy Manual*, and the relevant awards. There was no industrial action taken that impacted upon patient care during 2001/2002.

Workers' Compensation and Rehabilitation

The following table shows the number of workers' compensation claims made through the Bruce Rock Memorial Hospital:

CATEGORY	1999/2000	2000/2001	2001/2002
Nursing Services	0	0	0
Administration and Clerical*	1	0	0
Medical Support*	0	0	0
Hotel Services*	0	0	1
Maintenance	0	0	0
Medical (salaried)	0	0	0
Other	0	0	0
TOTAL	**1**	**0**	**1**

*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.

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 Bruce Rock Memorial 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.

- Hospital staff have elected EEO contact officers. The main role of these officers is to ensure Department of Health guidelines are adhered to in the workplace, and EEO policies are updated when necessary. The officers also act as a contact for staff who wish to raise queries or make grievances.

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

- A *Code of Conduct* document has been prepared outlining the level of behaviour expected of all Hospital staff. The document follows the guidelines regarding discipline for unacceptable behaviour covered by the *Public Sector Standards in Human Resource Management*.

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

- The Hospital is committed to equitable, open, merit-based processes to ensure the most suitable applicants are selected and recruited to the workforce. A commitment also exists to meet the principles and standards of the *Public Sector Standards in Human Resource Management*. All employees are afforded equal opportunities to secure promotion and advancement in their area of employment through performance management processes.

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 Bruce Rock Memorial Hospital has been able to meet these goals:

Plan or Process	Level of Achievement
EEO Management Plan	Implemented
Organisational plans reflect EEO	In progress
Policies and procedures encompass EEO requirements	In progress
Established EEO contact officers	Implemented
Training and staff awareness programs	In progress
Diversity	In progress

Marketing

The Bruce Rock Memorial Hospital continues to use the local monthly magazine, *Rock Review*, to raise public awareness of health issues, and to advise the public of health care services.

The Hospital has no expenditure to report on marketing and promotional activities during 2001/2002.

Publications

Annual Reports, health review statistics and emergency plans are made accessible to the general public. Copies of these documents are available at the Bruce Rock Shire Council offices, police station and the Hospital.

Details of health-related activities and events run by the Hospital are published in the local monthly newsletter, *Rock Review*, on a regular basis.

Research and Development

The Bruce Rock Memorial Hospital carried out no major research and development programs during 2001/2002.

Evaluations

The Bruce Rock Memorial Hospital carried out no major evaluations during 2001/2002.

Risk Management

Our Policy

The Bruce Rock Memorial 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

Risk management strategies evolved in the following ways during 2001/2002:

- Health Service Managers from the Central Wheatbelt region attended a workshop conducted by Stanton Partners — an internal audit and assurance service provider — under the auspices of the Department of Health. Managers met as a group following the workshop to discuss adopting an action plan for the region, and to assume individual responsibilities for sections of risk management.
- The District Risk Management Plan was accepted at all sites within the Central Wheatbelt region, including the Bruce Rock Memorial Hospital, during 2001/2002. The plan had been developed following two workshops conducted by RiskCover during 1999/2000 that were attended by all Health Service Managers from the Central Wheatbelt region.

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 Bruce Rock Memorial 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. The Bruce Rock Memorial Hospital Board oversees the operation of internal audit functions, and ensures management addresses any findings arising from internal and external audit reports.

Audit findings identified during 2001/2002 have been disclosed under the category of moderate shortcomings.

Waste Paper Recycling

The Bruce Rock Memorial Hospital does not produce enough waste paper or other recyclable products to make it an economical or viable option to transport the material to Perth for recycling. The remote rural location of the Hospital also impedes recycling practices.

No records were kept of the amount of waste paper recycled during 2001/2002 as a result.

The Hospital uses recycled products where possible and practical.

Pricing Policy

The Bruce Rock Memorial 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.

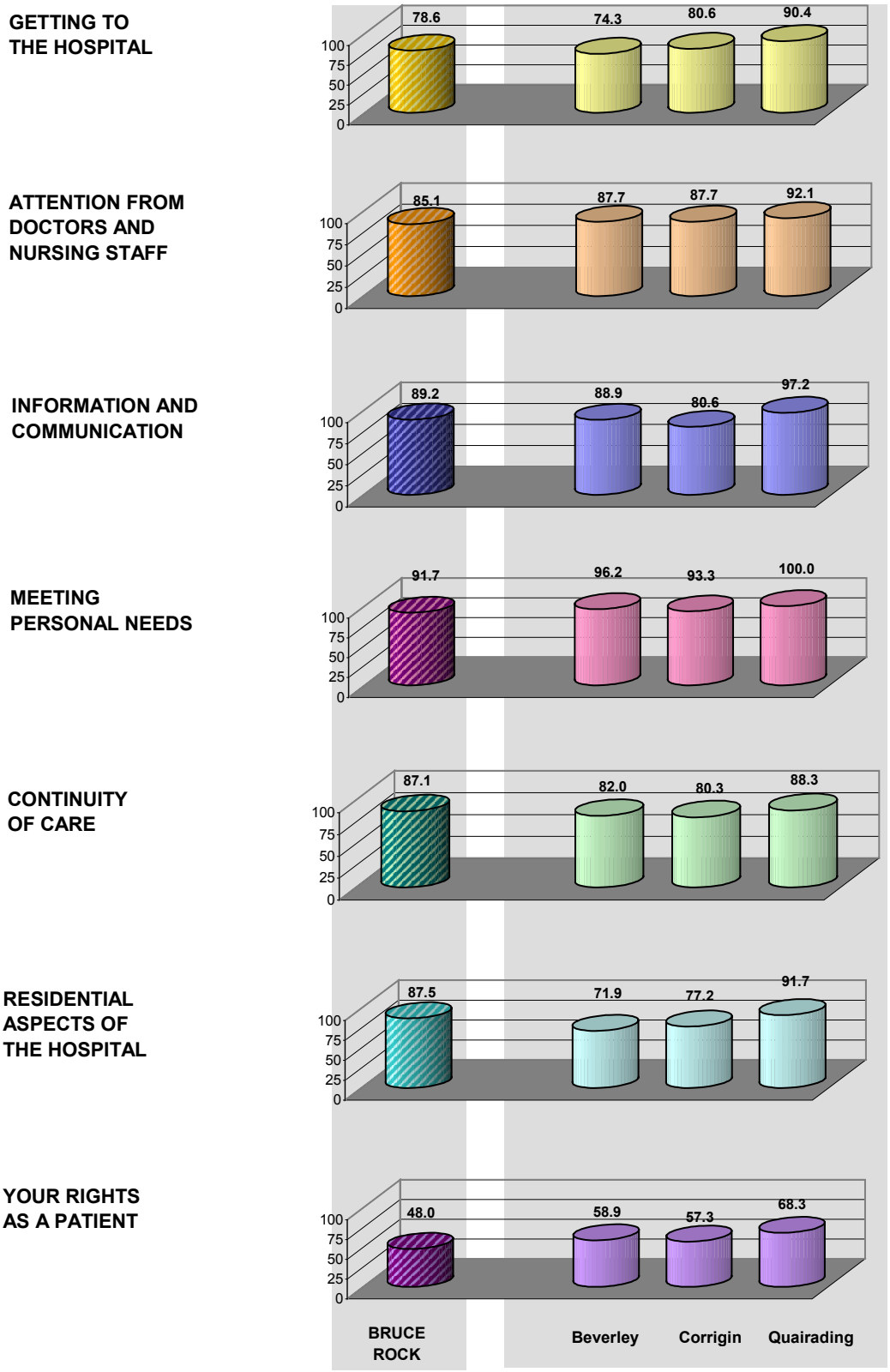
No fees are raised against registered public and private outpatients of the Hospital.

Client Satisfaction Surveys

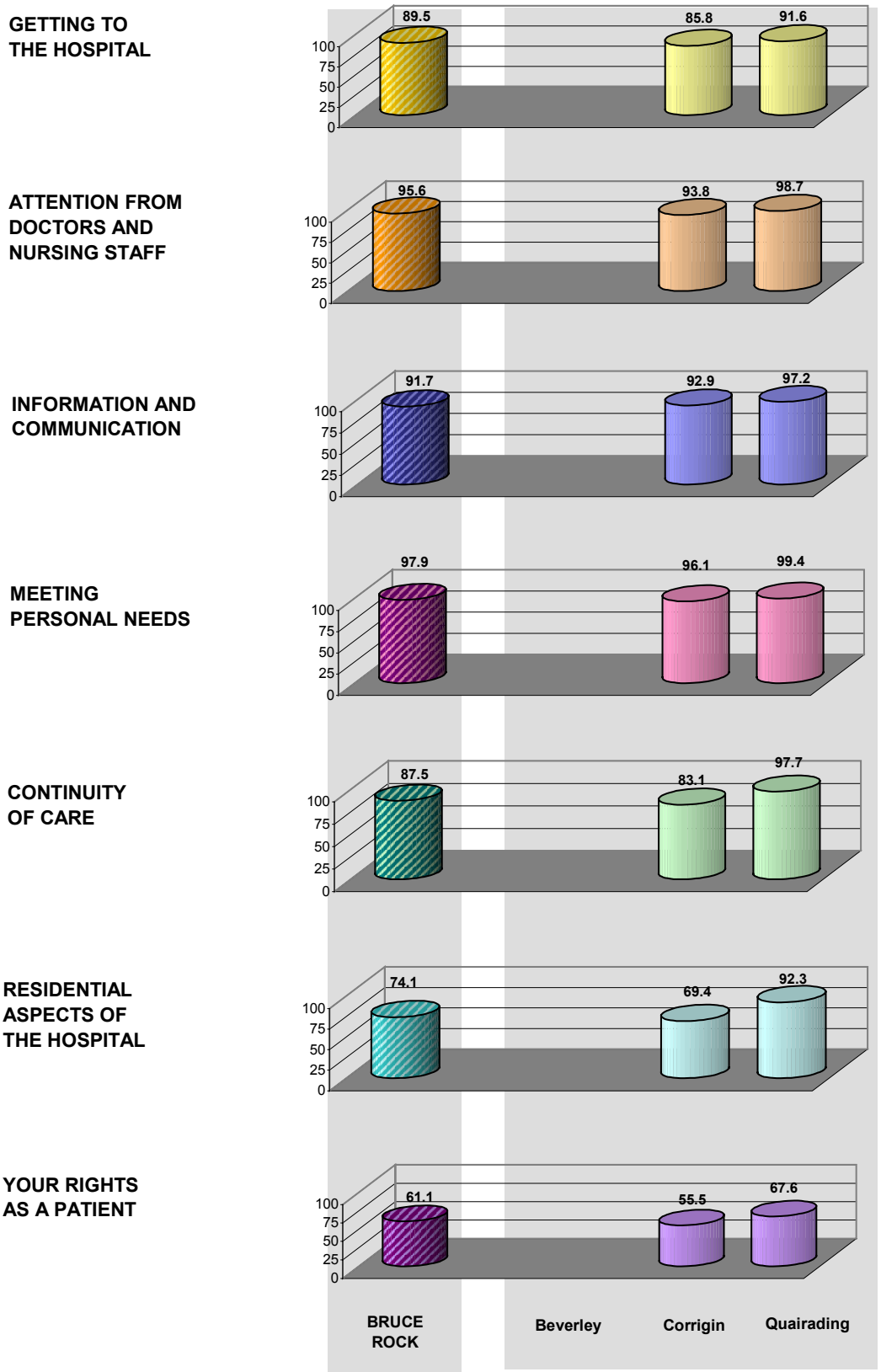
Favourable satisfaction ratings have been associated with favourable health outcomes. In addition, if a patient's perception of health service provision is favourable they will be more likely to seek timely help, assistance or treatment. The Department of Health has produced Client Satisfaction Survey 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 46) of this report.

KPI 2.2: EMERGENCY PATIENTS — RURAL



KPI 2.2: OUTPATIENTS — RURAL



AUDITOR GENERAL

To the Parliament of Western Australia

BRUCE ROCK MEMORIAL HOSPITAL BOARD
PERFORMANCE INDICATORS FOR THE YEAR ENDED JUNE 30, 2002

Scope

I have audited the key effectiveness and efficiency performance indicators of the Bruce Rock Memorial 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 Bruce Rock Memorial 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 Bruce Rock Memorial 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 21, 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

BRUCE ROCK MEMORIAL 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 Bruce Rock Memorial Hospital Board for the year ended June 30, 2002 by February 28, 2003.

Whilst the Minister for Health granted the Bruce Rock Memorial 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.

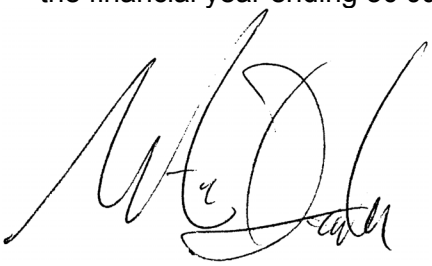
It is anticipated that the opinions will be issued by March 31, 2003.

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

BRUCE ROCK MEMORIAL 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 Bruce Rock Memorial Hospital Board and fairly represent the performance of the Health Service 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.*

MEDIAN WAITING TIMES FOR COMMUNITY AND ALLIED HEALTH SERVICES (HOSPITAL AND COMMUNITY BASED)	KPI 1.1

Timely and easy access to health services is effective in reducing the incidence of preventable diseases and premature death by providing clinically appropriate treatment of illness and injury.

Access to health services are provided on the basis of clinical need but situations where clients are waiting longer than the average may reflect sub-optimal practices or under-resourcing within the organisation.

This indicator measures the median (middlemost) waiting time in weeks that clients waited from the date of referral or initial presentation for their first occasion of service. It must be noted that the time waiting for first available appointment in each of the specialties may differ. This indicator highlights different waiting times for different specialities.

Availability of practitioners for rural Health Services vary significantly from year to year and are in some situations available for some parts of the year and not able to be provided continuously; all of which make comparisons from one year to another of limited value.

Different Health Services for which peer comparisons are appropriate for other Output 1 Indicators operate such a different range and mix of clinics that comparisons here are of limited value.

There are no waiting lists for allied health services in the Central Wheatbelt.

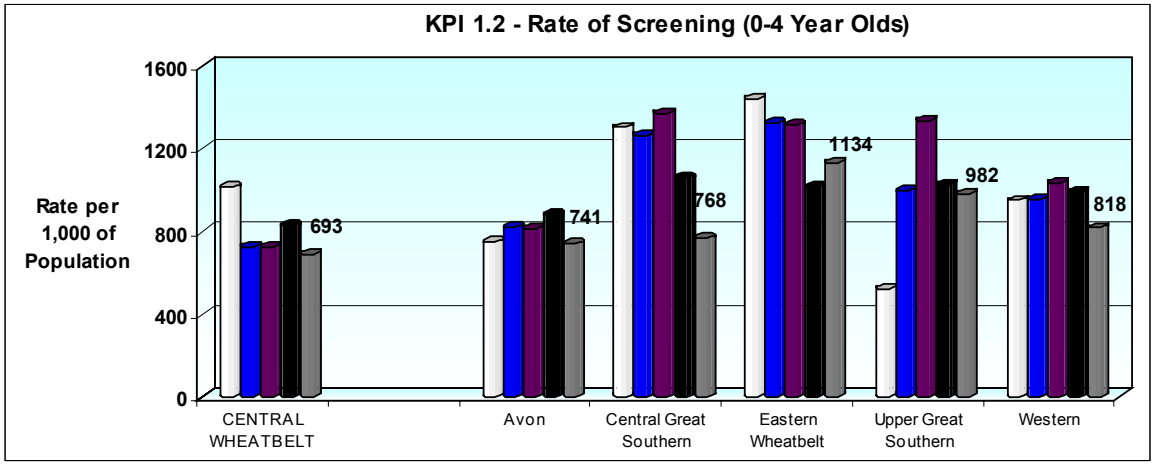
RATE OF SCREENING IN CHILDREN — KPI 1.2

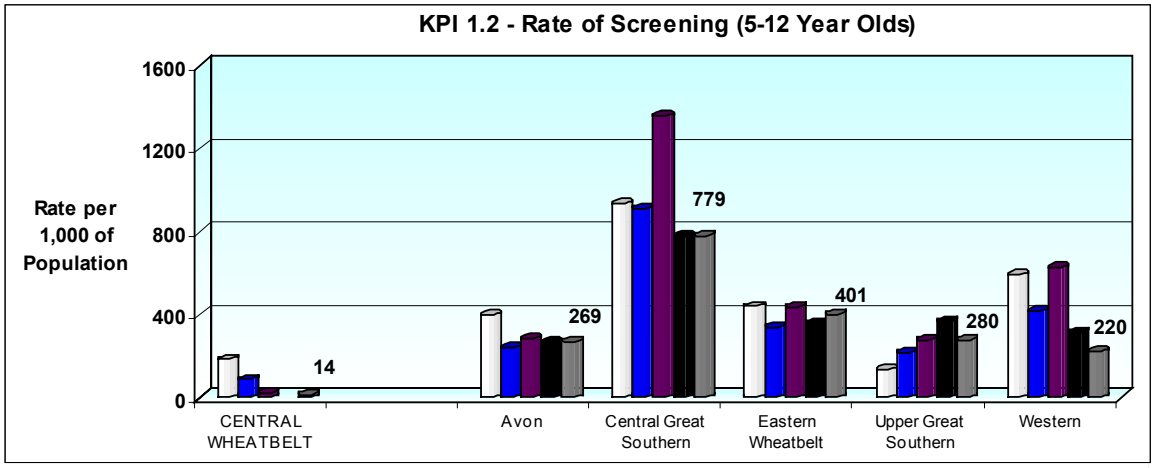
The community sets a very high priority on ensuring that the health and well being of children are safeguarded. Screening programs designed to detect disability and disease in the early stages of childhood development can prevent long-term disability. These programs not only restore children to good 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.

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





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.

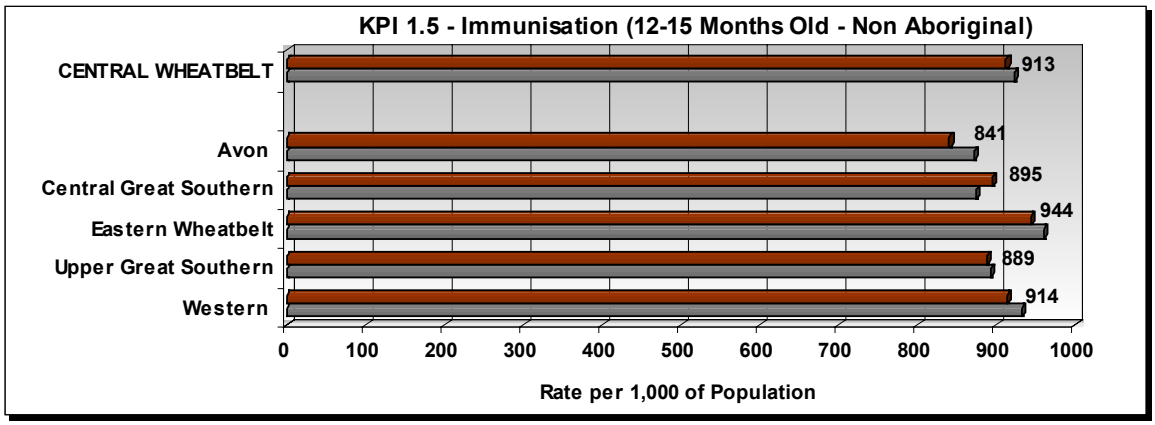
Without access to immunisation for children the consequences of any illness or disability are likely to be more disabling and more likely to contribute to a premature death.

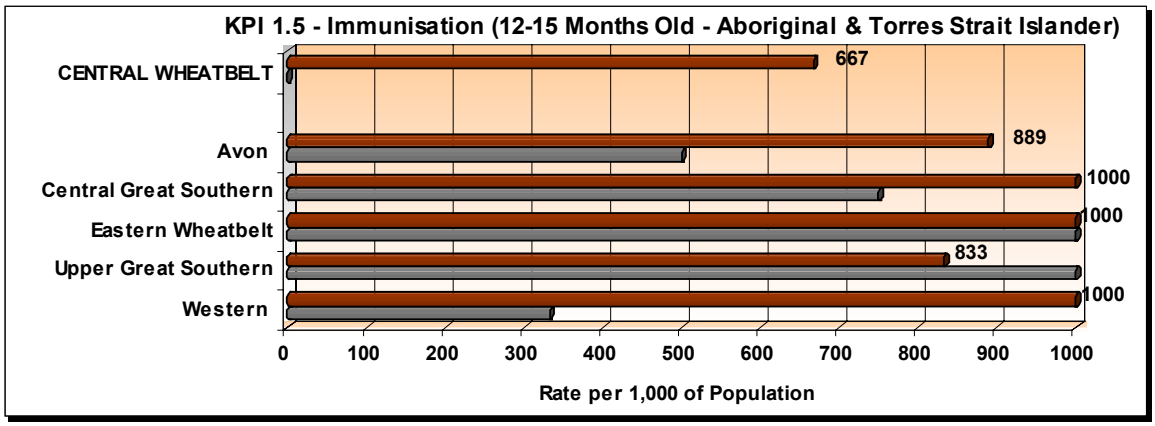
This indicator measures the rate of immunisation against particular diseases, by age group, of the resident child population in the catchment for the Health Service.

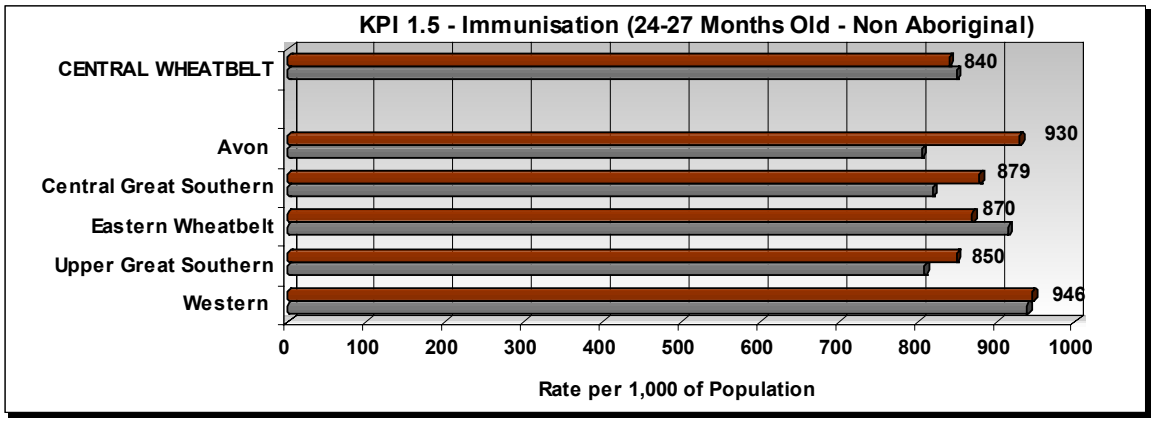
In calculating the rate of Immunisation, the number of Immunisations refer to the number of children who were fully vaccinated in accordance with the National Health and Medical Research Council (NH&MRC) standard vaccination schedule.

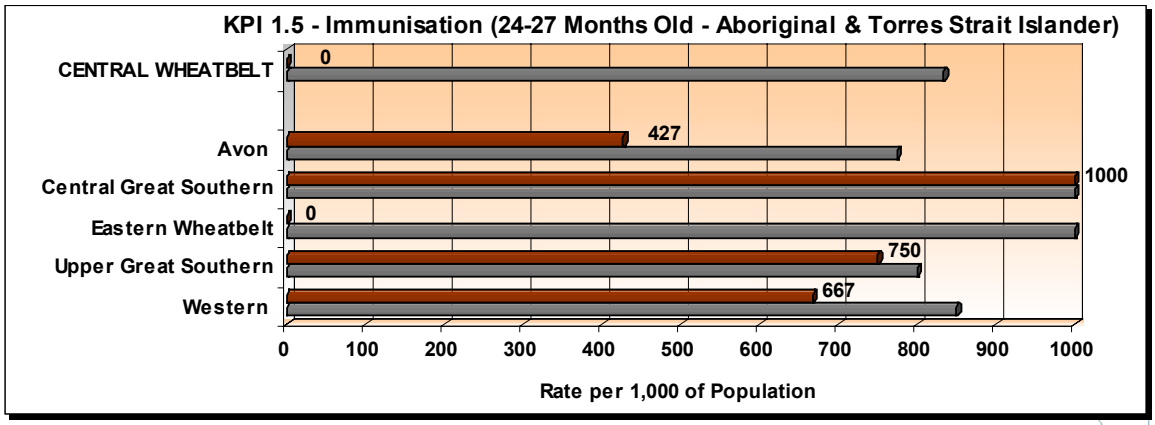
All infants born after May 2000 (but not before) were to be vaccinated against Hepatitis B at birth and again at 12 months. This effectively created 2 classes of immunised infants in that age group (12-15 months). It also means that there will be some discrepancies with the 24-27 month age group of the 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.

This year's data was taken from March only. In previous years the entire year figures were used. Aboriginal and Torres Strait Islander records were not reported on separately in previous years.









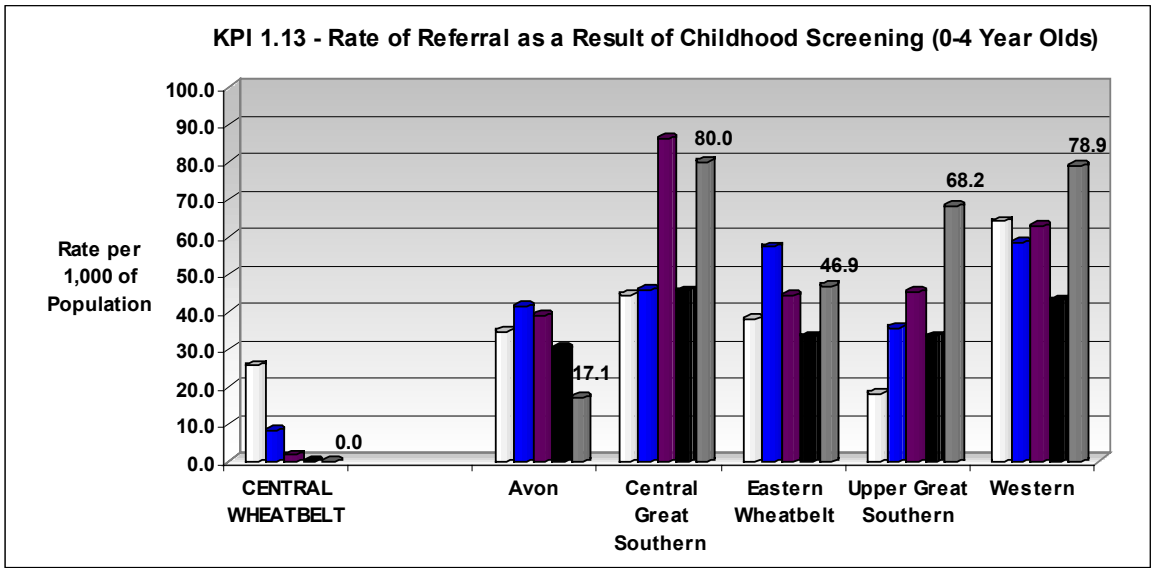
Calendar Year 2001 2002

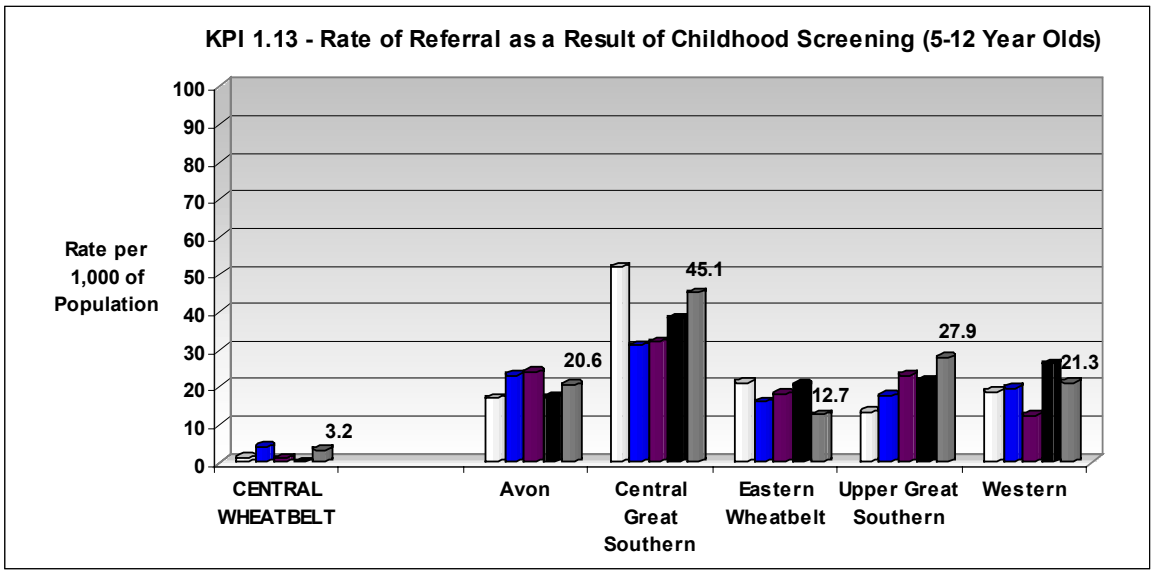
RATE OF REFERRAL AS A RESULT OF CHILDHOOD SCREENING SCHEDULE	KPI 1.13

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.



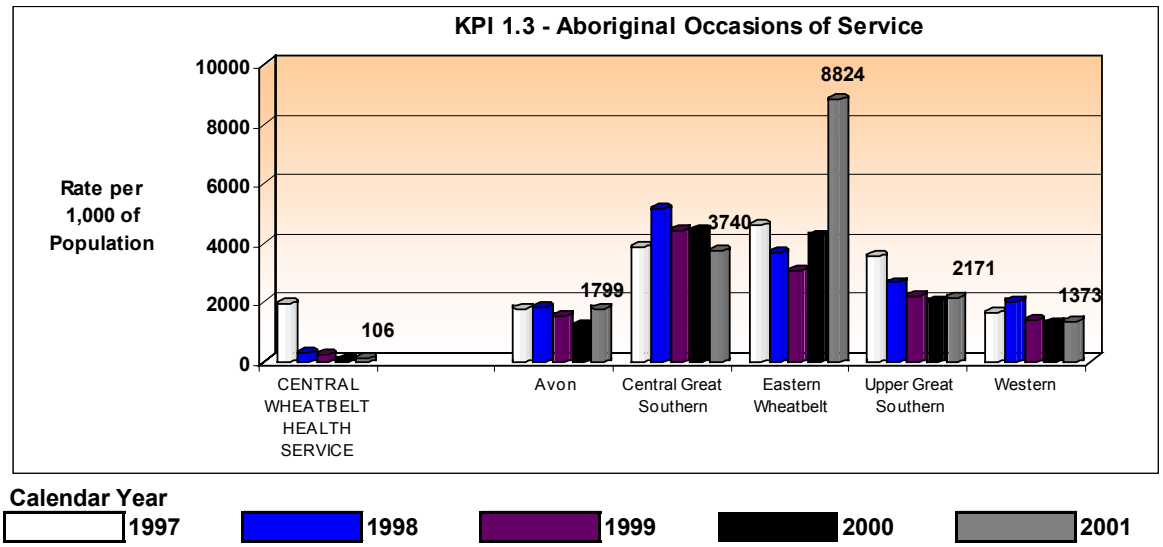


RATE OF SERVICE PROVISION BY COMMUNITY HEALTH STAFF TO ABORIGINAL PEOPLE	KPI 1.3

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.



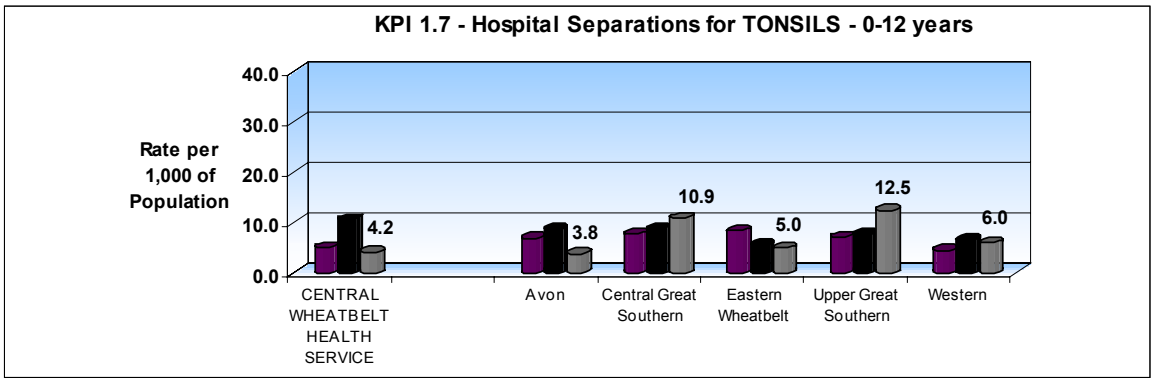
HOSPITAL SEPARATIONS FOR TONSILLECTOMIES & GROMMETS — KPI 1.7

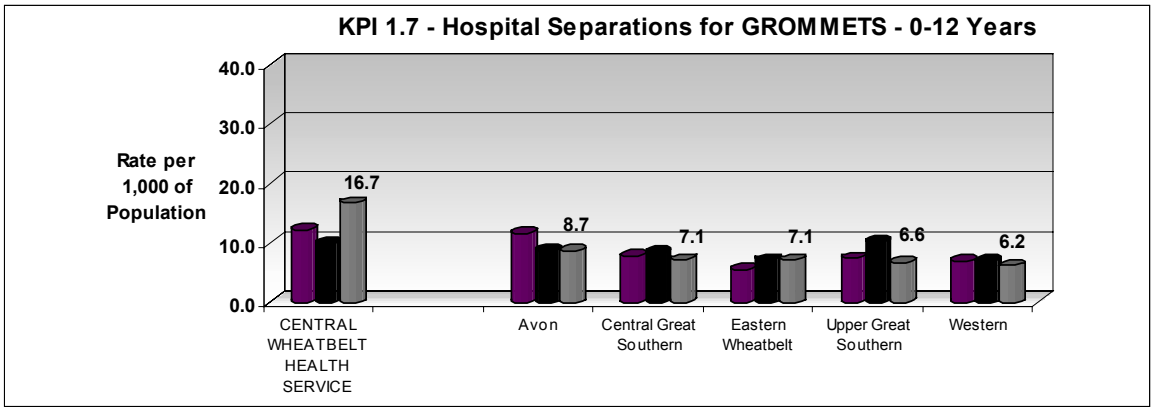
Current evidence suggests many tonsillectomies and grommet insertions are unnecessary and 'watchful waiting' and presurgery testing may be effective in reducing inappropriate surgery.

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.





HOSPITAL SEPARATIONS FOR GASTROENTERITIS IN CHILDREN — KPI 1.9

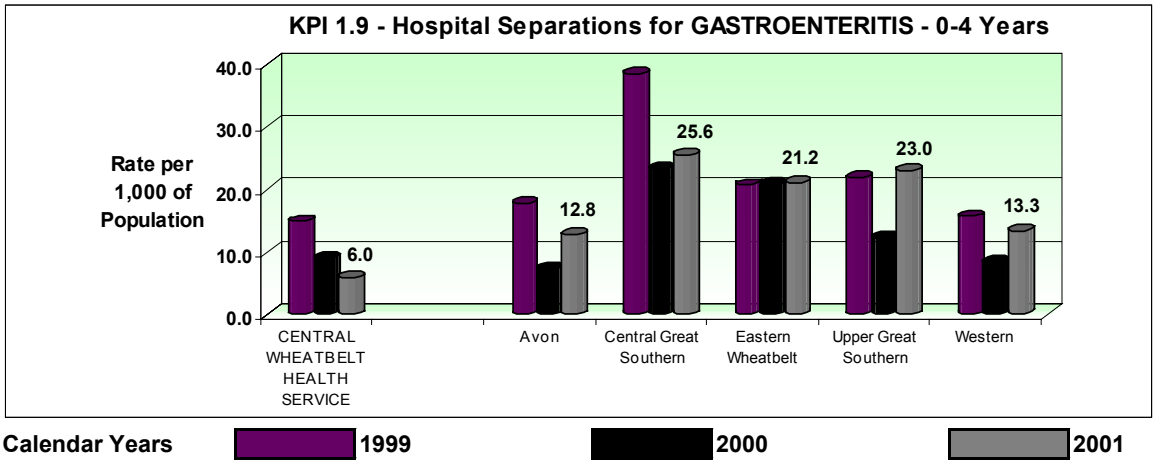
Public health and environmental health programs are aimed at maintaining safe water and sewerage disposal systems, and establishing and enforcing effective food processing and handling practices.

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.

Over the last three years the Central Wheatbelt Health Service has seen a reduction in the number of hospitalisations for gastroenteritis in children aged 0 to 4 years. It is difficult, however, to draw any conclusions as the data size is very small.



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

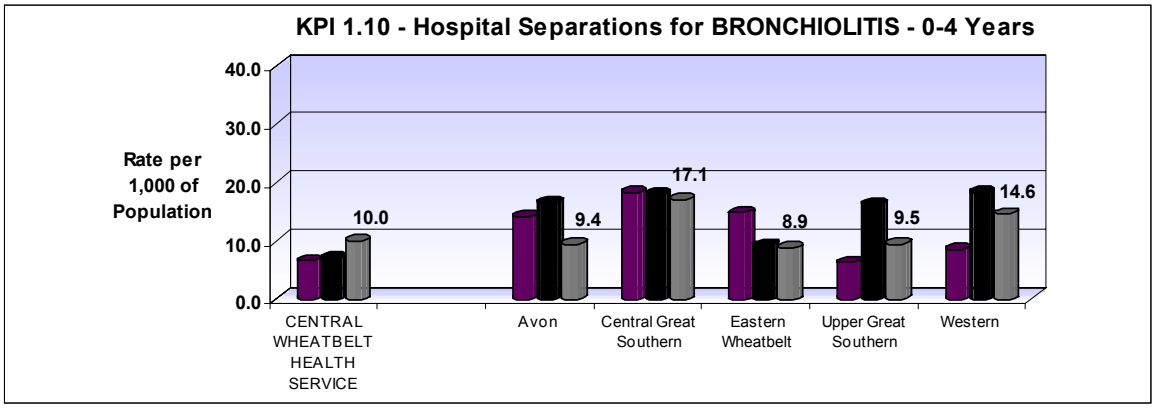
The graph shows individuals aged 0-4. Of those individuals aged 5-12 and 13-18, none were hospitalised.

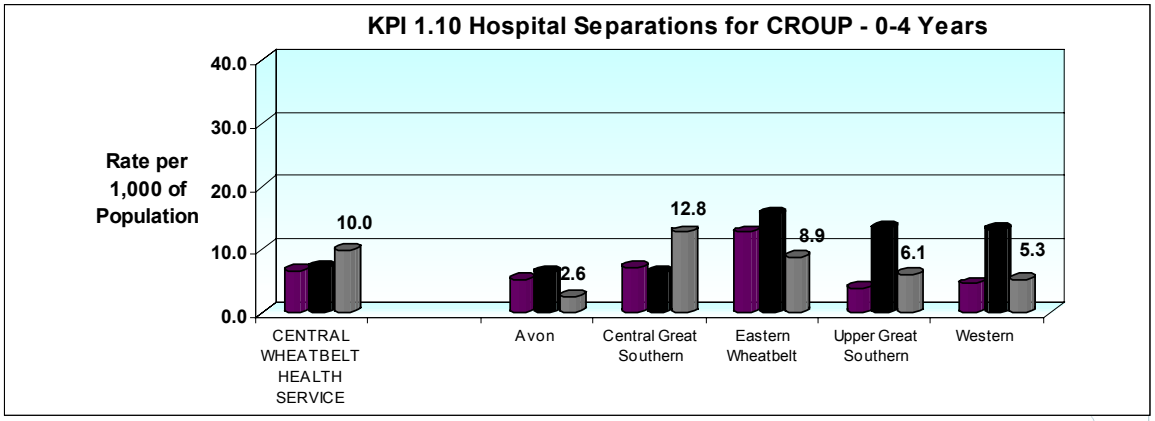
Croup

The graph shows individuals aged 0-4. Of those individuals aged 5-12, only 1 was hospitalised this year, a rate of 1.1 per thousand and of those individuals aged 13-18, none were hospitalised.

Acute Bronchitis

No individuals were admitted for any of the age groups 0-4, 5-12 and 13-18 this year.





Calendar Years 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.

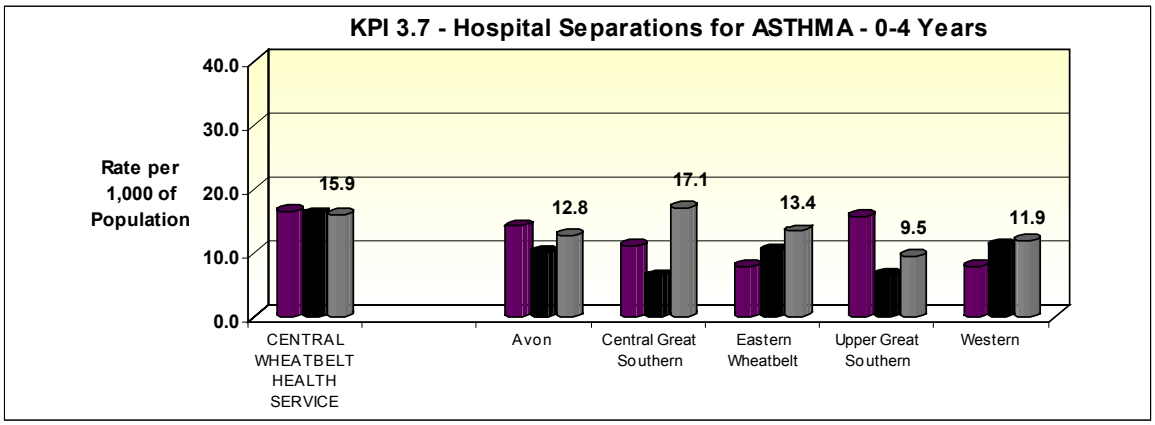
Hospitalisation for Asthma is part of managing this chronic condition. It is being reported in Output 1, instead of Output 3, in order to highlight the focus on measuring the effectiveness of Prevention and Promotion services for the condition.

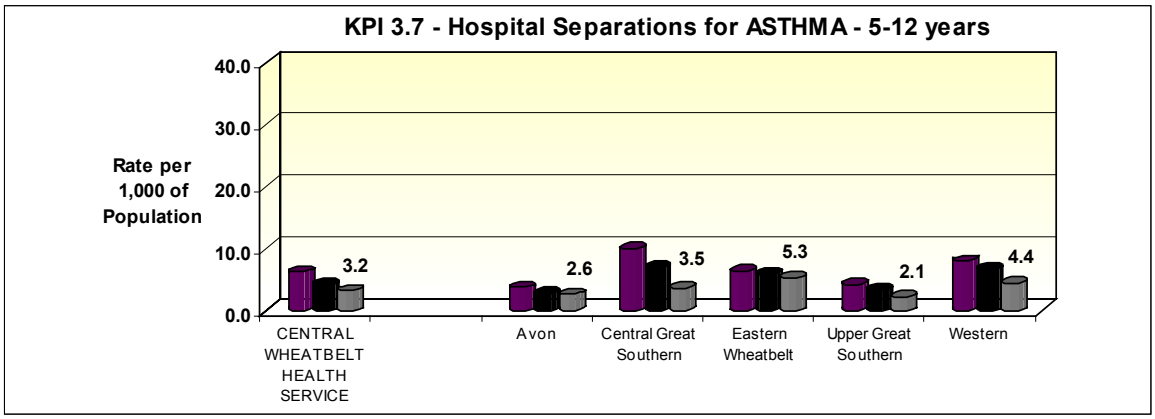
The number of patients who are admitted to hospital per 1,000 population for treatment of Asthma may be an indication of improved primary care or community health strategies - for example, health education.

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.

Data from the Bruce Rock Memorial hospital has been reported as part of an overall Central Wheatbelt Health Service result for this KPI.

The graphs show individuals aged 0-4 and 5-12. Only 1 individual aged 13-18 at a rate of 2.2 per thousand was hospitalised this year, with 1 individual being admitted aged 19-34 at a rate of 0.8 per thousand and with 8 individuals aged 35 years and over at a rate of 2.1 per thousand.





COST PER OCCASION OF SERVICE OF COMMUNITY HEALTH SERVICE	KPI 1.14

Community health occasions of service measure the provision of primary and community health services undertaken by a range of health service professionals in a community setting, with a focus on improving the overall health of the State population. Child health nursing, clinical psychology, occupational and speech therapy are some examples of the types of community-based services provided under this Indicator. It provides a measure of, on average, how cost effective these activities are over time.

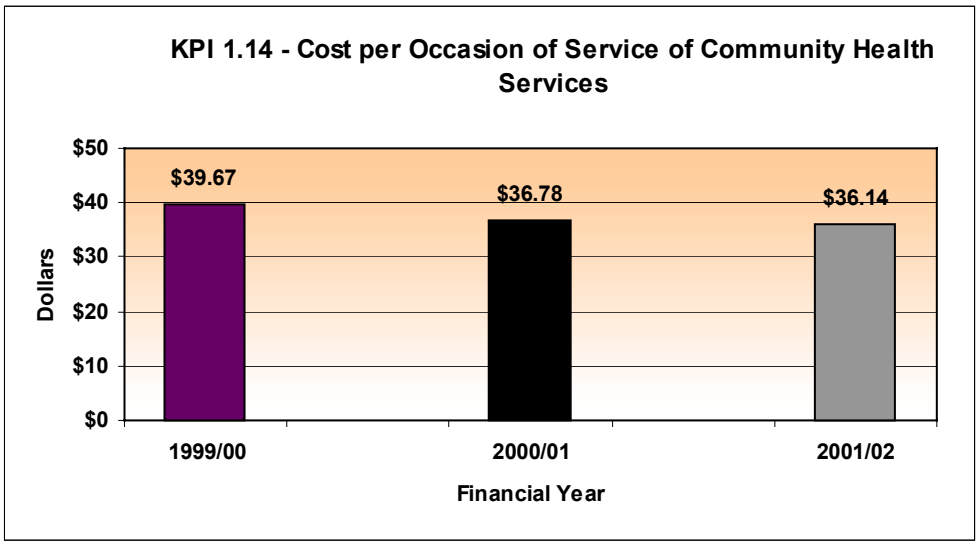
A wide range of interventions by practitioners from many specialties are used, singularly and in combination, to effect changes in the health of individuals, their families and their communities. These interventions are quantified as occasions of service but can cover a wide range of services in terms of time and complexity.

This indicator measures the average cost of an occasion of service for the particular use of programs that each health service provides. Given what has been said above, it is only useful for broad comparisons of trends and must be considered in conjunction with an understanding of current program delivery priorities.

The cost of Community Health Services in the Central Wheatbelt is reported through Quairading Hospital.

NOTE:

- This is the first year that this indicator has been reported. It is expected that over time the collection of Community Health data and the reporting of this indicator will become more refined.
- The figures used to calculate the cost per community occasion of service were based on 6 months (July to December 2001) expenditure and activity data.



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 Bruce Rock Memorial Hospital report overall satisfaction score of 81 for emergency patients and 85 for outpatients over the last financial year with a standard error of 3.79 and 2.68 respectively on a confidence interval of 95%. The estimated populations of individuals surveyed were 309 Emergency Services patients and 416 Outpatients.

The table below shows the response rate by patient type.

SURVEY QUESTIONNAIRES			
PATIENT TYPE	**NUMBER SENT**	**NUMBER RETURNED**	**RESPONSE RATE**
Emergency Patients	34	20	59%
Outpatients	47	19	40%

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.

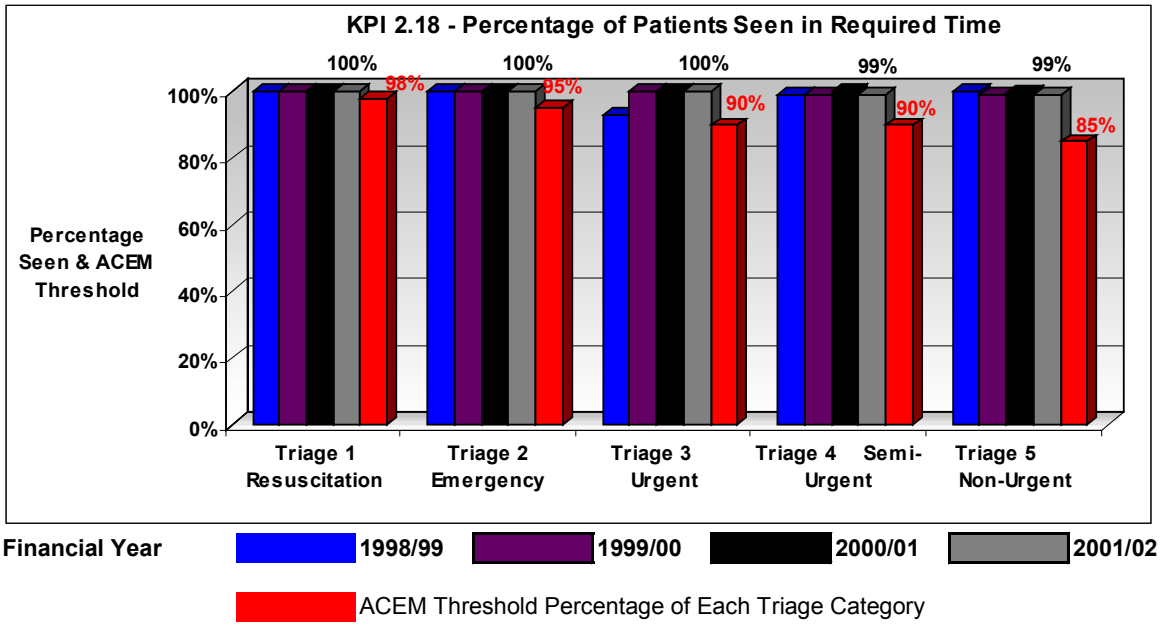
When patients first enter an Emergency Department, they are assessed by nursing staff and allocated a triage code between 1 and 5 that indicates their urgency. This code provides an indication of how quickly patients should be reviewed by medical staff. In rural areas however, where a medical practitioner 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%

Bruce Rock Memorial hospital is above the ACEM threshold for emergency departments waiting times across all triage codes.

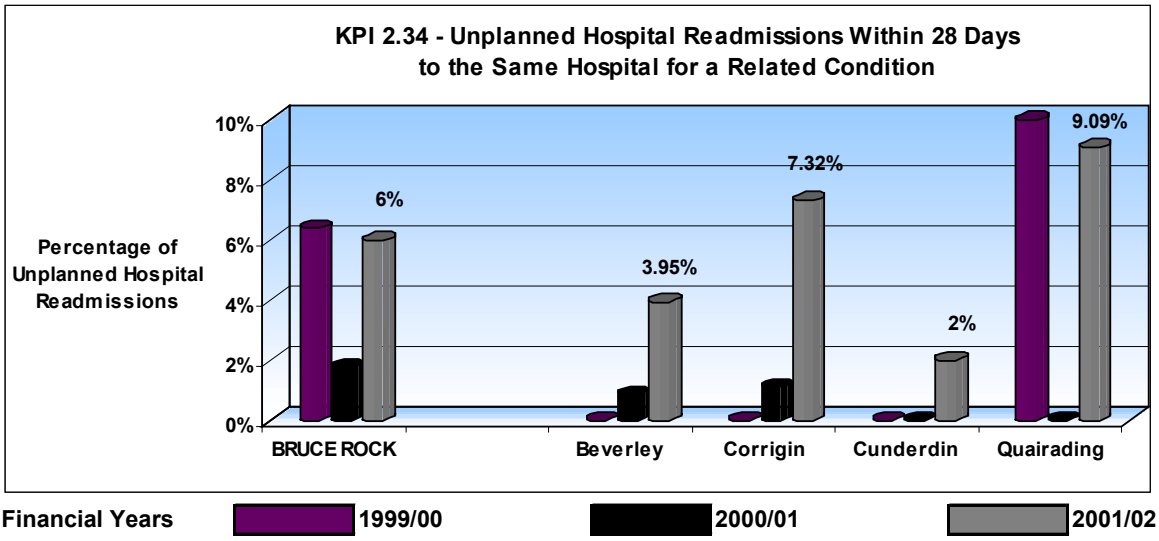


UNPLANNED HOSPITAL READMISSIONS WITHIN 28 DAYS TO THE SAME HOSPITAL FOR A RELATED CONDITION	KPI 2.34

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.

For 2001/2002 data has been derived from a three-month sample. In previous years this indicator has counted all cases for a full financial year. For hospitals the size of those in the Central Wheatbelt Health Service this can mean a significant variance from previous years' results due to the very small sample size and possible seasonal variations. One or two episodes can make a big difference to the percentage of readmissions, as can possible seasonal variations.



UNPLANNED HOSPITAL READMISSIONS WITHIN 28 DAYS TO THE SAME HOSPITAL FOR TREATMENT AND CARE FOR A RELATED MENTAL HEALTH ILLNESS	KPI 2.35

Readmissions to hospital within 28 days is an indicator of the effectiveness of hospital treatment and discharge planning, but may also reflect post-discharge treatment and care. The treatment and care needs of different age groups may be quite different. Readmission rates for these different age groups may provide a measure of the effectiveness of services in addressing these needs.

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.

There were no unplanned readmissions reported at Bruce Rock Memorial hospital.

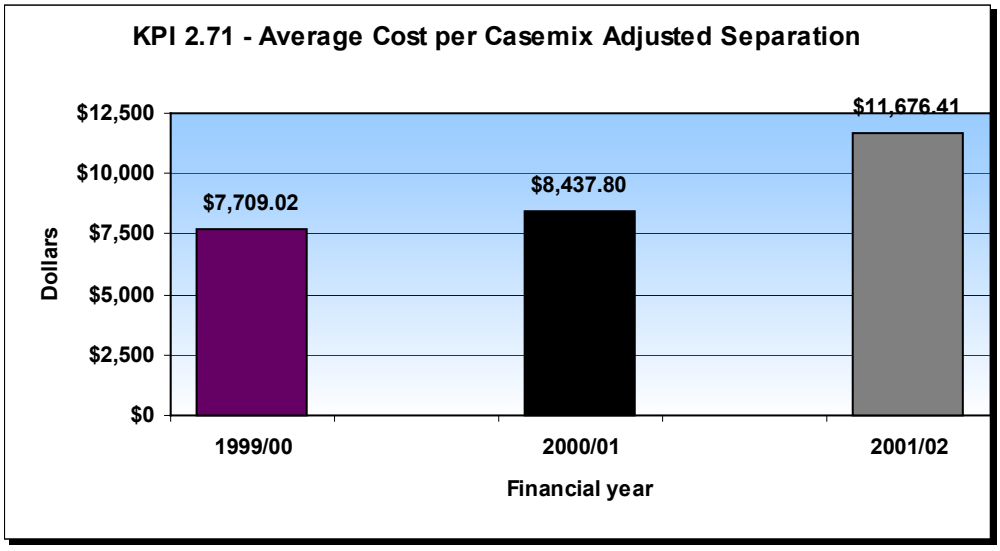
AVERAGE COST PER CASEMIX ADJUSTED SEPARATION FOR RURAL NON-TEACHING HOSPITALS	KPI 2.71

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.

It is important to note that in hospitals this size there is a significant cost in maintaining minimum staffing levels. The average cost per separation is variable depending upon the number of separations.



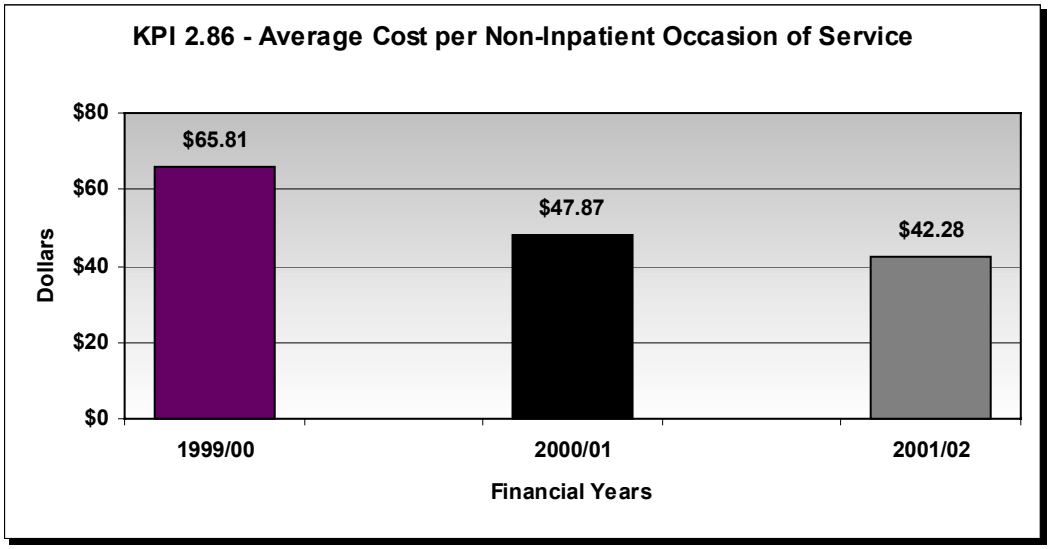
AVERAGE COST PER NON-INPATIENT OCCASION OF SERVICE	KPI 2.86

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.

It is important to note that in hospitals of this size there is a significant cost in maintaining minimum staffing levels. Whether outpatient occasions of service increase or decrease has little relevance to increases or decreases to operating expenses.



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 AVERAGE COST PER NURSING HOME TYPE PATIENT BED DAY	KPI 3.5 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.

Due to the very small data size no relevant conclusion can be drawn. There were eight Nursing Home Patients in hospital on 1st July 2001. There were five new admissions during the year with an average bed day of 6.25.

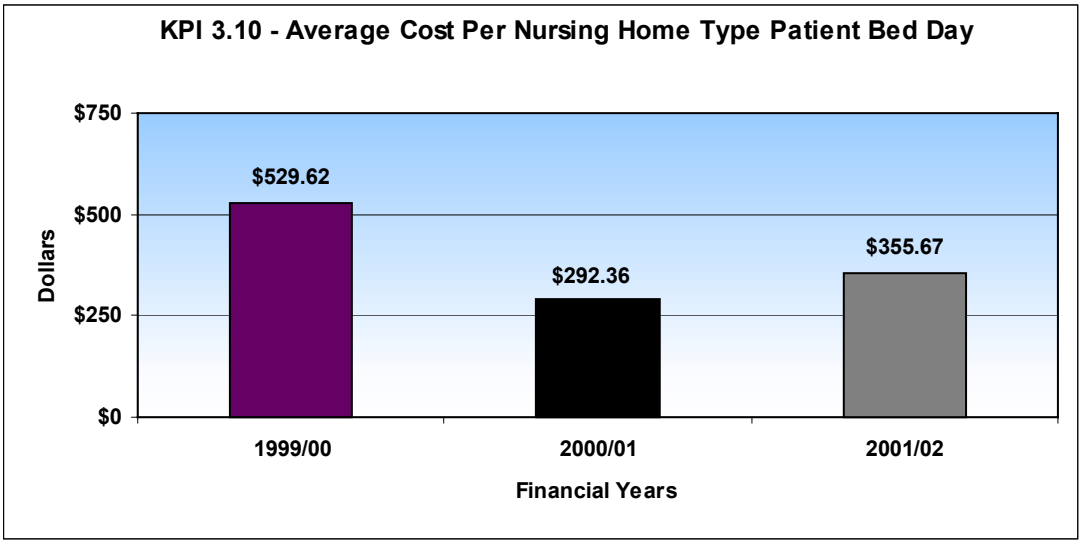
Average Cost per Nursing Home Type Patient Bed Day

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 Nursing Home Type Patient 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 Nursing Home Type Patients compared to providing the same service in another health service may indicate the inefficient use of resources.

In hospitals of this size there is a significant cost in maintaining minimum staffing levels whether Nursing Home Type Patient bed days increase or decrease.

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.

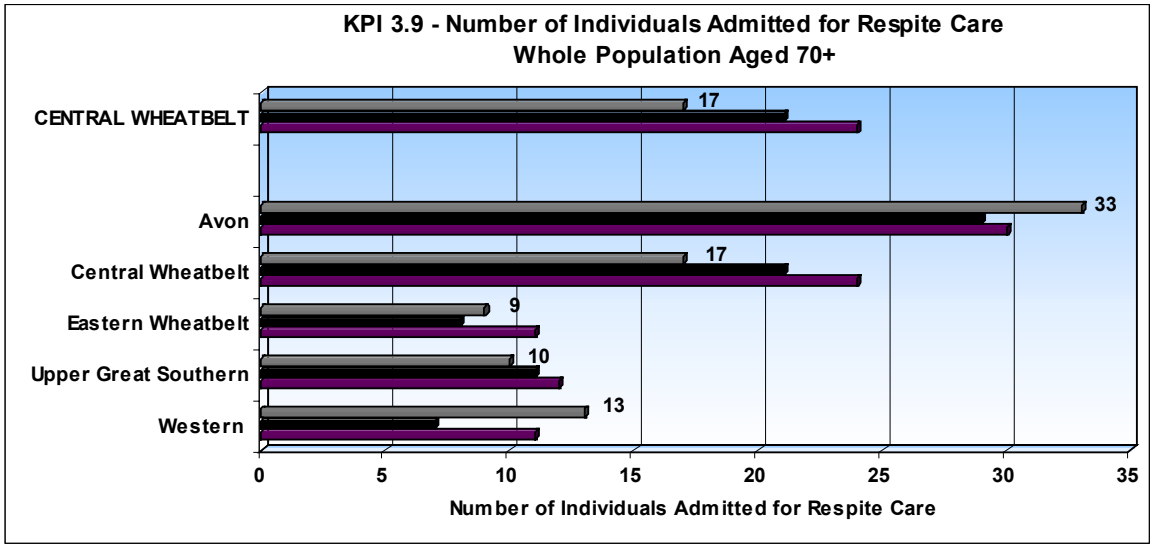


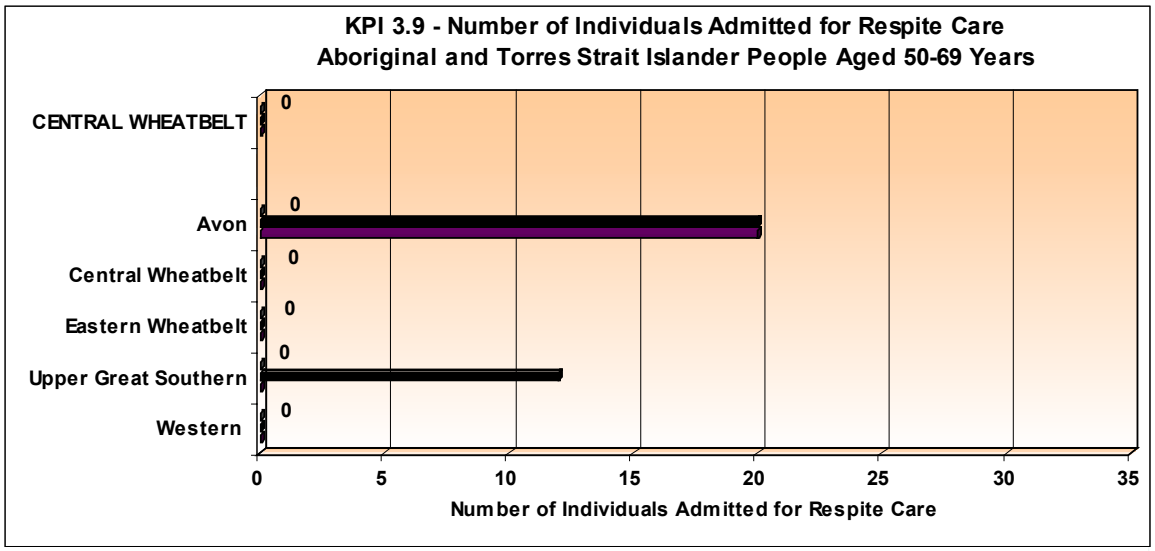
NUMBER OF INDIVIDUALS WITHIN TARGETED AGE GROUP ADMITTED FOR RESPITE CARE	KPI 3.9

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.

This indicator measures the extent to which people within the targeted age groups are admitted for Respite Care in their region.

Due to the very small data size it is difficult to reach any meaningful conclusions.





Financial Year 1999/00 2000/01 2001/02

AUDITOR GENERAL

To the Parliament of Western Australia

BRUCE ROCK MEMORIAL HOSPITAL BOARD
FINANCIAL STATEMENTS FOR THE YEAR ENDED JUNE 30, 2002

Scope

I have audited the accounts and financial statements of the Bruce Rock Memorial 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 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 Board 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 Board'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

Bruce Rock Memorial Hospital Board
Financial Statements for the year ended June 30, 2002

Audit Opinion
In my opinion,

(i) the controls exercised by the Bruce Rock Memorial 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 Board at June 30, 2002 and its financial performance and its cash flows for the year then ended.

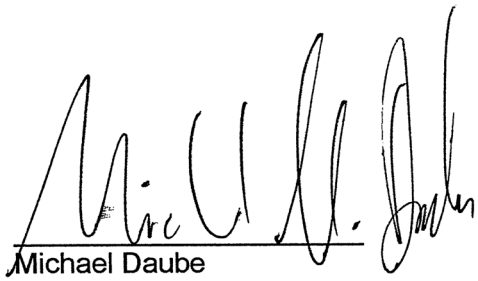
D D R PEARSON
AUDITOR GENERAL
March 14, 2003

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

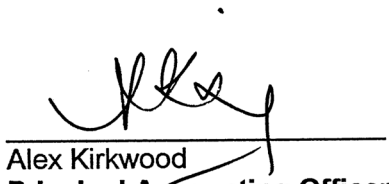
The accompanying financial statements of the Bruce Rock Memorial Hospital Board have been prepared in compliance with the provisions of the *Financial Administration and Audit Act 1985* from proper accounts and records to present fairly the financial transactions for the twelve months ending 30 June 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
Bruce Rock Memorial
Hospital Board

30 August 2002



Alex Kirkwood
Principal Accounting Officer
Bruce Rock Memorial
Hospital Board

30 August 2002

Statement of Financial Performance
For the year ended 30 June 2002

	Note	2001/02 $	2000/01 $
COST OF SERVICES			
Expenses from Ordinary Activities			
Employee expenses		1,061,350	1,109,213
Fees for visiting medical practitioners		25,320	39,958
Superannuation expense		87,847	93,674
Patient support costs	3	133,773	173,794
Patient transport costs		27,215	28,811
Repairs, maintenance and consumable equipment expense		58,212	39,671
Depreciation expense	4	53,300	54,470
Net loss on disposal of non-current assets	5	8,229	10,918
Capital user charge	6	81,237	-
Other expenses from ordinary activities	7	97,820	145,845
Total cost of services		1,634,303	1,696,354
Revenues from Ordinary Activities			
Patient charges	8	208,747	190,298
Commonwealth grants and contributions	9	1,440	3,875
Donations revenue	10	1,850	15,984
Interest revenue		676	5,357
Other revenues from ordinary activities	11	36,881	32,971
Total revenues from ordinary activities		249,594	248,485
NET COST OF SERVICES		**1,384,709**	**1,447,869**
Revenues from Government			
Output appropriations	12	1,396,794	1,215,000
Capital appropriations	12	-	25,948
Liabilities assumed by the Treasurer	13	-	93,674
Resources received free of charge	14	6,000	5,000
Total revenues from government		1,402,794	1,339,622
Change in net assets		**18,085**	**(108,247)**
Total changes in equity other than those resulting from transactions with WA State Government as owners		**18,085**	**(108,247)**

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

Statement of Financial Position
As at 30th June 2002

	Note	2001/02 $	2000/01 $
CURRENT ASSETS			
Cash assets	15	25,776	26,686
Receivables	16	2,965	13,821
Inventories	18	18,673	22,522
Total current assets		47,414	63,029
NON-CURRENT ASSETS			
Amounts receivable for outputs	17	58,600	-
Property, plant and equipment	19	1,372,764	1,416,596
Total non-current assets		1,431,364	1,416,596
Total assets		**1,478,778**	**1,479,625**
CURRENT LIABILITIES			
Payables		10,508	33,176
Accrued salaries	20	44,981	50,336
Provisions	21	255,623	239,638
Total current liabilities		311,112	323,150
NON-CURRENT LIABILITIES			
Provisions	21	336,254	348,549
Total non-current liabilities		336,254	348,549
Total liabilities		**647,366**	**671,699**
Net Assets		**831,412**	**807,926**
EQUITY			
Contributed equity	22	5,400	-
Asset revaluation reserve	23	22,066	22,066
Accumulated surplus / (deficiency)	24	803,946	785,860
Total Equity		**831,412**	**807,926**

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

Statement of Cash Flows
For the year ended 30 June 2002

	Note	2001/02 $ Inflows (Outflows)	2000/01 $ Inflows (Outflows)
CASH FLOWS FROM GOVERNMENT			
Output appropriations	25(c)	1,256,957	1,215,000
Net cash provided by Government		1,256,957	1,215,000
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Supplies and services		(431,428)	(428,105)
Employee costs		(1,070,668)	(1,075,167)
GST payments on purchases		(26,916)	(31,955)
Receipts			
Receipts from customers		212,675	223,652
Commonwealth grants and contributions		1,440	3,875
Donations		1,850	9,224
Interest received		676	5,357
GST receipts on sales		8,662	5,824
GST receipts from taxation authority		20,458	21,069
Other receipts		37,681	31,574
Net cash used in operating activities	25(b)	(1,245,570)	(1,234,652)
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments for purchase of non-current assets	19	(12,297)	(10,871)
Net cash used in investing activities		(12,297)	(10,871)
Net decrease in cash held		(910)	(30,523)
Cash assets at the beginning of the reporting period		26,686	57,209
Cash assets at the end of the reporting period	25(a)	25,776	26,686

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
Other plant and equipment	4 to 50 years

(g) Leases

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 valued on a weighted average cost basis at the lower of cost and net realisable value.

(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.

(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.

Note 2 Administered trust accounts	**2001/02 $**	**2000/01 $**
Funds held in these trust accounts are not controlled by the Health Service and are therefore not recognised in the financial statements.		
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	36	36
Closing Balance	36	36

Note 3 Patient support costs		
Medical supplies and services	29,101	60,258
Domestic charges	28,940	33,540
Fuel, light and power	31,679	33,300
Food supplies	42,385	42,494
Purchase of external services	1,668	4,202
	133,773	173,794

	2001/02 $	2000/01 $
Note 4 Depreciation expense		
Buildings	38,911	40,114
Computer equipment and software	3,023	3,089
Furniture and fittings	3,716	3,333
Other plant and equipment	7,650	7,934
	53,300	54,470
Note 5 Net loss on disposal of non-current assets		
Loss on disposal of non-current assets:		
Computer equipment and software	(1,811)	(778)
Furniture and fittings	(545)	(3,678)
Other plant and equipment	(5,873)	(6,462)
	(8,229)	(10,918)
Note 6 Capital user charge		
	81,237	-

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.

Note 7 Other expenses from ordinary activities		
Workers compensation insurance	21,255	30,602
Other employee expenses	1,429	3,254
Motor vehicle expenses	39,886	45,536
Insurance	7,431	8,873
Communications	10,147	15,536
Printing and stationery	5,807	5,731
Rental of property	(3,380)	14,144
Audit fees - external	6,000	5,000
Other	9,245	17,169
	97,820	145,845
Note 8 Patient charges		
Inpatient charges	208,277	190,206
Outpatient charges	470	92
	208,747	190,298
Note 9 Commonwealth grants and contributions		
Home and Community Care non-recurrent funding	1,440	3,875
Note 10 Donations revenue		
General public contributions	1,850	15,984
Note 11 Other revenues from ordinary activities		
Rent from properties	302	-
Boarders' accommodation	94	364
Recoveries	29,956	26,178
Use of hospital facilities	1,022	1,609
Other	5,507	4,820
	36,881	32,971

	2001/02 $	2000/01 $
Note 12 Government appropriations		
Output appropriations (I)	1,396,794	1,215,000
Capital appropriations (II)	-	25,948
	1,396,794	1,240,948

(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

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 Treasurer". (Refer note 1(n)(ii)).

Superannuation	-	93,674

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	6,000	5,000

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

Cash on hand	701	701
Cash at bank - general	11,532	4,418
Cash at bank - donations	13,543	6,179
Term deposits and bank bills	-	15,388
	25,776	26,686

Note 16 Receivables

Patient fee debtors	1,643	4,700
GST receivable	427	8,466
Other receivables	895	655
	2,965	13,821

Note 17 Amounts receivable for outputs

Non-current	58,600	-

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 Inventories

Supply stores - at cost	6,076	7,263
Pharmaceutical stores - at cost	12,597	15,259
	18,673	22,522

Note 19 Property, plant and equipment	2001/02 $	2000/01 $
Land		
At fair value (ii)	11,850	11,850
	11,850	11,850
Buildings		
Clinical:		
At valuation - 1998	5,450,645	5,450,645
Accumulated depreciation	(4,192,533)	(4,153,622)
	1,258,112	1,297,023
Computer equipment and software		
At cost	17,522	21,725
Accumulated depreciation	(10,088)	(11,410)
	7,434	10,315
Furniture and fittings		
At cost	76,418	70,568
Accumulated depreciation	(39,437)	(39,176)
	36,981	31,392
Other plant and equipment		
At cost	119,941	149,197
Accumulated depreciation	(61,554)	(83,181)
	58,387	66,016
Total of property, plant and equipment	1,372,764	1,416,596

Land and buildings

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:

Paid as cash by the Health Service from output appropriations	12,297	10,871
Paid by the Department of Health	5,400	22,435
Gross payments for purchases of non-current assets	17,697	33,306

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	11,850
Carrying amount at end of year	11,850
Buildings	
Carrying amount at start of year	1,297,023
Depreciation	(38,911)
Carrying amount at end of year	1,258,112
Computer equipment and software	
Carrying amount at start of year	10,315
Additions	142
Depreciation	(3,023)
Carrying amount at end of year	7,434
Furniture and fittings	
Carrying amount at start of year	31,392
Additions	9,305
Depreciation	(3,716)
Carrying amount at end of year	36,981
Other plant and equipment	
Carrying amount at start of year	66,016
Additions	21
Depreciation	(7,650)
Carrying amount at end of year	58,387

	2001/02 $	2000/01 $
Note 20 Accrued salaries		
Amounts owing for:	44,981	50,336
Shift Workers		
14 calendar days from 17 June to 30 June 2002		
13 calendar days from 18 June to 30 June 2001		
Non-shift Workers		
14 calendar days from 17 June to 30 June 2002		
10 Working days from 18 June to 30 June 2001		

Note 21 Provisions

Current liabilities:		
Annual leave	200,942	181,683
Long service leave	54,681	57,955
	255,623	239,638
Non-current liabilities:		
Long service leave	42,191	54,486
Superannuation	294,063	294,063
	336,254	348,549
Total employee entitlements	591,877	588,187

The superannuation liability has been established from data supplied by the Government Employees Superannuation Board.

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

Note 22 Contributed equity

Balance at beginning of the year	-	-
Capital contributions (i)	5,400	-
Balance at end of the year	5,400	-

(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 23 Asset revaluation reserve

Balance at beginning of the year	22,066	22,066
Balance at end of the year	22,066	22,066

Note 24 Accumulated surplus / (deficiency)

Balance at beginning of the year	785,860	894,107
Change in net assets	18,085	(108,247)
Balance at end of the year	803,946	785,860

Note 25 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)	25,776	26,686
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)	(1,245,570)	(1,234,652)
Increase / (decrease) in assets:		
GST receivable	(8,039)	8,469
Other receivables	(2,817)	(33,654)
Inventories	(3,849)	3,780
Prepayments	-	(832)
Decrease / (increase) in liabilities:		
Payables	22,668	(9,193)
Accrued salaries	5,355	(15,346)
Provisions	(3,690)	(9,784)
Non-cash items:		
Depreciation expense	(53,300)	(54,470)
Profit / (loss) from disposal of non-current assets	(8,229)	(10,918)
Capital user charge paid by Department of Health	(81,237)	-
Superannuation liabilities assumed by the Treasurer	-	(93,674)
Resources received free of charge	(6,000)	(5,000)
Other	(1)	7,405
Net cost of services (Statement of Financial Performance)	(1,384,709)	(1,447,869)
c) **Notional cash flows**		
Output appropriations as per Statement of Financial Performance	1,396,794	1,215,000
Capital appropriations as per Statement of Financial Performance	-	25,948
Capital appropriations credited directly to Contributed Equity	5,400	-
	1,402,194	1,240,948
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	(81,237)	-
Capital subsidy	(5,400)	(25,948)
Less non-cash component of ouput appropriations (Refer Note 17)	(58,600)	-
	(145,237)	(25,948)
Net cash provided by Government as per Statement of Cash Flows	1,256,957	1,215,000

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
$50,001 - $60,000	-	1
$60,001 - $70,000	1	-
Total	1	1
	$	$
The total remuneration of senior officers is:	67,751	59,451

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).

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% or $10,000.

	2001/02 $	2000/01 $	Variation $
Salaries & Wages The main factors responsible for the decrease in Salaries & Wages expense over the reporting period were the effect of a benchmarking exercise in the support services area, the successful redeployment of an administrative person and the replacement of a full-time Community Health staff member with a part-time staff member.	1,061,350	1,109,213	(47,863)
Other Goods & Services An increase in Repairs & Maintenance expenditure, due mainly to the extensive Painting program was offset by significant reductions in a number of other areas such as Drugs, Other Medical and Surgical, Motor Vehicle expenses, Communication and Workers Compensation insurance. Capital User Charge applied for the first time in 2001/2002.	572,953	587,141	(14,188)

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 or $10,000.

	2001/02 Actual $	2001/02 Estimate $	Variation $
Salaries & Wages The reasons for the variation as described above were not considered at the time of compiling the Section 42 estimates.	1,061,350	1,121,000	(59,650)
Other Goods & Services A reduction in Fees for Medical Practitioners, Patient Support Costs, and Other Expenses from Ordinary Activities were offset by an increase in Repairs & Maintenance and the introduction of a Capital User Charge for the first time.	572,953	552,000	20,953
Revenue A reduction of $28,000 in Patient Charges between the two years was not anticipated.	249,594	270,000	(20,406)

Note 28 Contingent liabilities

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

Note 29 Events occurring after reporting date

The Bruce Rock Memorial 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 30 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 31 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 32 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	3.6%	25	0	0	0	1	26
Receivables		0	0	0	0	3	3
		25	0	0	0	4	29
Financial Liabilities							
Payables		0	0	0	0	11	11
Accruals		0	0	0	0	45	45
Provisions		0	0	0	0	592	592
		0	0	0	0	638	638
Net financial assets / (liabilities)		25	0	0	0	(634)	(609)
As at 30th June 2001							
Financial Assets							
Cash assets	3.9%	26	0	0	0	1	27
Receivables		0	0	0	0	14	14
		26	0	0	0	15	41
Financial Liabilities							
Payables		0	0	0	0	33	33
Accruals		0	0	0	0	50	50
		0	0	0	0	83	83
Net financial assets / (liabilities)		26	0	0	0	(68)	(42)

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 33 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	216	224	415	435	430	450	1,061	1,109
Fees for visiting medical practitioners	4	6	11	17	11	18	25	40
Superannuation expense	12	13	37	39	39	41	88	94
Patient support costs	19	24	56	73	59	76	134	174
Patient transport costs	4	4	11	12	12	13	27	29
Repairs, maintenance and consumable equipment expense	8	6	24	17	26	17	58	40
Depreciation expense	7	8	22	23	23	24	53	54
Net loss on disposal of non-current assets	1	2	3	5	4	5	8	11
Capital user charge	11	0	34	0	36	0	81	0
Other expenses from ordinary activities	14	20	41	61	43	64	98	146
Total cost of services	297	306	656	681	682	709	1,634	1,696
Revenues from Ordinary Activities								
Patient charges	29	27	88	80	92	84	209	190
Commonwealth grants and contributions	0	1	1	2	1	2	1	4
Donations revenue	0	2	1	7	1	7	2	16
Interest revenue	0	1	0	2	0	2	1	5
Other revenues from ordinary activities	5	5	15	14	16	15	37	33
Total revenues from ordinary activities	35	35	105	104	110	109	250	248
NET COST OF SERVICES	**262**	**272**	**551**	**577**	**572**	**599**	**1,385**	**1,448**
Revenues from Government								
Output appropriations	196	170	587	510	615	535	1,397	1,215
Capital appropriations	0	4	0	11	0	11	0	26
Liabilities assumed by the Treasurer	0	13	0	39	0	41	0	94
Resources received free of charge	1	1	3	2	3	2	6	5
Total revenues from government	196	188	589	563	617	589	1,403	1,340
Change in net assets	**(65)**	**(84)**	**38**	**(14)**	**45**	**(10)**	**18**	**(108)**

Note 33 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).