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

East Metropolitan Health Service

Annual Report 2017-18

Statement of compliance

For year ended 30 June 2018

Honourable Roger Cook MLA Deputy Premier; Minister for Health; Mental Health

In accordance with section 63 of the *Financial Management Act 2006*, I hereby submit for your information and presentation to Parliament, the final Annual Report of the East Metropolitan Health Service for the financial year ended 30 June 2018. This Annual Report has been prepared in accordance with the provisions of the *Financial Management Act 2006*.

Ian Smith PSM
Board Chair
East Metropolitan Health Service
11 September 2018

Peter Forbes
Board Member
East Metropolitan Health Service
11 September 2018

Ian Smith PSM, EMHS Board Chair and Liz MacLeod, EMHS Chief Executive

"We are proud of everything we have accomplished together".

Statement from East Metropolitan Health Service Board Chair and Chief Executive

On behalf of the East Metropolitan Health Service (EMHS) Board and Executive, we feel privileged to present the 2017-18 EMHS Annual Report.

This report puts the spotlight on what it takes to deliver on our vision of **healthy people, amazing care** each and every day across our hospital sites and community programs.

We provide outstanding healthcare to more than 725 500 people within our catchment area, which takes in a land area of 3647 square kilometres in the Perth metropolitan area, from Bullsbrook in the north, to Sawyers Valley in the east and Jarrahdale in the south. EMHS is also a tertiary referral hub for patients from the Kimberley, Pilbara and Eastern and Western Wheatbelt regions of WA.

We continue to build on our proud history, with our hospitals providing a combined total of more than 330 years of excellent healthcare to the community. Throughout the pages of this annual report you will learn many more 'fast facts' and information about our services and the amazing care we provide.

While a lot has changed in the provision of healthcare across the years, one thing that has remained consistent is the patient experience being at the forefront of everything we do. This could not be achieved without the commitment, care and compassion of our wonderful staff.

We have some of the best clinicians in the world working within our health service, however many people do not realise the integral role our support staff play in the delivery of world-class care. In this year's report, we are saluting the unsung heroes of EMHS – the people who keep everything running smoothly behind the scenes, 24 hours a day, 7 days a week, 365 days a year.

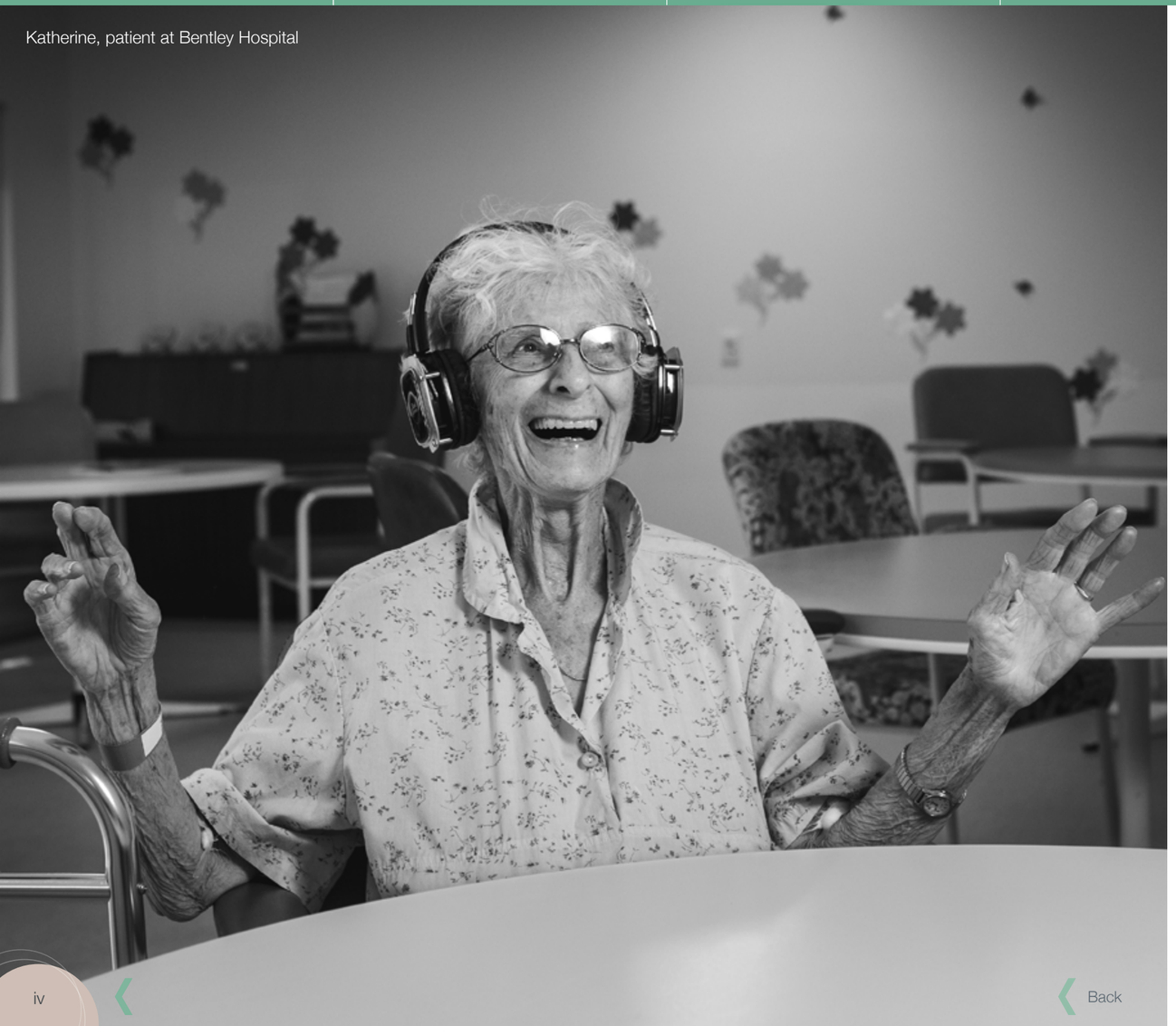
Throughout 2017-18, we have remained focused on our seven service delivery principles: high performing systems and teams, supporting cultural diversity, consumer-centred, intellectual curiosity, active partnerships, valuing our staff, and doing the right thing. These principles are supported by our comprehensive strategic and operational plans which will help guide our health service to continue to deliver amazing care for years to come.

Some key priority areas for EMHS this year include harnessing the immense knowledge and experience of our staff into world-class research and innovation programs; ensuring that we are able to continue to deliver amazing, consumer-centred care in clinically appropriate timeframes; maintaining a focus on strong financial and clinical performance; and supporting our staff and leaders to continue to be the best they can be.

We are proud of everything we have accomplished together this past year and eagerly anticipate what lies ahead.

Ian Smith PSM
Board Chair, EMHS

Liz MacLeod
Chief Executive, EMHS



Katherine, patient at Bentley Hospital

Contents

Annie, nurse at Armadale Hospital with baby Manahil

East Metropolitan Health Service

Executive summary

A look at where we have come from *1897*

Perth Hospital Then

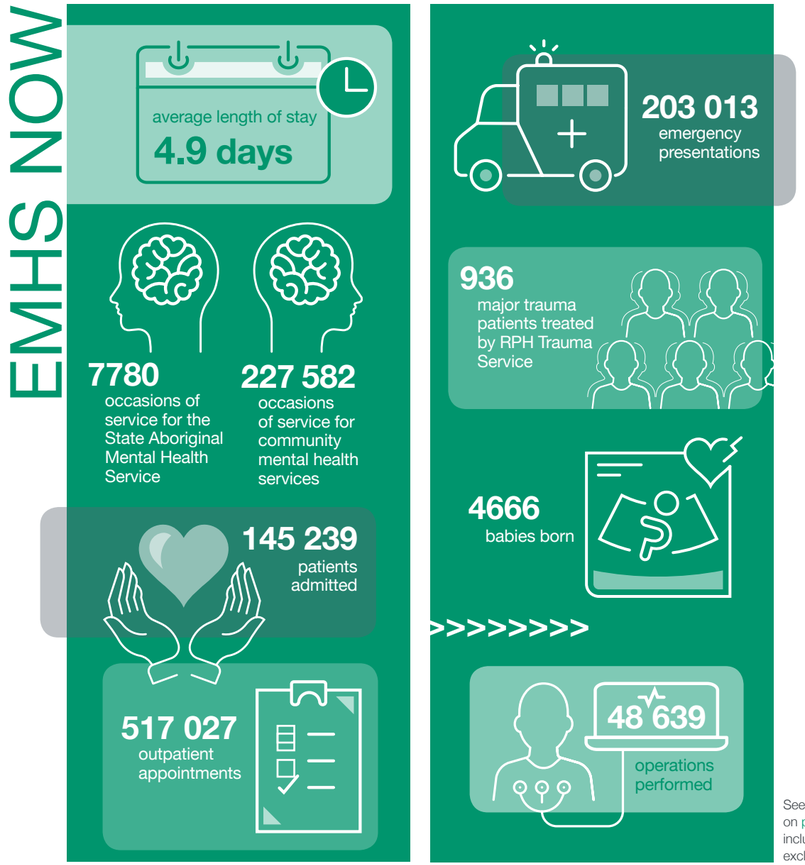
A lot has changed in the provision of healthcare over the years, and EMHS is proud to recognise the long and proud history of its health services.

As Western Australia's longest-serving hospital, Royal Perth Hospital (RPH) has origins dating back as far as 1829, with the establishment of the former Colonial Hospital on Garden Island. In July 1855, RPH was officially opened in its current location, with approximately 30 beds.

These statistics were obtained from the 1897 Annual Report for Perth Public Hospital (now RPH), providing an interesting insight into how much has changed across the health service over the years.

A look at where we are now 2018

EMHS NOW



We had 23 sets of multiple births

Our oldest patient was 105 years old

See data table on page 221 for inclusions and exclusions

Financial overview

Total cost of services (expense limit) sourced from Statement of Comprehensive Income

2017-18 target $000	2017-18 actual $000	Variation $000
1,407,684	1,467,413	59,729[1]

Net cost of services sourced from Statement of Comprehensive Income

2017-18 target $000	2017-18 actual $000	Variation $000
736,489	763,954	27,465[2]

Total equity sourced from Statement of Financial Position

2017-18 target $000	2017-18 actual $000	Variation $000
1,252,807	1,266,504	13,697[3]

Net increase in cash held sourced from Statement of Cash Flows

2017-18 target $000	2017-18 actual $000	Variation $000
–	29,521	29,521[4]

Approved salary expense level sourced from Statement of Comprehensive Income

2017-18 target $000	2017-18 actual $000	Variation $000
786,274	791,277	5,003

See page 100 for full financial statements

Explanations for key major variations:

[1]Total cost of services variance of $59.729 million. The variance was caused by a re-basing of the original target to take into consideration increases in price per purchased unit of activity that occurred during the year, together with a mid-year budget transfer for PathWest resources received free of charge costs.
[2]Net cost of service variance of $27.465 million. This variance primarily relates to general increases in gross expenditure in contracts for services and patient support costs, which were partially offset by additional Commonwealth revenue.
[3]Total equity variance of $13.697 million. This variance is primarily due to an increase in the asset revaluation reserve as a result of an increase in the valuation of EMHS building assets.
[4]Net increase in cash held of $29.521 million. This variance is the result of increases in cash receipts, including additional revenues from grants and contributions.

Summary of key performance indicators

Key Performance Indicators (KPIs) and KPI targets (determined by the Department of Health) assist EMHS to assess and monitor achievement of the outcomes outlined in the outcome based performance management framework (see page 21).

Effectiveness indicators provide information on the extent to which outcomes were achieved through the funding and delivery of services to the community.

Efficiency indicators monitor the relationship between the service delivered and the resources used to produce the service (i.e. activity and cost).

KPIs also provide a means to communicate to the community how EMHS is performing.

Note: This summary should be viewed in conjunction with detailed information on each KPI found in the KPI section of this report (see page 65).

Data legend **undesired** result **desired** result

Outcome one: public hospital based services that enable effective treatment and restorative healthcare for Western Australians.		
	2017-18 Target	2017-18 Actual
Key effectiveness indicators		
Unplanned hospital readmissions of public hospital patients within 28 days for selected surgical procedures (per 1000)		
Knee replacement	26.2	**21**
Hip replacement	17.2	**15.3**
Tonsillectomy and adenoidectomy	61	**94.4**
Hysterectomy	41.3	**68.4**
Prostatectomy	38.8	**33.8**
Cataract surgery	1.1	**1.2**
Appendicectomy	32.9	**17.5**
Proportion of elective wait list patients waiting over boundary for reportable procedures		
Category 1	0%	**25.4%**
Category 2	0%	**22.4%**
Category 3	0%	**5.2%**

Summary of key performance indicators

Outcome one: public hospital based services that enable effective treatment and restorative healthcare for Western Australians.		
	2017-18 Target	2017-18 Actual
Key effectiveness indicators		
Hospital infection rates (healthcare-associated staphylococcus aureus bloodstream infections (HA-SABSI) per 10 000 occupied bed-days in public hospitals)		
	1 per 10 000	**0.97 per 10 000**
Survival rates for sentinel conditions		
Stroke		
0 to 49 years	94.3%	**95%**
50 to 59 years	92.4%	**94.4%**
60 to 69 years	92.8%	**98.3%**
70 to 79 years	89.5%	**95.9%**
80+ years	80.9%	**90.8%**
Acute Myocardial Infarction (AMI)		
0 to 49 years	99.2%	**97.8%**
50 to 59 years	98.9%	**99.2%**
60 to 69 years	98.1%	**99.3%**
70 to 79 years	96.1%	**96.8%**
80+ years	91.7%	**94.6%**
Fractured Neck of Femur (FNoF)		
70 to 79 years	98.9%	**98.5%**
80+ years	95.3%	**97.2%**
Percentage of admitted Aboriginal and non-Aboriginal patients who discharged against medical advice		
Aboriginal patients	0.77%	**7.48%**
Non-Aboriginal patients	0.77%	**1.33%**
Percentage of liveborn term infants with an Apgar score of less than seven at five minutes post delivery		
	1.8%	**0.89%**
Rate of total hospital readmissions within 28 days to an acute designated mental health inpatient unit		
	12%	**15.7%**
Percentage of contacts with community-based public mental health non-admitted services within seven days post discharge from an acute public mental health inpatient unit		
	75%	**78.4%**

Summary of key performance indicators

Outcome one: public hospital based services that enable effective treatment and restorative healthcare for Western Australians.		
	2017-18 Target	2017-18 Actual
Key efficiency indicators		
Average admitted cost per weighted activity unit		
	$7285	**$6230**
Average Emergency Department cost per weighted activity unit		
	$7043	**$6842**
Average non-admitted cost per weighted activity unit		
	$7160	**$7238**
Average cost per bed-day in specialised mental health inpatient units		
	$1144	**$1482**
Average cost per treatment day of non-admitted care provided by public clinical mental health services		
	$409	**$422**

Outcome two: prevention, health promotion and aged and continuing care services that help Western Australians to live healthy and safe lives.		
	2017-18 Target	2017-18 Actual
Key efficiency indicators		
Average cost per person of delivering population health programs by population health units		
	$4	**$15**

This painting represents and incorporates the elders past and present that have led the way for better health for our Aboriginal and Torres Strait Islander people. It captures the stength and importance of working together and building a pathway for the next generation.

This painting represents East Metropolitan Health Service and the journey of holistic health and wellbeing of its community.

East Metropolitan Health Service

Governance/Overview

Enabling legislation

The *Health Services Act 2016 WA (HSA 2016)* introduced changes to the governance of the Western Australian health system by clarifying roles, responsibilities and accountabilities and by devolving decision making to the local level.

Section 32 of the *HSA 2016* provides for the establishment of Health Service Providers (HSPs). EMHS was established as a HSP by the Minister for Health under section 32(1)(b) of the *HSA 2016* on 1 July 2016.

Section 70(1)(b) of the *HSA 2016* stipulates that the Board is the governing body of the statutory authority and is to perform or exercise all of the functions of EMHS under this Act or any other written law.

Accountable authority

EMHS is a board governed statutory authority, where the EMHS Board is directly accountable to the public through the Minister for Health and works with the Director General of the Western Australian Department of Health (DoH).

The EMHS Chief Executive is employed by the Director General as the 'chief employee' of the HSP and is accountable to the Board.

Responsible Minister

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

WA Health governance structure, roles and responsibilities

Roles and responsibilities under the current governance model (as per the *HSA 2016* and in line with the Department of Health Statutory Board Governance Policy 2016) are outlined below:

The **Minister for Health** has overall responsibility for the Western Australian health system and provides direction to the Director General of the DoH and HSPs. The Minister for Health establishes (and dissolves) HSPs and appoints individual Board members (and designates a Board chair and deputy chair).

The **Director General** of the DoH, **(System Manager)**, is responsible for strategic leadership, including planning, policy and system performance. The System Manager enters into service agreements with HSPs for the provision of services.

EMHS, as the **Health Service Provider**, enters into service agreements which outline services and performance measures. EMHS provides safe, high quality healthcare to the community in compliance with the policy frameworks and directions issued by the Director General.

The **EMHS Board** determines the strategic direction of EMHS, ensuring compliance with WA health system policy frameworks, legislation, policies and standards. The Board is accountable for the service delivery and performance of the agency.

The **EMHS Chief Executive** is the 'chief employee' of EMHS and is responsible for coordinating and managing the day-to-day operations of EMHS, including employment of staff and other human resource functions.

Our vision and values

EMHS' strategic intent and operational plan were released in 2017, laying the foundation for the future of our health service, enabling us to deliver on a shared vision of **healthy people, amazing care.**

Our vision and values provide a basis for which excellent healthcare, innovation and creativity will be delivered to our community. These are aligned with the overall WA health system goal for the **delivery of safe, quality, financially sustainable and accountable healthcare for all Western Australians** and the whole of Government goal of **strong communities, safe communities, and supported families.**

EMHS values

The strategic intent and operational plan provide a blueprint for our strategic and operational priorities, grouped under the service delivery principles of:

- high performing systems and teams
- supporting cultural diversity
- consumer-centred
- intellectual curiosity
- active partnerships
- valuing our staff
- doing the right thing.

Note: please see page 26 for additional information on service delivery principles.

Our operational plan includes **46** key areas of focus to support our service delivery principles

Our Data and Digital Innovation team provided more than **400 000** reports

EMHS overview

EMHS provides a comprehensive range of surgical, emergency, mental health, ambulatory and primary health services to over 725 500 people living within Perth's eastern corridor. This includes the provision of both hospital and community based services within the East Metropolitan catchment area, in addition to statewide services such as the State Major Trauma Unit, based at RPH.

EMHS comprises the following health groups and hospitals:

Armadale Kalamunda Group (AKG), which consists of:
- Armadale Health Service (AHS)
- Kalamunda Hospital (KH).

Armadale Health Service, incorporating Armadale Hospital (AH) and mental health services, delivers a range of quality healthcare services including:
- 24 hour emergency department (ED)
- Intensive Care Unit (ICU)
- sub-acute services including rehabilitation and aged care
- general medicine and surgery
- maternity, paediatric and neonate
- mental health (adult and older adult)
- renal medicine and dialysis
- ambulatory care.

Kalamunda Hospital provides palliative care, geriatric medicine and endoscopic surgery services.

Royal Perth Bentley Group (RPBG), which consists of:
- Royal Perth Hospital (RPH)
- Bentley Hospital (BH).

Royal Perth Hospital is a tertiary hospital that provides an extensive range of services including:
- 24 hour ED
- ICU
- State Major Trauma Unit
- complex and elective surgery
- highly specialised surgical services
- tertiary mental health
- specialist medical services
- a range of same-day clinical support services.

Bentley Hospital is a specialist community hospital providing a range of inpatient and outpatient services including elective and same-day surgery, rehabilitation, obstetrics and gynaecology, aged care and mental health services.

St John of God Midland Public Hospital (SJGMPH): operates under a public private partnership with St John of God Health Care.

SJGMPH offers a range of public services including:
- 24 hour ED
- general medicine and surgery
- orthopaedics
- obstetrics, gynaecology and paediatrics
- geriatrics
- rehabilitation
- allied health
- mental health
- outpatient services.

St John of God Mt Lawley (SJGML): EMHS contracts assessment and restorative services for public patients through SJGML.

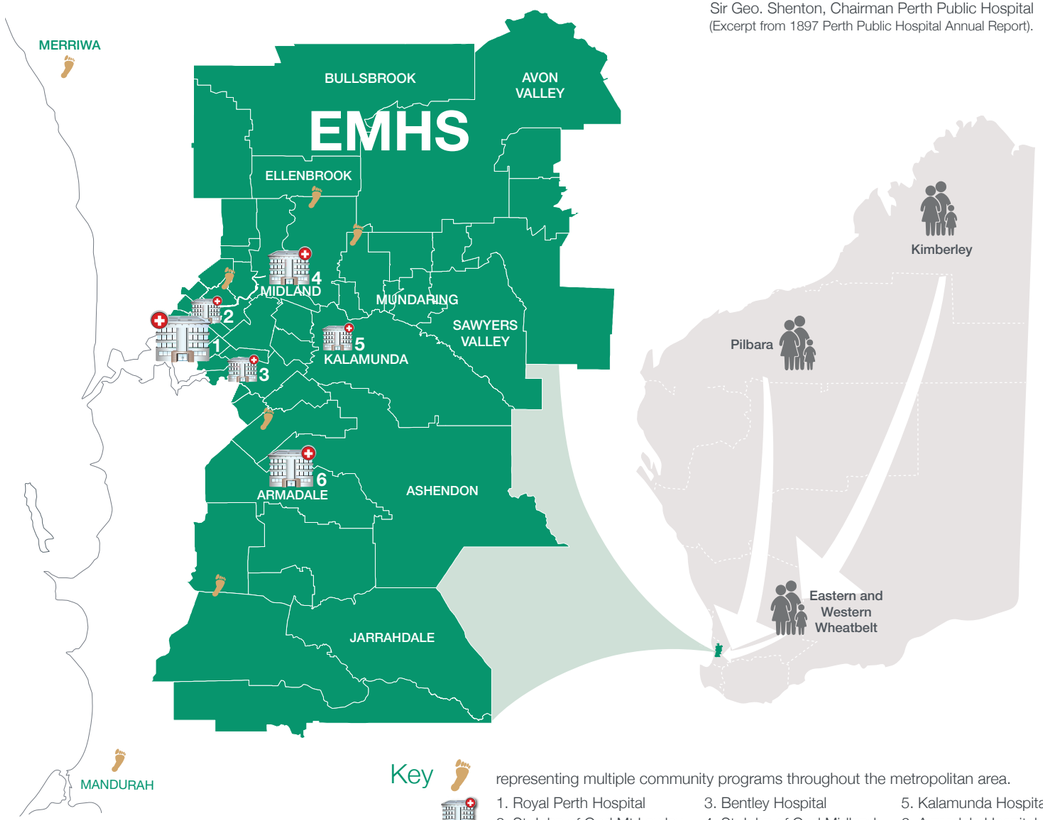
Population health programs: provide a range of community services to people both within the EMHS catchment and in the wider metropolitan area including Aboriginal health, rehabilitation, health promotion and public health services.

In addition, EMHS is the tertiary referral hub for WA Country Health Service (WACHS) patients from the Kimberley, Pilbara, Eastern and Western Wheatbelt regions of WA.

For more information, please see www.eastmetropolitan.health.wa.gov.au.

*"It may here be mentioned that cases presented for admission were by no means confined to the sick of Perth and suburbs, **but a large number came from country districts** and from the goldfields".*

Sir Geo. Shenton, Chairman Perth Public Hospital
(Excerpt from 1897 Perth Public Hospital Annual Report).



EMHS Board

From left
Richard Guit
Debra Zanella
Geraldine Ennis
Denise Glennon
Ross Keesing
Ian Smith
Peter Forbes
Suzie May
Kingsley Faulkner

Mr Ian Smith PSM
EMHS Board Chair

Ian Smith PSM has held various senior roles in WA Health, including Chief Executive of WACHS and the South Metropolitan Health Service (SMHS), and has overseen multiple capital redevelopments of hospitals and health infrastructure. Mr Smith has extensive experience in delivering health services throughout regional WA including personal advocacy for the improvement of Aboriginal Health. Mr Smith also chairs the Governing Council for the North Regional TAFE (Pilbara and Kimberley) and is a member of the Agency Management Committee for the Australian Health Practitioners Regulatory Agency (AHPRA). He was awarded a Public Service Medal in 2014 for outstanding public service for the provision of health services in WA over many years.

Mrs Suzie May
EMHS Board Deputy Chair
Chair, EMHS Board People and Partnerships Committee

Suzie May has had a varied career in government law, justice and prison reform, welfare, mental health and health consumer advocacy. She has been a state and national consumer advocate in musculoskeletal disease for 15 years and is currently a Consumer Advisor to the Australian and New Zealand Musculoskeletal Clinical Trials Network. Mrs May has been lecturing medical and allied health students on the lived experience of chronic disease at various WA universities for 13 years. She is currently a researcher with the Centre for Indigenous Peoples and Community Justice at the University of Western Australia (UWA) Law School.

Ms Debra Zanella
Chair, EMHS Board Audit and Risk Committee

Debra Zanella has worked in the not-for-profit sector for over 20 years, with significant experience in senior leadership roles in health and community services, particularly in the area of complex needs. Ms Zanella is currently the Chief Executive Officer of Ruah Community Services, an organisation that provides a range of services to address circumstance of disadvantage and marginalisation in the community, including housing and homelessness, mental health and domestic violence.

Mr Peter Forbes
Chair, EMHS Board Finance Committee

Peter Forbes is a chartered accountant and has held roles including CEO of specialist medical indemnity mutual MDA National, Managing Director of its wholly owned insurer, MDA National Insurance and was a founding partner and former Managing Director of the WA branch of chartered accountants HLB Mann Judd. Mr Forbes was also a Director of LawCover (the NSW statutory insurer for NSW solicitors), Chairman of Victorian health fund provider Transport Health and is currently a Non-Executive Director of the Local Government Insurance Scheme WA. In 2014 Mr Forbes was appointed as a Non-Executive Director of the Lions Eye Institute and was later elected Chair in early 2017. He is also a Non-Executive Director of Farmers Mutual Ltd and an external member of the Law Society of WA Professional Indemnity Insurance Management Committee.

Mr Ross Keesing
Chair, EMHS Board Planning and Service Delivery Performance Committee

Ross Keesing has worked in the health industry for 40 years, initially as a health facility architect and project director, then in a number of directorships and as an Assistant Commissioner for WA Health. Mr Keesing has experience managing WA metropolitan and regional health services, as well as private hospitals. As a consultant for nearly two decades, Mr Keesing has provided a wide range of tactical and strategic advice on health issues and directions to governments both in Australia and the Middle East.

Professor Kingsley Faulkner AM
Chair, EMHS Board Safety and Quality Committee

Kingsley Faulkner has worked in a range of clinical positions in both the United Kingdom (UK) and Australia. As well as his widely acclaimed surgical work, he has also contributed to the broader community and health sector through health advocacy, along with a range of teaching roles at the UWA and the University of Notre Dame. Professor Faulkner received a Member of the Order of Australia award in 2006 for service to medicine and is also a Professor at the University of Notre Dame School of Medicine.

EMHS Board and Chief Executive

Ms Geraldine Ennis PSM

Geraldine Ennis has over 30 years experience improving the delivery of health services in rural and remote communities. A registered nurse and midwife, Ms Ennis has been the Goldfields Regional Director of WACHS for the last 10 years and was formerly Director of Nursing and Health Service Manager of Katanning Hospital, where she was actively involved in establishing and working with the Board of Management for Katanning Health Service. Ms Ennis was also previously Chair of St Patrick's Catholic School Board in Katanning.

Ms Ennis was awarded a Public Service Medal in 2013 for outstanding public service in the provision of health services in rural and remote Western Australia.

Mr Richard Guit

Richard Guit is a partner in the infrastructure group at the global law firm Ashurst. With a diverse background in public-private partnerships and infrastructure, Mr Guit has extensive experience working with government agencies, investors and financiers across a range of infrastructure sectors. Mr Guit's main area of focus is social and economic infrastructure and he has advised on health-related undertakings in Australia and the UK such as the development of new acute care hospitals and the implementation of primary care initiatives and clinical outsourcings.

Dr Denise Glennon

Dr Denise Glennon is a graduate of the UWA and a Geriatrician who established the Orthogeriatric service at Sir Charles Gairdner Hospital (SCGH). Dr Glennon has spent the last decade embedding evidence based, best practice clinical care that has made SCGH Orthogeriatric Unit a leader in its field. Her commitment to continual quality improvement includes helping design and implement projects such as the WA Hip Fracture Registry, WA Hip Fracture Premium Payment Scheme and Health Round Table Global Improvement Initiatives in Hip Fracture Care. Dr Glennon is also committed to improvements in the workplace such as equal opportunity and delivery of a safe working environment through membership of the Australian Medical Association (AMA) Sexual Harassment Taskforce. Dr Glennon is also actively involved in medical education at all levels including being an examiner for the Royal Australasian College of Physicians.

EMHS also wishes to acknowledge Dr Stephanie Trust who was an inaugural EMHS board member serving from 1 July 2016 until her resignation on 17 January 2018.

EMHS Area Executive Group

Chief Executive
Liz MacLeod

Area Director of Nursing
Maha Rajagopal

Area Director of Allied Health and Health Sciences
John Buchanan

Area Director of Clinical Services
Mark Platell

Executive Director Corporate Services and Contract Management
Brad Sebbes

- Workforce
- Data and Digital Innovation
- Health Technology Management Unit
- Clinical Coding
- Procurement and Contract Management

Executive Director Safety, Quality and Consumer Engagement
Sandra Miller

- Clinical Governance
- Consumer Engagement
- Audit and Risk
- Policy

Director Office of the Chief Executive
Anne-Marie Presho

- Ministerial and Parliamentary Liaison
- Office of Chief Executive Support
- Board Support
- Legal / Freedom of Information
- Communications
- Research and Ethics

Acting Executive Director Clinical Services Planning and Population Health
Lisa Seaburne-May

- Population Health
- Aboriginal Health
- Clinical Services Planning
- Mental Health Coordination

Executive Director Finance and Infrastructure
Graeme Jones

- Finance
- Facilities Management and General Services

Executive Director Armadale Kalamunda Group
Diane Barr

- Armadale Health Service
- Kalamunda Hospital

Executive Director Royal Perth Bentley Group
Aresh Anwar

- Royal Perth Hospital
- Bentley Hospital

To view the EMHS Executive Group professional biographies please visit:
ww2.health.wa.gov.au/About-us/East-Metropolitan-Health-Service/About/Executive

EMHS would like to acknowledge Shae Seymour, who worked as the Executive Director, Armadale Kalamunda Group until 1 December 2017; and Karen McMenamin, who worked as the Executive Director, Clinical Services Planning and Population Health until 9 February 2018.

EMHS Area Executive Group

Outcome based performance management framework

To comply with its legislative obligation as a WA Government agency, EMHS operates under the Outcome Based Management (OBM) performance management framework determined by the DoH. This framework describes how outcomes, activities, services and KPIs are used to measure agency performance towards achieving the overarching whole-of-Government goal of **strong communities, safe communities and supported families** and the WA health system agency goal of **delivery of safe, quality, financially sustainable and accountable healthcare for all Western Australians.**

This is underpinned by key principles of:

Transparency: transparent reporting of performance against agreed outcome targets.

Accountability: clearly defined roles and responsibilities to achieve agreed outcome targets.

Recognition: acknowledgment of performance against agreed outcome targets.

Consistency: consistent systems to support the achievement of agreed outcome targets.

Integration: integrated systems and policies to support the achievement of agreed outcome targets.

DoH's 2017-18 KPIs measure the effectiveness and efficiency of EMHS in achieving the health outcomes of:

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

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

EMHS services that support outcomes one and two include:

Outcome one

Service 1. Public hospital admitted services.

Service 2. Public hospital emergency services.

Service 3. Public hospital non-admitted services.

Service 4. Mental health services.

Outcome two

Service 6. Public and community health services.

Please see pages 22-23 which show the correlation of outcomes and services to KPIs.

Performance against these services and outcomes are summarised in the Summary of KPIs section (see page 5) and described in detail in the KPI section (see page 65).

Outcome one

Public hospital based services that enable effective treatment and restorative healthcare for Western Australians.

Key effectiveness indicators for outcome one

1. Unplanned hospital readmissions of public hospital patients within 28 days for selected surgical procedures
2. Proportion of elective wait list patients waiting over boundary for reportable procedures
3. Hospital infection rates (healthcare-associated staphylococcus aureus bloodstream infections (HA-SABSI) per 10 000 occupied bed-days in public hospitals)
4. Survival rates for sentinel conditions
5. Percentage of admitted Aboriginal and non-Aboriginal patients who discharged against medical advice
6. Percentage of liveborn term infants with an Apgar score of less than seven at five minutes post delivery
7. Rate of total hospital readmissions within 28 days to an acute designated mental health inpatient unit
8. Percentage of contacts with community-based public mental health non-admitted services within seven days post discharge from an acute public mental health inpatient unit

Services delivered to achieve outcome one

1. Public hospital admitted services
2. Public hospital emergency services
3. Public hospital non-admitted services
4. Mental health services

Key efficiency indicators for outcome one

9. Average admitted cost per weighted activity unit
10. Average Emergency Department cost per weighted activity unit
11. Average non-admitted cost per weighted activity unit
12. Average cost per bed-day in specialised mental health inpatient units
13. Average cost per treatment day of non-admitted care provided by public clinical mental health services

WA Government Goal: Strong communities, safe communities and supported families.

Whole of WA Health agency goal: Delivery of safe, quality, financially sustainable and accountable healthcare for all Western Australians.

Outcome two

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

Services delivered to achieve outcome two

5. Aged and continuing care services
6. Public and community health services
7. Community dental health services
8. Small rural hospital services

Key efficiency indicators for outcome two

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

1956 Olympian Eric Roy with his wife Trisha and dietician Ellen at AH

Changes to the outcome based performance management framework

On 16 May 2017 the Under Treasurer endorsed a revised WA Health OBM Framework and suite of KPIs, for annual reporting from 2017-18 and beyond. This replaced a 15 year framework that was not contemporary or reflective of the current WA health system.

Changes to the framework included revision of existing outcomes one and two, as well as the introduction of an additional outcome to capture the role of the DoH and Health Support Services (HSS).

EMHS reports performance against outcomes one and two (see page 65), which encompass continuum of care across hospital (activity based funded) and community based settings and reflects WA health's strategic intent. These strategic outcomes provide a more accurate depiction of the impact of services delivered by WA health, while the revised KPIs correlate to existing reporting obligations.

The 2017-18 OBM framework and KPIs were included in the 2017-18 Government Budget Statements (GBS) and published in Budget Paper 2 on 7 September 2017, with targets determined as part of this process.

Shared responsibilities with other agencies

EMHS works closely with the System Manager, other HSPs and a large number of Government and non-Government agencies to deliver programs and services to achieve better health outcomes for the community of the eastern metropolitan region.

East Metropolitan Health Service

Service delivery and performance

EMHS service delivery principles

Our service delivery principles guide the way our health service performs, with a strong focus on establishing EMHS as a sustainable, forward thinking organisation.

These service delivery principles encompass the entire health service; the people who deliver safe effective healthcare, the consumers who use our hospitals and community-based programs, the EMHS community as a whole, and our researchers and innovators.

High performing systems and teams

Developing and maintaining high performing systems and teams to ensure our stakeholders have confidence in the care that we provide, both now and into the future.

Supporting cultural diversity

Partnering with Aboriginal and culturally diverse communities to provide networks that are free from prejudice and are culturally informed.

Consumer-centred

Providing consumer-centred care that empowers individuals to optimise their health and wellbeing.

Intellectual curiosity

Exploring and leading the translation of research into evidence based practice and innovations that will deliver excellent health outcomes.

Active partnerships

Working with our partners to build and facilitate health and wellbeing in our communities.

Valuing our staff

Standing out in our field as an employer of choice.

Doing the right thing

Encouraging and empowering our staff and consumers in making the right decisions to support better health outcomes.

One patient's journey

Four years ago, Grant was living in Bangkok with his wife Sue enjoying his retirement years. Suddenly, the couple were faced with an entirely new life course when Grant suffered a brain injury from a fall.

With a range of significant ongoing health issues, Grant and Sue moved back to Australia. After inpatient treatment at Fremantle Hospital, they then moved specifically to the AKG catchment area, to access its community rehabilitation service.

AKG Community Rehabilitation is a patient-centred, multidisciplinary service for adult clients who require comprehensive assessment and rehabilitation to optimise their function and remain in, or integrate back into, the community.

The team provides allied health, medical, and nursing services, with care delivered at Armadale Hospital, as well as in patient homes and at community venues.

When Grant arrived at the service, he was suffering from a range of physical, speech and memory health problems, as well as depression. He was assessed by the team, and was provided a suite of integrated services tailored to his needs – including social work, speech therapy, physiotherapy, occupational therapy and psychology services, and a regular overarching consultant physician.

"I felt supported right from the start. You can tell that everyone in the team wants to help," Grant says.

Shareenah Virahsawmy, Manager Community Rehabilitation, explains that the team has a holistic approach to patient management, working collaboratively from the time the referral is received, right up to discharge.

Other tools allow the integrated service to function optimally – for example patients are given a RehabPad to bring to appointments to track their progress, and weekly team meetings are held to discuss progress and ensure patients are tracking well with their goals.

Navigating different health systems can be particularly confusing and physically difficult for Grant. He explains that the integration of the services provided has been of immense benefit.

"It is really helpful that the services are all under one umbrella, because it has made me feel at ease. I haven't had to think about where I am going. This is really important for me as I would become confused otherwise."

The continuity of care provided by the team through excellent communication is also singled out as an important positive factor by the couple.

"I might go to a visit with the consultant, and the next week all of the other staff know everything that happened," says Grant. "I had one psychologist and then she swapped to another one – and it was like it was the same person but with a different face."

"It has been excellent how we are always able to access information from the different therapists, who are always very knowledgeable and helpful," adds Sue, who is Grant's full-time carer.

The team's patient-centred approach means that programs and appointments are customisable to the patient. "Without the flexible system I really believe that I wouldn't develop. I wouldn't be able to come to the appointments if they didn't fit them around my sleep routines," says Grant.

The service actively partners with community services such as the Community Physiotherapy Service, Silver Chain, Arche Health and 360 Health, to ensure linkage with the community and to continue any rehabilitation that may be required.

For Grant, this has meant that he has been able to access a local community leisure centre physiotherapy program.

He counts this, and other small things such as the social worker assisting Grant to access the NDIS and Sue to assist carer-support services, as having made all the difference.

The provision of programs in regular, small and familiar settings have been very helpful. Grant describes his weekly speech group – which he has been attending for a year – as "like a family".

The couple are both highly appreciative of the improved quality of life that the services have provided them.

"I can see a lot of areas of improvement in Grant's health. We are really very grateful," says Sue.

High performing systems and teams

In EMHS' second year of operation as a board-governed statutory authority under the *HSA 2016*, we continued to place a strong focus on monitoring a range of performance measures through a number of Board and executive-level committees.

The committees provide oversight of our performance relating to safety and quality; finance; planning and service delivery; mental health; audit and risk; and people and partnerships. Informing the Board, Chief Executive and Area Executive Group, the committees ensure our health service is operating as efficiently and effectively as possible, while still providing a safe, high-quality service to our staff and community.

Focusing on safety and quality

Recommendations of the 'Review of Safety and Quality in the WA health system', conducted by Professor Hugo Mascie-Taylor, were incorporated into an EMHS Implementation Plan. Strategies are being progressed and reported through to the Area Executive Group (AEG). A stocktake of current audit processes is currently being undertaken, with the aim of increasing safety, quality and visibility of patient outcomes across our health service.

Each of the hospitals within EMHS continued to work towards achieving the National Safety and Quality Health Service (NSQHS) Standards, with accreditation surveys scheduled early in the 2018-19 financial year at RPBG and AKG.

SJGMPH received positive feedback from the Australian Council of Healthcare Standards (ACHS) in a progress report received during 2017-18, in addition to full accreditation from the Postgraduate Medical Council of WA to train interns and resident medical officers in general medicine, stroke and neurology.

RPH's State Major Trauma Unit was recognised with formal Level One Trauma Verification from the Royal Australasian College of Surgeons in mid-2018, while the hospital also received accreditation from the Royal Australasian College of Physicians as a Level Three Teaching Hospital. AH also achieved a range of clinical accreditations throughout the year, including verification from the Postgraduate Medical Council of WA for the hospital's General Medicine and Medical Admissions Unit.

All EMHS sites have achieved Hazard Analysis at Critical Control Points (HACCP) accreditation which involves biannual audits to ensure food service compliance across a range of critical points, including food storage, refrigeration, preparation and disposal.

We used over **147 946** litres of milk across all of our hospitals

We served over **858 720** meals to inpatients

Enhancing systems and processes

During 2017-18, EMHS continued to prioritise quality of care in order to improve patient outcomes through comprehensive corporate audit processes. The appointment of a principal auditor strengthened the organisation's expertise in contemporary corporate audit practice, while also providing an advisory service on audit programs and functionality.

We continued to maintain our focus on strong financial performance, through a range of mechanisms including revenue reforms, expenditure and cost-control initiatives.

EMHS also expanded our upgraded patient administration system (webPAS) to include RPBG. WebPAS provides clinical staff across public hospitals with easier access to patient information, to improve patient care.

Patient information management was also addressed through improving patient billing and revenue collection. Processes were changed to ensure the accuracy of stored patient information, so that billing could be issued correctly and in a more timely manner. Increased efficiencies across other areas of the health service also helped to contribute to our overall strategic direction of high performing systems and teams. One example is the EMHS Clinical Coding Department, who work to record information from patients' medical records into a data classification system that is used for research, funding and healthcare planning. The Clinical Coding Department this year reported a consistent achievement of 99 per cent of clinical files coded (recorded) within defined reporting periods as per WA health policy.

Other cost-control initiatives introduced included a communications campaign across EMHS hospitals for staff to locate and return missing hospital scrubs, resulting in a cost saving of approximately $70 000 over a two month period.

RPH, BH, AH and KH have more than **387 150** patient files on site

Finding cost effective solutions

EMHS recognises that good inventory practices of consumable hospital stock ensure the right items are available for use, without wastage.

From March to December 2017 HSS and EMHS worked in collaboration to review all consumable stock levels on EMHS imprests[1]. This resulted in a one-off saving of approximately $600,000, and a reduction of approximately 400 000 registered individual stock items.

EMHS is continuing to work with HSS and ward leaders to define responsibilities and processes in the management of ward imprest stock; identify stock of nil demand; finalise a consumable stock management policy; improve reporting processes; review opportunities for cost-effective substitutes for some consumable items; and standardised ordering of imprest items across medical and surgical wards.

[1]An imprest stores frequently used and critical stock items for a ward.

Risk management

EMHS has an active risk management culture with clinical and corporate risks integrated into a single risk management system. Throughout 2017-18, EMHS has continued to develop risk management practices, ensuring that risks are identified, recorded, mitigated and monitored by the most appropriate areas of the organisation. Risk information is then reported through the AEG to the Board.

Key achievements in risk management for the 2017-18 year include:

- development of an EMHS Risk Appetite Statement
- identification of EMHS Board strategic risks
- implementation of a new EMHS Board Sub-committee risk accountability framework
- procurement and implementation of a new electronic risk management system.

The EMHS Risk Appetite Statement has provided clear direction from the Board regarding target levels of risks and how the organisation should review, act and monitor breaches.

The identification of strategic risks ensures the risk, controls, and activities are regularly monitored by the AEG and Board. Risk monitoring has been further strengthened by the implementation of a risk accountability framework, where all extreme risks are assigned to a sub-committee for monthly monitoring and oversight.

The sub-committees then report to the Board Audit and Risk Committee on a bi-monthly basis, on actions taken to mitigate risks and make recommendations on current risk status.

Key to EMHS achieving its improved monitoring and reporting of risk has been the implementation of an electronic risk management system. The system has standardised risk management processes across the organisation and has significantly improved the identification and assessment of controls.

EMHS plans to further refine risk management processes throughout 2018-19, with a focus on controls adequacy assessment and ongoing refinement of risks where there continues to be a residual risk rating above the documented risk appetite.

Enhancing leadership capabilities

Building leadership capacity by supporting staff to participate in leadership development programs is key to achieving our vision as a high performing health service. EMHS proudly supports leadership development across Executive and senior leadership, middle management, Aboriginal health staff, research staff, and specific staff groups which this year included Patient Support Services staff. The delivery of site-based programs is tailored to meet the needs of each hospital or service.

Through the establishment of a leadership alumni group, along with a range of additional programs and workshops including coaching, mentoring and targeted skill development, EMHS staff continue to access a range of opportunities to enhance their leadership capabilities.

In 2017-18, EMHS partnered with the Australasian College of Health Service Management (ACHSM) to present a ‘Women in Leadership’ series to support women in the workplace. Health is a female-dominant industry with approximately 73 per cent of the EMHS workforce comprising of female staff members.

State Major Trauma Unit celebrates tenth anniversary

In February 2018, the State Major Trauma Unit (SMTU) located at RPH celebrated its tenth anniversary.

As the designated provider of major trauma services for adults in Western Australia, SMTU treats approximately 80 per cent of the State’s major trauma cases.

The service provides world-class multidiscliplinary emergency trauma and critical care for patients suffering complex injuries both on a physical and emotional level, and has cared for more than 24 500 patients during the past decade.

The quality of care provided at SMTU has been recognised with formal Level One Trauma Verification from the Royal Australasian College of Surgeons.

Armadale Dialysis Unit celebrates 20 years of improving quality of life for renal patients

In April 2018, the AKG Renal Dialysis Unit marked 20 years of delivering high quality renal care to patients.The Unit was formed in 1988 to support the high population of people with kidney disease in the Armadale catchment area. At the time, the only option for patients requiring dialysis was to travel to the tertiary hospitals in Perth. Since its establishment, the service has grown from strength-to-strength and has marked a number of significant milestones in its 20 year history.

These include:

- Developing the service from a satellite dialysis unit to a comprehensive ‘in-centre’ unit for renal outpatients.
- Developing and training WA’s first Renal Nurse Practitioner.
- Initiating a number of innovative and ground-breaking pilot studies that have influenced the practice of renal care in WA.

The unit provides haemodialysis for up to 52 patients each week, equating to about 7500 dialysis sessions each year. It is WA’s only dialysis unit located outside a tertiary hospital that looks after intensive care and rehabilitation patients on site, enabling local patients to access tertiary-level dialysis care closer to home.

Supporting cultural diversity

Our vision of **healthy people, amazing care**, captures the essence of what we do, and what we inspire each other to do every day – show compassion, dedication and professionalism.

We celebrate the diversity of culture and languages across our health service, where our staff, patients and consumers hail from a variety of different cultural backgrounds.

Approximately 17 per cent of our total workforce was born overseas. This diversity allows our patients, consumers and carers to feel welcome, understood and supported when interacting with our staff.

Consumers from culturally and linguistically diverse (CALD) backgrounds are also provided with support and assistance to access professional and confidential interpreting services. Interpreters were accessed more than 13 300 times during 2017-18, facilitating better communication between CALD consumers and clinicians.

Cultural security

EMHS is committed to providing culturally secure services to the Aboriginal community within the catchment area. During 2017-18, EMHS implemented the Aboriginal Health Impact Statement and Declaration (ISD), which aims to ensure that the needs, interests and circumstances of Aboriginal people, including clients and employees, are incorporated into the development of new and revised policies, strategies, program practices and procedures. Policy owners within EMHS are now required to demonstrate that Aboriginal people have been consulted and negotiated with, and that the health impacts of Aboriginal people have been considered and appropriately incorporated whenever the health service is implementing new corporate or clinical policies, strategies or initiatives.

The introduction of a dedicated strategy to address institutionalised racism was also launched in late 2017. The strategy allocates key initiatives and clear deliverables for implementation by the health service to proactively address racism.

Statement from the Aboriginal Health Community Advisory Council

"We are committed to working alongside EMHS to build the foundations to achieve the best health outcomes for the Aboriginal community.

We continue to represent the community to create a health service that is built on respect and culturally appropriate care that meets the needs of Aboriginal people.

Together we are working towards closing the gap in Aboriginal health."

Ngalak balatj kidji working with EMHS warniny kidj moorditj kwabadak ngalak noongar moort.

Ngalak noongar boola moort warniny health services warniny moorditj noongar moort wangkiny.

Noonakutt moort kuryarn barangin warniny, dapakan woort kwoorl.

(Noongar translation)

Strengthening our relationship with the community

As part of our commitment to supporting cultural diversity across EMHS, the organisation has placed a strong emphasis on developing and nurturing strong links with our community through a range of engagement initiatives. This includes the formation of Aboriginal Health Community Advisory Groups and an Aboriginal Health Advisory Council which provide advice on service, program and policy development impacting Aboriginal consumers. Collectively, the four community advisory groups and the Aboriginal Health Advisory Council have nearly 40 community members representing over 18 700 Aboriginal people in the EMHS catchment area.

During 2017-18, the Aboriginal Health Community Advisory Groups and Aboriginal Health Advisory Council:

- Established nine working groups to address key issues in relation to racism, dental services, workforce, Aboriginal volunteer program, cultural respect framework, artwork, communication, patient journey and service delivery.
- Received recruitment and selection training to build members' capacity to participate in recruitment panels.
- Strengthened partnerships with EMHS through engagement and consultation on key strategic initiatives.
- Played a significant role in consultation on the development of EMHS policies, programs and services.
- Supported and contributed to significant cultural creations such as the commissioning of a dedicated EMHS Aboriginal artwork.

With strong engagement from Aboriginal community members, EMHS hospitals and services have been working to improve the patient experience for Aboriginal patients. Initiatives launched during 2017-18 include the Aboriginal Acute Care Coordination Program which aims to enhance the quality of care provided to Aboriginal people admitted to hospital with acute care conditions, while also providing follow-up care after patients are discharged.

Over the next twelve months, work will be undertaken to develop a cultural respect framework and cultural protocols guideline to assist staff in providing culturally secure services to our community.

17% of EMHS staff were born overseas

Some of the languages most commonly accessed through interpreting services were:

- Vietnamese
- Arabic
- Italian
- Farsi (Persian)
- Mandarin
- Dari

Aboriginal health programs

EMHS continues to support and invest in the delivery of services and programs designed to close the gap in the health system and improve the health and wellbeing of Aboriginal people. A range of healthy lifestyle and health promotion programs are delivered across the EMHS catchment area. These are designed to specifically meet the needs of the Aboriginal community, and are delivered by trained Aboriginal staff members at approximately 50 locations across the Perth metropolitan area.

There were 14 763 occasions of service recorded for these programs during 2017-18, which include:

- Walyup Kworpading Koort (healthy heart): Health education sessions are provided to consumers in the southern suburbs, including an exercise program facilitated by an exercise physiologist, podiatry services, walking groups and healthy food preparation.
- Moorditj Maarman (males yarning group): Held in Middle Swan, Aboriginal men are provided with health checks, the opportunity to discuss health issues, and support for spiritual, emotional and physical wellbeing.
- I'm Moordidjabinj (becoming strong): A healthy lifestyle and nutritional education program designed to help community members change unhealthy lifestyles, improve fitness and make healthy food choices. The program includes exercise, education and cooking sessions.
- Bibra Lake Men's Group: A program that promotes exercise, diabetes education and health checks for participants.

Boodjari Yorgas team at AH

- Boodjari Yorgas (pregnant women) Midwifery Group Practice: A service that provides holistic, culturally appropriate maternity and postnatal care for Aboriginal women and their families, based at AH. The service is comprised of midwives, an Aboriginal Health Officer and Grandmother Liaisons who work in collaboration with the hospital's mainstream maternity services.
- Journey of Living With Diabetes (JLWD): A culturally-appropriate program delivering diabetes prevention, education and self-management skills.
- JLWD and Perth Diabetes Care: A holistic diabetes health education program incorporating individual health assessments and education sessions. Participants have access to trained exercise physiologists, diabetes educators, dieticians and Aboriginal health professionals.
- Yarning it Up: A program that aims to reduce tobacco-related harm in the adult Aboriginal population. It includes community workshops and training for health professionals and promotes culturally appropriate services, including referral to nicotine replacement therapy.
- Aboriginal Youth Health: A service that delivers culturally appropriate health programs at schools. The program gives young people the opportunity to improve their knowledge of the harms related to alcohol and tobacco use and risky sexual behaviour. In addition, it increases their knowledge of how to access appropriate health services.
- Living Improvements for Everyone (LIFE): A culturally appropriate six-week program that provides a holistic, general model of care for the management of chronic conditions. The program recognises cultural, language and life differences, grief and loss, alternative communication methods, problem solving and action plans.
- Moort Boodjari Mia (family pregnancy place): Located in Midland, the service provides community-based antenatal and postnatal support to Aboriginal patients in partnership with SJGMPH.
- Moorditj Djena (strong feet): An award-winning mobile community outreach service providing chronic disease assessment, diabetes education and podiatry services. The service also includes the provision of general health, diet and medication advice and support.

Moorditj Djena community outreach in Midland

EMHS recognised at 2017 NAIDOC Awards

EMHS Community and Population Health Service's Moorditj Djena outreach podiatry and diabetes program was named 2017 Service Provider of the Year. Furthermore, Aboriginal Health Liaison Officer, Susan Jetta, was announced as the 2017 Elder of the Year for her work with the program at the prestigious Midland 2017 NAIDOC Awards.

Manager Aboriginal Health, Selena West said the NAIDOC Awards is an opportunity to recognise the outstanding contributions Aboriginal and Torres Strait Islander Australians make to improve the lives of Aboriginal people, promote issues in the wider community, or the excellence they have shown in their chosen field.

"Moorditj Djena is a holistic program and focuses on providing education to Aboriginal people about the prevention and management of diabetes, and the risk of foot complications, at various community clinics throughout the metropolitan area," Selena said.

"Moorditj Djena podiatry and diabetes staff play a vital role in raising community awareness about the importance of foot care, diabetes, nutrition and general healthy lifestyle management."

This year EMHS had:

78	Aboriginal staff
710	patient contacts with Aboriginal Health Liaison Officers (AHLO)
18 703	Aboriginal people living within the EMHS catchment area
22 379	Aboriginal outpatients
14 016	Aboriginal inpatients

Consumer-centred

More than 9000 patients had clinical photographs taken at RPH

Central to our vision of **healthy people, amazing care** is the provision of safe, high quality, consumer-centred care.

RPBG Executive Director talking with patient Mathana at BH

Improving the patient experience

In October 2017 EMHS launched its Walk a Day in My Shoes strategy, which builds upon the good work already undertaken by staff to provide consumer-centred care. This strategy provides staff with the tools to improve the patient experience through communications with colleagues, patients, families, carers and the wider community.

As part of the Walk a Day in My Shoes strategy, 459 clinical staff and 398 corporate/support staff across EMHS attended a series of workshops about how to enrich the patient experience through compassion, respect and professionalism. An educational video was also launched across EMHS to demonstrate real-life examples of how staff can have a significant positive impact on the patient experience through demonstrating compassion and empathy.

This year also saw leadership rounding commence, with members of the Executive team and RPH Consumer Advisory Council (CAC) visiting frontline services to meet with staff and consumers to discuss key achievements and challenges, and look at ways we can continue to improve our services.

Engaging with our consumers

In June 2018, EMHS held an inaugural public board meeting, which was attended by 55 consumers, carers, staff and members of the community. The initiative reflects our ongoing commitment to transparency and accountability, and provides our stakeholders with the opportunity to find out first-hand how our healthcare services are planned and delivered, and provide feedback.

Throughout the year, we continued to work closely with our community through consumer advisory councils and community advisory groups. The committees perform a valuable function, with members providing input as community representatives into the design and delivery of our services. This helps ensure that we are able to continue to work towards better health outcomes for our consumers.

EMHS Board at the inaugural public board meeting in Maylands

Valuing our volunteers

EMHS is fortunate to have the support of approximately 400 volunteers who dedicate their time to provide an enhanced level of care for our patients and consumers.

The unwavering commitment, generosity and compassion of our volunteers is evident across many areas of the health service. Examples include providing concierge services to help patients and visitors find their way in our hospitals; transporting patients to and from appointments; running on-site kiosks and snack trolleys throughout the hospitals, serving thousands of cups of tea in patient waiting rooms; and much more.

Volunteers Pauline and Keith with physiotherapist Ellie at the 'Forget Me Not' display at RPH

Our patient transport volunteers at RPH travelled more than 91 612 kms

In late 2017, a group of RPBG volunteers of the Forget Me Not program were recognised at the Rotary Allied Health Team Excellence Awards and as finalists in the WA Health Awards for their significant contribution to improving the care provided to patients with cognitive impairment. The Forget Me Not volunteers are trained to provide comfort and support to patients with dementia and delirium, and have quickly established themselves as a vital component in providing amazing care to patients.

A similar program, Vital, has been launched at SJGMPH, with volunteers providing high levels of comfort and support to patients with cognitive impairment.

Empowering our patients to manage chronic health conditions

In April 2018, AKG presented a workshop for members of the community about self management of chronic health conditions, in partnership with the WA Primary Health Alliance (WAPHA) and the City of Armadale.

Recognising that chronic disease impacts approximately one in two Australians and is associated with more than one in three potentially preventable hospitalisations, the education sessions were developed as a means to help empower patients to have a voice throughout their healthcare journey.

The workshop included presentations from AKG Executive Director, Di Barr, who spoke about the importance of healthcare services listening to patients, and from health consumers and consumer advocates who drew on their personal experiences of managing chronic health conditions and navigating the healthcare system.

Workshop attendees were given the opportunity to share their story, and provide feedback on their experiences with the healthcare system directly to healthcare providers.

Workshops were facilitated as part of the Building Collaborative Care with Community Services project, which has led a range of initiatives. These include the development of a directory of community service providers for clinicians and healthcare workers; hosting a networking forum for General Practitioners (GPs) and care providers about health and social care support services for patients with chronic disease; and improvements in the referral pathways for patients with chronic conditions.

Honouring excellence in consumer-centred care

KH Chaplain, Colleen McLevie, was recognised for her unwavering dedication to patients, their families and staff when presented with the Compassionate Care Award in the 2018 Health Consumer Excellence Awards.

These awards recognise the everyday heroes in health and acknowledge those who truly demonstrate a focus on ensuring consumers receive outstanding care throughout their healthcare journey. A large number of individuals and programs across EMHS were selected as finalists in these awards.

Alanah with mum Kellie at SJGMPH

Listening to our consumers

Listening to and acting on feedback from our patients, their families and carers about our health services is one of the most important aspects of delivering high quality care.

EMHS is committed to meaningfully engaging consumers, carers and community members in decision making to improve the health and wellbeing of the community. This meets the requirements of the National Safety and Quality Health Service Standard 2: Partnering with Consumers.

Feedback from our consumers is welcomed through a variety of mediums, and is used to recognise staff or services who have done a great job, or as a tool to help us improve our services. Consumers are encouraged to provide feedback through a number of different mediums, including direct contact with hospital staff and consumer engagement units; feedback forms; suggestion boxes; email; completion of a survey upon discharge; and sharing stories via Patient Opinion.

Patient Opinion is a social media website that enables members of the public to give feedback about their recent health care experiences. It provides EMHS with the opportunity to authentically respond and make changes where possible, to any concerns that are raised. The use of Patient Opinion as a feedback tool has been well embedded across EMHS. More than 132 stories were received about our services during the past year, and of these, 17 have directly lead to the implementation of service improvements, and a number of others have changes planned.

Patient Opinion: **what we did well**

Sourced from Patient Opinion

Patient Opinion: **what we could improve**

Sourced from Patient Opinion

EMHS Patient Opinion homepage: www.patientopinion.org.au/services/lhn_emhs_6000

The human element of caring, responding with compassion, empathy and building respectful relationships are the fundamentals for building positive experiences for our patients.

EMHS has comprehensive formal feedback management processes in place. Feedback about the provision of healthcare can be made by anyone who has contact with our services. People who submit feedback often have some basic expectations. They want to:

- be heard and understood
- be respected
- be taken seriously
- be given support or assistance if required
- have their concerns dealt with effectively and efficiently
- be informed of the process, progress, findings and outcome
- have appropriate action taken as a result of their complaint, and
- not be fearful of any repercussions of making a complaint.

During 2017-18, EMHS received 3341 contacts from patients through formal feedback processes, which included 883 complaints and 1979 compliments.

Communication issues underpin most complaints received by EMHS, with many people simply looking for an explanation to their concern or an apology. Complaints are used by EMHS as a learning opportunity, in order to prevent the same thing happening to other patients. EMHS is committed to acknowledging and responding to complaints in a timely manner.

Staff recognise that the complaint management process is not intended to apportion blame but strives to resolve the issue, where possible, and in doing so affect change in order to make improvement. It highlights key areas that patients and their families feel are important to them and require the health service to address.

Complaints in 2017-18 most commonly raised issues of:

- Quality of care – with themes relating to managing expectations and communication regarding assessment, treatment/therapy and discharge arrangements.
- Access - including delays in admission/treatment, inadequate resources and waiting list delays.
- Communication issues - including inadequate information about services, and problems with staff communication.

The launch of the Walk a Day in My Shoes strategy is providing EMHS staff with additional tools to tackle one of the most common causes of complaint, by driving targeted, patient-centric communication.

EMHS also reports complaint numbers and trends to the Health and Disability Services Complaints Office (HaDSCO) in accordance with the *Health and Disability Services (Complaints) Act 1995*.

Compliments received by EMHS recognised the efforts of staff with:

- 892 compliments including the word helpful.
- 701 compliments mentioning care, caring, or attention.
- 213 mentioning compassionate, thoughtful, or kind.
- 126 including polite, pleasant, or courteous.

We had over **20 million** hits on business intelligence applications

Over **2000** users regularly access data and analytics products

Intellectual curiosity

EMHS recognises the important role that research plays in the provision of amazing care, and actively encourages a culture of research, innovation and the ongoing pursuit of intellectual curiosity across all areas of the organisation.

EMHS is proud to be a centre of excellence for medical research and evidence-based clinical practice. Through the legacy of RPH, our health service has a long and distinguished history of innovation.

Focusing on improvement and innovation

A range of strategies have been explored to increase access to research programs across EMHS, and raise the profile of research and innovation within the health service. These include the development of a dedicated EMHS research strategy, strengthening partnerships with the Medical Research Foundation (MRF), stakeholder engagement forums and education sessions for staff involved in research.

In August 2017, EMHS appointed an EMHS Director of Research, Professor Graham Hillis. Professor Hillis' extensive international research experience, coupled with his experience as Head of Cardiology at RPH and Clinical Professor of Medicine at the UWA, is being used to advance research capability.

Work has been undertaken to enhance research processes across the health service. EMHS successfully implemented the Research Governance Service (RGS) - a WA health-wide information technology system for the approval and monitoring of research. The RGS will help ensure EMHS maintains high standards of research governance and oversight, including monitoring and reporting on research activities.

As part of a key State Government election commitment, EMHS is currently working to establish an innovation hub at RPH. The aim of the hub is to bring together external stakeholders to establish new and innovative ways to care for the people of WA, as well as create new opportunities abroad for technologies developed within the RPH precinct.

In early 2018, EMHS established the Data and Digital Innovation (DDI) division, with a focus on maximising our data, analytical and technological capabilities to optimise clinical care and deliver high quality services for our community. DDI assists EMHS in striving for excellence in healthcare by being at the forefront of innovative digital technologies and exploring emerging capabilities such as Artificial Intelligence (AI), machine learning, augmented reality, cognitive computing and the Internet of Things (IoT).

Two of our achievements to date include the release of the new Enterprise Data Warehouse - IDEA (Innovate Discover Experiment Analyse), and CCAR - a platform which automates the Clinical Coding Audit process.

A great deal of effort has also gone into the work required to modernise the IT infrastructure that supports EMHS, in particular Wi-Fi technology. Plans are underway to install Wi-Fi, which will be a key enabler for the introduction of an Electronic Medical Record (EMR) in the future. An EMR will not only allow clinicians to access real-time patient data at the bedside, but will also increase the data available for the development of algorithms that can predict and augment decision making.

DDI have also developed an AI implementation plan – Accelerate and Motivate, which details fifteen projects for the next financial year. These include a digital platform for our patients (eCarePLUS), voice activated bedside assistants, predictive algorithms for outpatient Did Not Attends and Hospital Readmissions, ChatBots for human resources as well as a number of other exciting activities.







The EMHS Health Technology Management Unit (HTMU) provides a range of important functions to the health service, including the provision of advanced biomedical engineering services to hospitals throughout WA. During the past 20 years, the unit has assisted more than 1000 patients with the manufacture of life-changing customised medical devices.

The service is a cooperative partnership between engineers, clinicians, scientists and researchers, and focuses on the translation of the latest technology into real life practice. This is founded on a long tradition of excellence in translational medicine, practical research and teaching.

The above images depict the process by which the HTMU team creates a spinal brace for a patient. This involves 3D scanning of the patient's torso, carving of a model torso through robotic technology, development of the spinal brace through moulding of a plastic sheet to the model, and finishing, trialling and fitting the brace to the patient.

HTMU made **26** titanium skull plates for patients

Research

A broad range of research projects are currently underway throughout the health service, across four main categories:

- Public health research: developing and improving disease prevention programs.
- Basic research: improving understanding of the causes and mechanisms of disease.
- Clinical research: improving the treatment and management of disease.
- Health services and systems research: enhancing the quality and effectiveness of healthcare delivery.

EMHS is supported by a number of organisations and programs that provide funding and resourcing for our research projects. These include the RPH MRF, the National Health and Medical Research Council, the WA Health Research Translation Program, and specialist local and national institutes including the Cancer Council, Healthway, Raine Medical Research Foundation, Alzheimer's Australia, the Heart Foundation and Kidney Health Australia.

These important relationships strengthen the impact and reach of EMHS' research progams.

During 2017-18, 77 newly conducted research studies were approved across fields including nursing, allied health and clinical areas.

Visit the EMHS website: www.eastmetropolitan.health.wa.gov.au to see examples of many other research projects underway across EMHS.

More than $1.027million in grants was awarded for human research studies within EMHS

Clinical trials commencing in 2017-18 will be commercially funded to the tune of $4.15million

Australian-first treatment of Fabry disease

RPH's Haematology and Nephrology departments have combined with our in-house Cell and Tissue Therapies WA unit to perform an Australian-first procedure to give hope to WA's Darling family, who have four children born with Fabry disease. The odds of all four children inheriting the debilitating disease is an astonishing one in 200 million.

Fabry disease is a rare genetic condition linked to a deficiency of an enzyme, alpha-galactosidase A. This disease can impact many parts of the body including the skin, eyes, gastrointestinal system, kidney, heart, brain and nervous system.

In June 2018, RPH patient, Reece Darling, participated in an Australian-first gene replacement trial using stem cells to carry healthy genes back into Reece's body, which is hoped to produce the missing enzyme, and potentially lead to a cure of Fabry disease.

The trial brought together a range of medical experts from across the hospital, who labelled the procedure as "absolute break through technology".

2017-18 research snapshot

77 newly conducted studies

26 investigator-initiated studies conducted by local staff and sites within WA Health

21 studies conducted in collaboration with not-for-profit organisations and institutions

14 clinical trials commenced, investigating new drugs and devices

16 studies performed in collaboration with Western Australian universities.

Claude, patient at BH

'GotRhythm'

An innovative research project is currently underway to explore the use of a mobile phone app, 'GotRhythm', in supporting patient rehabilitation following stroke. The 'GotRhythm' pilot study combines music therapy, technology and real-time biofeedback in an app which offers a simple, individually tailored rehabilitation program, set to music.

A/Professor Christopher Etherton-Beer said that stroke can have devastating effects on the body and finding ways to exercise after stroke can often be difficult.

"There is considerable interest in using music therapy combined with movement as a way to change the brain and improve recovery after stroke. This app enables stroke patients to participate in physical rehabilitation set to music in their own time, in the comfort of their own homes.

This is the first time this app has been used to support patients who have experienced stroke, and it's showing promising signs in helping to aid their recovery," said A/Professor Etherton-Beer.

Australian Team Approach to Polypharmacy Evaluation and Reduction (AusTAPER) study

Polypharmacy is the concurrent use of multiple medications by a patient, and in many instances, can lead to negative patient outcomes or diminished treatment effectiveness.

RPH is participating in a study of 'Australian Team Approach to Polypharmacy Evaluation and Reduction (AusTAPER)', which explores the effectiveness of a team approach to polypharmacy for older hospital inpatients. This study involves the use of a web-based interface which can be used in both hospital and community settings to record, evaluate and reduce instances of polypharmacy.

A/Professor Christopher Etherton-Beer said that the AusTAPER study can potentially bridge the gaps between hospital and community healthcare.

The program works by pharmacists and treating multi-disciplinary teams inputting the patient's full medication history into the program, which will then electronically flag any potentially inappropriate medicines.

"This study will help us to improve the clinical pathway for patients moving from the hospital to community health setting, and enable patients to better manage their own medications", said A/ Professor Etherton-Beer.

Chief Pharmacist David with A/Professor Etherton-Beer

Active partnerships

In 2017-18, EMHS partnered with a range of healthcare and community service providers in order to achieve our vision of **healthy people, amazing care** across our community. The past year has also seen greater collaboration and partnerships within the health service, to achieve more effective service delivery and greater continuity of care for our patients.

Partnerships within EMHS

EMHS works closely with St John of God Health Care (SJGHC) in the provision of public hospital services at SJGMPH, and assessment and restorative care services at SJGML.

EMHS continues to develop our contract management functions and team who oversee the contracts with SJGHC. A comprehensive suite of KPIs monitor the overall quality of the public healthcare services provided at both SJGMPH and SJGML.

A considerable amount of work has been undertaken across the health service to build interactive relationships between EMHS sites and services. The EMHS Planning, Innovation and Commissioning team has coordinated a broad range of initiatives that have built and strengthened collaborative working relationships between sites, including the development of a Clinical Services Plan; the Winter Collaborative program which sees EMHS hospitals work together to improve the patient journey during the busy winter months; and coordination of a uniform approach to management of the ear, nose and throat (ENT) outpatient wait list to improve patient waiting times through GP education and streamlined referral processes.

Interim Director of Corporate and Nursing Services Michelle and A/Nursing and Site Director Annette at BH

At Bentley Hospital, substantial work has been undertaken to integrate mental healthcare streams with allied health and general medicine, resulting in a more collaborative approach to mental healthcare. Patients have benefited from a new outdoor gym and increased access to allied health services, including a mental health physiotherapy service. This service has produced excellent results, including a reduction in falls within the older adult mental health patient cohort.

Partnering with care providers

Recognising that the patient journey continues well beyond the hospital environment, many services across EMHS continue to work with healthcare and community service providers to achieve the best outcomes for our patients.

At RPH, an Acute Medical Ambulatory Centre trial is underway to provide rapid access for acute medical consultations for general practise patients via a consultation telephone service. The trial service was launched in January 2018 and is being piloted through thirteen general practices, including Derbarl Yerrigan Health Service, within Perth's eastern metropolitan region. The service enables GPs to have direct and timely access to acute medical specialists to plan investigations and treatment for patients who may have otherwise been referred to the RPH Emergency Department. It is anticipated that the service will be expanded to more GPs in the second half of 2018. RPH has worked closely with the WAPHA who have provided support in engagement with GPs.

In early 2018, Bentley Hospital's Maternity Unit launched a shared care program which is a joint arrangement between the hospital and GPs. Shared care enables healthy, low-risk pregnant women to continue to see their GP for most antenatal appointments during their pregnancy, while also enabling access to antenatal care with a specialist obstetrician. This program improves the patient experience by providing greater continuity of care for the patient between the hospital and primary health providers.

AKG's Community Mental Health team are also trialling a strategy to improve community team management of mental health conditions, focussing on improving collaboration and links with GP liaison services and support to carers.

Aboriginal patients within our community are also benefiting from a new Aboriginal Acute Care Coordination program, which was launched in early 2018. This program aims to improve the client health journey through advocacy, health education, linking with relevant Primary Health Network programs, follow-up GP appointments and support to attend outpatient appointments.

Improving access to care

As part of a focus on improving access to care, EMHS utilises video technology to assist patients unable to attend appointments in person to communicate with healthcare professionals through the Telehealth and Video Call programs.

In 2017-18, 5603 patients from regional areas were able to attend appointments with RPH clinicians via Telehealth, as part of an ongoing partnership between EMHS and WACHS. This technology brings care closer to home, enabling regional patients to attend a local clinic or hospital and have an appointment with a Perth-based clinician via video link.

We ordered more than **3.965 million** individual items of linen

We ordered more than **591 560** disposable hospital gowns

In partnership with the Department of Justice, RPH commenced a program in late 2017 where hepatitis patients in WA prisons can now attend specialist appointments with the RPH Hepatitis C Service via Video Call. Chronic Hepatitis C can be associated with conditions such as liver failure and liver cancer, and through the use of Video Call, these patients are now able to receive essential specialist care more quickly and easily.

Video call technology is also available to both metropolitan and regional patients to have face-to-face appointments with RPH clinicians using their home computer, phone or tablet device without having to travel to hospital for the appointment. Both Telehealth and Video Call help to make the patient experience more comfortable and convenient, by enabling patients to consult with their medical specialists from the comfort of their own home or local community.

Partnering to support students and graduates

EMHS continues to partner with a range of educational and research institutes to provide opportunities for staff and students to further their education through clinical placements, internships, quality improvement initiatives and research projects.

In May 2018, SJGMPH entered into an agreement with Curtin University to host a number of medical students for work experience placements commencing in 2019.

EMHS continues to monitor student placements, with a survey conducted of nursing and midwifery placements between July to December 2017 indicating a high level of student satisfaction.

We provided **2394** undergraduate placements for nursing and midwifery students

88 per cent of students surveyed noted that they were able to develop their competence and confidence as a nurse or midwife through their clinical placements, while 91 per cent agreed that the manner of clinical instruction provided by EMHS hospitals enhanced their learning experience.

"I loved this placement very much and I would be absolutely ecstatic to have a placement here again when I pursue my registered nursing."

Student nurse from Kalamunda Hospital

More than 700 doctors in training across Perth's tertiary hospitals contributed to the 2018 'Hospital Health Check' review conducted by the AMA WA which awarded RPH high marks for morale, culture, teaching and training. The review found that 92 per cent of surveyed doctors noted that they would recommend RPH to others – the highest score across all hospitals surveyed, with 84 per cent indicating that they felt supported by the hospital.

Partnering for a healthier community

Through its dedicated health promotion team, EMHS partners with a range of community, government and non-government agencies to reduce the prevalence of lifestyle-related chronic disease, particularly within vulnerable communities.

The five key priorities for the health promotion team are obesity, physical activity, smoking, diet and injury prevention, and a range of programs have been developed to address each one.

We ordered more than
1.672 million
pathology tests

Partnerships with organisations including Curtin University, Live Lighter, the Australian Prevention Partnership Centre, the Sax Institute and the Heart Foundation have aided the team to explore a range of initiatives to help create healthier communities and prevent lifestyle-related chronic health problems.

In partnership with local governments, EMHS led the 2017 Food Access and Cost Survey (FACS), which monitors the cost, quality and availability of food as a determinant of food choice, health and food security. The FACS mapped grocery store locations and collected information about retail costs, promotion and quality ratings of approximately 450 commonly available foods from 136 supermarkets across the Perth metropolitan area. The survey analysed household affordability by local government area; the cost of foods across all food groups; and the cost and promotion of sugary drinks. The information gained from the FACS will be used to inform and support policy discussions regarding food pricing, affordability and access.

In conjunction with Curtin University and the Heart Foundation, EMHS is piloting the Australian Prevention Partnerships Centre Prevention Tracker – an approach that assists local communities to better understand their prevention systems, in an effort to address lifestyle-related chronic disease. This pilot will address the complex issues of obesity and assist in implementing systems for the prevention of chronic disease.

The EMHS Health Promotion team are also working with a range of organisations to develop a plan to reduce alcohol-related harm in the local government areas of Armadale, Gosnells and Canning. This project is currently underway in partnership with the Mental Health Commission, WA Police, Child and Adolescent Community Health, School Drug Education and Road Aware, Richmond Wellbeing, Hope Community Services, Australian Drug Foundation, Parkerville Children and Youth Care, Neami National, City of Canning, City of Gosnells, City of Armadale and the WAPHA.

Partnering for youth injury prevention

The Prevent Alcohol and Risk-related Trauma in Youth (PARTY) program is an injury prevention initiative which was launched at RPH in 2006. The initiative has since been introduced via satellite programs to a range of other regional hospitals around the state, as well as SJGMPH.

The PARTY program, which is offered to high school students in years 10, 11 and 12, has been attended by more than 15 000 students since its inception and has played a big role in helping students to adopt behaviours and actions that minimise risk.

In order to completely involve the students in the experience of injury and recovery, the group is taken through the common course of injury and treatment of someone involved in a trauma, often due to risk-taking behaviours.

Through a variety of teaching techniques including interactive lectures, videos and tours of the ICU, ED and trauma wards, as well as a visit from an injury survivor, students see first-hand the potential consequences of risk-taking actions.

The program engages and collaborates with injury prevention organisations and health professionals both within the hospital and externally including St John Ambulance, Headwest, RPH drug and alcohol and physiotherapy staff and the Paraplegic Benefit Fund.

During 2017, the PARTY Program was selected as a Finalist in the Insurance Commission of Western Australia's Regional Safety Award. It was also recognised as a highly commended finalist in the Injury Prevention and Safety Promotion Awards presented by the Injury Control Council of Western Australia and Know Injury.

"Our goal is to reduce the incidences of trauma particularly in 16 to 24 year olds and ultimately see a reduction in the rates of injury and mortality."

Valuing our staff

The outstanding achievements of our health service reflects the achievements of our staff – a group of 7935 dedicated and compassionate individuals who work across EMHS sites and services.

Note: please see 'important note' in disclosure and legal compliance section on page 186 regarding staff inclusions.

Staff support and wellbeing

EMHS continued its firm commitment to supporting staff with a range of strategies, including the provision of ongoing learning and professional development opportunities; prioritising staff safety and wellbeing; and eliminating discrimination and harassment in the workplace.

All EMHS staff are provided with access to employee assistance programs and support networks such as pastoral care and employee support officers.

Employee wellbeing and wellness committees have been established across the health service, with each committee leading initiatives including fitness and healthy lifestyle programs, mindfulness, and self-care programs.

A dedicated junior doctor wellbeing program provides integrated care and support to junior doctors as they rotate through EMHS hospitals. This program provides tailored support to junior clinicians with peer support, a dedicated wellbeing officer and targeted strategies including peer group sessions, workshops and training designed to support both the mental and physical health of our junior doctors.

EMHS has also worked closely with organisations including the AMA WA, and the Royal Australasian College of Surgeons to implement programs aimed at eliminating sexual harrassment, discrimination and bullying in the workplace.

RPH chaplain, Rich

Engaging with our staff

EMHS Board and Executive continue to seek opportunities to engage with staff through a range of initiatives, including leadership rounding – where members of the leadership team regularly visit work areas, in addition to regularly scheduled staff forums and events.

In early 2017, EMHS conducted a staff survey which provided staff the opportunity to provide feedback on all areas of the organisation, including job satisfaction, workplace safety, leadership, work-life balance and engagement. Results from this survey have been used to develop action plans to address areas for improvement across the health service.

Using ideas to drive real change

Across both RPBG and AKG, staff have been invited to contribute ideas and suggestions which can improve the way we work, our services and the care we provide to patients. These ideas have been used to drive real change throughout the health service.

At BH, Geriatric Clinical Nurse Marilyn Sebastian submitted an idea of a pet therapy program for the hospital's dementia patients. This idea has been put into practice, with patients in two wards receiving regular visits from the therapy dogs. Other areas of the health service are now exploring options to implement pet therapy in their areas.

Celebrating achievements

A significant number of EMHS programs, services and individuals were recognised as winners and finalists throughout 2017-18 for excellence to the healthcare sector, in the WA Nursing and Midwifery Awards, WA Health Excellence Awards, Rotary Allied Health Team Excellence Awards, Health Roundtable Awards, and the Health Consumer Excellence Awards.

At a local level, staff recognition programs have been developed to recognise long serving staff, and those individuals who go the extra mile and perform above and beyond their call of duty.

Pet therapy dog, Imshi, at BH

Dr Lucy, RPH Director of Postgraduate Medical Education and Geriatrician; Maxine, RPH Trauma Program Manager; Christine, Bentley Hospital Registered Nurse; and Michael, RPH Mailroom Courier receiving RPBG Outstanding Service Awards. These annual awards recognise excellent staff for their hard work and dedication to RPBG.

RPH Staff Development Educator Nick May's 'Take 5' education initiative has been recognised both within Australia and internationally as an innovative way to deliver informative and succinct education to health professionals.

'Take 5' presentations consist of a brief, five minute electronic education session, providing an alternative to traditional face-to-face training. The presentations cover both clinical and corporate topics and help to ensure staff skills and knowledge remain up to date.

'Take 5' was recognised at the Health Roundtable Symposium in August 2017 with first prize in the Developing a High Performing Organisation category. The initiative has since been used at health services within WA, New South Wales and in the UK.

Meet just a few of our unsung heroes

From left:
Leia Pilkington
Ward Clerk, Bentley Mental Health
Owen Vaughan
Plumber, Facilities Management, RPH
Maxine Nicholson-Turner Senior Project Officer, Community Engagement, Aboriginal Health Strategy
Sophie Lindley Human Resource Consultant, EMHS
Thomas Trowell Refrigeration Fitter, Facilities Management, RPH
Myo Kyaw Catering Assistant, RPH
Reverend Ken Devereux Chaplain, Pastoral Care Services
John Burrage Senior Medical Physicist, Health Technology Management Unit
Sally Longley Medical Artist, Medical Illustrations, RPH
Sharon Chambers Patient Catering Supervisor, RPH
Helen Stanley FOI Coordinator, RPH
Criona Smith Senior Contracts Manager, Contract Services
Ian Hewitson Patient Care Assistant, Patient Support Services, RPH
David Martin Operations Team Manager, Data and Digital Innovation
Trudi Young Travel Coordinator, EMHS Office of Chief Executive
Peter Lawrence Leading Hand, Linen Services, RPH
Ying Choo Planning, Innovation and Commissioning Consultant, Population Health
Dusty Ellen Clerk, Patient Information Management Services, AKG
Gina Ingram Coding Clerk, Health Information Management Services RPH
Malcolm Hare Analyst, EMHS Safety, Quality and Consumer Engagement
Fiona Heneker Aboriginal Health Promotion Worker, Population Health
Samantha Barac Medico-legal Officer, EMHS Medico-legal
Joshua Rivers Aboriginal Health Promotion Officer, Population Health
Phillip Aquilina Business Analyst, EMHS Finance.

Meet some of the unsung heroes of EMHS: the people who help our health service deliver on our vision of **healthy people, amazing care**, each and every day.

Doing the right thing

EMHS has developed a range of initiatives to support and empower staff and consumers to achieve better health outcomes.

Encouraging transparency and ethical practice

EMHS continues to actively encourage a culture of transparency and ethical practice at all levels of the organisation. This focus on transparency and accountability was demonstrated in the 2016-17 EMHS Annual Report, which received the Office of the Auditor General Award for Transparency and Accountability in the 2018 W.S. Lonnie Awards.

Detailed information about the health service's safety and quality performance has also been made publicly available on the EMHS website, with plans to release additional reporting measures during the course of the next year. This commitment to public transparency was one of the key recommendations from the review into safety and quality across the WA health system led by Professor Hugo Mascie-Taylor.

RPBG's 1000 Day Challenge was also introduced as a strategy to help achieve a goal of becoming Australia's Safest Healthcare Group. This challenge includes clearly defined goals and tasks for RPBG staff to complete across a period of 1000 days, with key priority areas including delivering what matters most; no patient harm; developing a culture of continuous improvement; and delivering consistent high quality care.

Improving the patient journey

A vast number of programs and initiatives are underway across EMHS which focus on improving the patient journey, including:

- Amazing nursing care: A targeted strategy to recognise and improve upon the care provided by EMHS nurses and midwives, recognising the immense role these individuals play in influencing patient care, treatment and recovery. Areas of focus as part of this program include strategies to improve falls, pressure injuries, escalation of care, rapid deterioration and improved handover.

Nursing team collaboration at AH

- Navigating NDIS: A steering group formed to aid staff and patients work through the National Disability Insurance Scheme (NDIS), to help ensure patients are not in hospitals for extended durations, and are provided with support to access funding or navigate eligibility criteria as quickly as possible.
- Length of stay: Programs across RPBG and AKG were implemented with the goal to prevent and limit unnecessary length of patient stay in hospital.
- Winter collaborative: A program designed to improve the journey and outcomes of patients presenting to hospitals during the busy winter period, and strengthening hospital capacity during periods of increased demand.

High value healthcare

Sustainability of health care is increasingly being recognised as one of the most important issues within our field. EMHS has taken the lead by promoting high value healthcare through programs such as Ensuring Essentials and Choosing Wisely.

These programs focus on improving the quality of patient care by eliminating unnecessary tests, treatments and procedures that do not add value to, or benefit, patient outcomes.

Through improved transparency, evidence-based practice and patient empowerment, these programs promote practices that reduce unwarranted clinical variation, minimise waste, improve efficiencies, drive value (and thereby reduce costs) and ensure sustainability.

Highlights of the Ensuring Essentials program during 2017-18 include:

- Successful engagement with clinical staff and consumer groups across EMHS to promote high value healthcare.
- A pilot consumer strategy to support patients in shared decision-making, including consumer information materials to enhance health literacy.
- A value-based quality improvement methodology to investigate unwarranted clinical variation with clinicians that raises questions about effectiveness and value and leads to evidence-based quality improvement changes to practice and better patient outcomes.

Better mental health support for youth patients

In June 2018, EMHS opened a new dedicated youth mental health ward at Bentley Hospital, known as the East Metropolitan Youth Unit (EMyU).

The EMyU is a 12-bed inpatient service that provides 24/7 mental health inpatient care and treatment for young people aged 16 to 24 years, presenting with complex and acute mental health issues, with a focus on early episode interventions.

Improving the response to clinical deterioration

AKG's Rapid Response to Clinical Deterioration (RRCD) project was recognised as a winner in the 2017 WA Health Excellence Awards for its innovative approach to improving safety and quality.

As part of the RRCD project, a new three-pronged approach was implemented that incorporated:

- Recognition: introduction of an early warning system using service-specific multi-parameter charts.
- Response: structured escalation protocols were established, and an ICU-led Medical Emergency Team (MET) and multidisciplinary clinical staff education program was rolled out.
- Critical care advice and support: a Critical Care Outreach Team was created which provides the wards with multidisciplinary advice, and post ICU follow-up and support in the management of patients with acute illnesses.

AH's ICU Head of Department, Dr David Blythe, said the initiative has improved the communication between ICU and other departments, such as general medicine and surgery.

"One of the aims was to change the thinking that the MET team was only to be called when the patient had stopped breathing or had gone into cardiac arrest," Dr Blythe said.

"We now prefer patients receive senior medical attention much earlier."

Since the initiative has been implemented, the number of cardiac arrests has dropped by 85 per cent while MET calls have more than tripled. This indicates that better patient outcomes were achieved when calls for help were made earlier.

A significant positive change in hospital culture was also achieved. Ward staff better understand and recognise deterioration, they are more confident to manage deteriorating patients, and are more willing to initiate a MET call without fear of being criticised.

"The staff on the ward feel safer knowing that we are there as a backup, should they require it."

As part of the RRCD initiative, the Recognising and Responding to Adult Inpatient Deterioration (RRAID) education program was successfully implemented. This course provides staff with structured learning in the management of patient deterioration.

Since RRCD was launched, AH has consistently been in the top quartile for RRCD parameters in the Health Roundtable reports, and the hospital's risk-adjusted rate for cardiac arrests has been in the best quartile since the final quarter of 2014.

AH has also been recognised as having one of the lowest hospital diagnosis standardised mortality ratios amongst similar sized hospitals across Australia and New Zealand.

We treated
580
inpatients who had no fixed address

Helping the homeless

More than 9000 people are estimated to be homeless in WA, with 12 per cent, or over 1000 individuals, 'sleeping rough', mostly in the Perth Central Business District. The unfortunate consequences for many homeless people include high rates of chronic health conditions, complicated co-morbidities, reduced life expectancy and social and economic vulnerability.

To address this challenge, RPH developed the Royal Perth Hospital Homeless Team (RPH HT), a collaboration with the Homeless Healthcare GPs and Ruah Community Services. Now in its second year, the program works to improve outcomes for homeless patients both inside and outside the hospital through inpatient support, improved discharge planning, and linking patients with community-based services to address underlying health and social needs.

RPH consultant, Dr Amanda Stafford is one member of this small team that is collectively working to address the missing piece of the puzzle when it comes to healthcare for homeless people.

"We see many highly vulnerable people who need support in many areas of their life. We're not just addressing a health issue – we're providing understanding and judgement-free interactions focused on making a long-term difference in that person's life," Dr Stafford said.

The RPH HT collaborates with dozens of community-based services to support and advocate for patients beyond the traditional model of service delivery. They have helped over 700 patients receive treatment for underlying medical and mental health issues, navigate the health system, engage with primary care services and link up with homelessness services to find the accommodation and support they need to move out of homelessness.

"Homeless patients are traditionally high users of hospital EDs, however frequent ED presentations and admissions are both costly to the health system and do little to address underlying chronic medical and social issues.

Homeless Healthcare team member with patient Andrew at RPH

Since we started the RPH HT, we've seen a significant reduction in the number of homeless patients within RPH's most frequent ED presenters.

People who are homeless can often feel like they're invisible, and we're working really hard to change that perception at RPH. We've seen great outcomes by making a strong connection with the patient and linking them with support networks and services to help address their individual needs.

We are very fortunate to work with many great community services because the most important health intervention for people experiencing homelessness is the stability of long term housing and individualised community-based supports. With a Homeless Team working within RPH, we are not just treating and discharging these patients, we are helping to improve their long-term health and wellbeing. That is great for these patients and for the hospital," Dr Stafford said.

Key areas of focus

During our second year of establishment as a board-governed statutory authority, key areas of focus included staff safety, workforce, meeting community demand, waiting times, and continuing to deliver safe and high quality care.

Staff safety

EMHS also continues to look at opportunities to address increasing levels of aggression and violence against staff.

In 2017-18, 6994 aggressive incidents were reported across EMHS sites. Incidents include situations where staff members felt threatened, duress alarms were activated, violent altercations occurred, verbal or physical abuse was experienced, and self-harm attempts or threats were made by patients. An additional 2449 'standby' incidents were reported, where a situation had the potential to escalate into an aggressive incident, but did not eventuate in security intervention.

As part of the Stop the Violence initiative, EMHS continues to focus on supporting staff in the management of aggressive incidents, while also seeking opportunities to actively reduce or prevent aggression. Key actions include increased staff training and awareness, workplace reporting and cultural change, staff and community engagement and increased closed-circuit television (CCTV) and security presence. A study tour to Victoria and New South Wales was also completed in mid-2018 to review strategies deployed by other hospitals to manage aggressive incidents.

"I can't care for you if I don't feel safe"

An average of **583** aggressive incidents were reported each month across EMHS

Workforce

Skill shortages in a small number of clinical specialties continues to present challenges for EMHS in attracting and retaining staff in areas such obstetrics and gynaecology, emergency registrars and general surgery, particularly in the general hospital sites. Initiatives launched to address these shortages include enhancing staff and clinical engagement and providing training opportunities to support medical leadership. Within the EMHS nursing workforce, challenges have included attracting appropriately skilled nursing staff; managing rates of sick leave, particularly over the busy winter period; and ensuring the correct skill mix. These issues are being addressed through comprehensive professional development and upskilling programs and the continued support of graduate programs and clinical placements for nursing and midwifery students.

In late 2017, an external review was undertaken of the City East Community Mental Health Service, which provides specialised mental health treatment and care to inner-city adults. The review identified opportunities for improvement across the areas of management and governance, the model of care, and engagement with employees. Following the review, RPBG Executive have been working with staff to address the recommendations to ensure the service is able to maintain a safe working environment for both employees and patients.

A range of strategies were also implemented to improve staff morale and engagement at AHS. A comprehensive staff engagement program and review into general medical services resulted in a number of recommendations implemented across the sevice.

The staff of both the City East Community Mental Health Service and AHS must be commended for their support and engagement with the change processes occuring within their work areas throughout the past year. The dedication and commitment of staff has enabled the continued provision of safe, high quality care to our patients and consumers despite challenging times.

Meeting community demand

EMHS maintains a strong focus on ensuring that services are delivered in the most appropriate setting; within clinically appropriate timeframes and within purchased activity.

Demand for EMHS services remains significant, and in 2017-18:

- 203 013 people were treated in our EDs
- 145 239 people were admitted as inpatients to our hospitals
- 4666 babies were born in our hospitals
- 48 639 operations were performed across our hospitals.

The health service has continued to target reducing elective surgery and outpatient appointment waitlists throughout the year, with key areas of focus including ENT, gastroenterology, urology and plastic surgery.

To address increases in the ENT outpatient waitlist, EMHS worked with other health service providers to develop a revised referral criteria for ENT patients presenting to metropolitan hospitals. This new criteria was supported by a program of GP engagement and education sessions to support GPs to provide better care for ENT patients in the primary care setting.

Strategies employed to reduce the elective surgery waitlist included scheduling additional theatre sessions, increased resourcing in key areas, and reallocation of surgical activity across hospital sites within EMHS where clinically appropriate, to enable patients to be seen faster.

Hospital EDs have also seen increased presentations of patients requiring attention with mental health, drug and alcohol-related issues. A dedicated Urgent Care Clinic (Toxicology) was opened at RPH in May 2018 to provide specialised services for patients presenting with drug and alcohol issues or behavioural disturbances.

Waiting times for emergency hospital care

Managing demand in hospital EDs is a priority for EMHS. Each EMHS site with an ED (RPH, SJGMPH and AH) measures performance against the WA Emergency Access Target (WEAT). WEAT is tracked on a daily, weekly and monthly basis, and a range of strategies are in place to ensure sustained performance, timely access and equity to patient care within the ED.

EDs are multidisciplinary units with expertise in providing healthcare for acutely unwell patients during their first few hours in hospital. To ensure effective and efficient care, it is imperative that the provision of services within the ED is monitored as the demand for these services continues to rise.

When patients arrive in the ED, they are assessed by specially-trained nurses as to how urgently their condition requires treatment. This process, which is known as triage, ensures treatment is provided within the appropriate time, assisting in the prevention of adverse outcomes which may arise as a result of deterioration in the patient's condition. The triage process and scores are recognised by the Australasian College for Emergency Medicine. Table 1 on page 61 articulates the triage category and targets for treatment activity to occur. A result equal to or above target is desired.

Dr Matthew and patient Paul in ED at AH

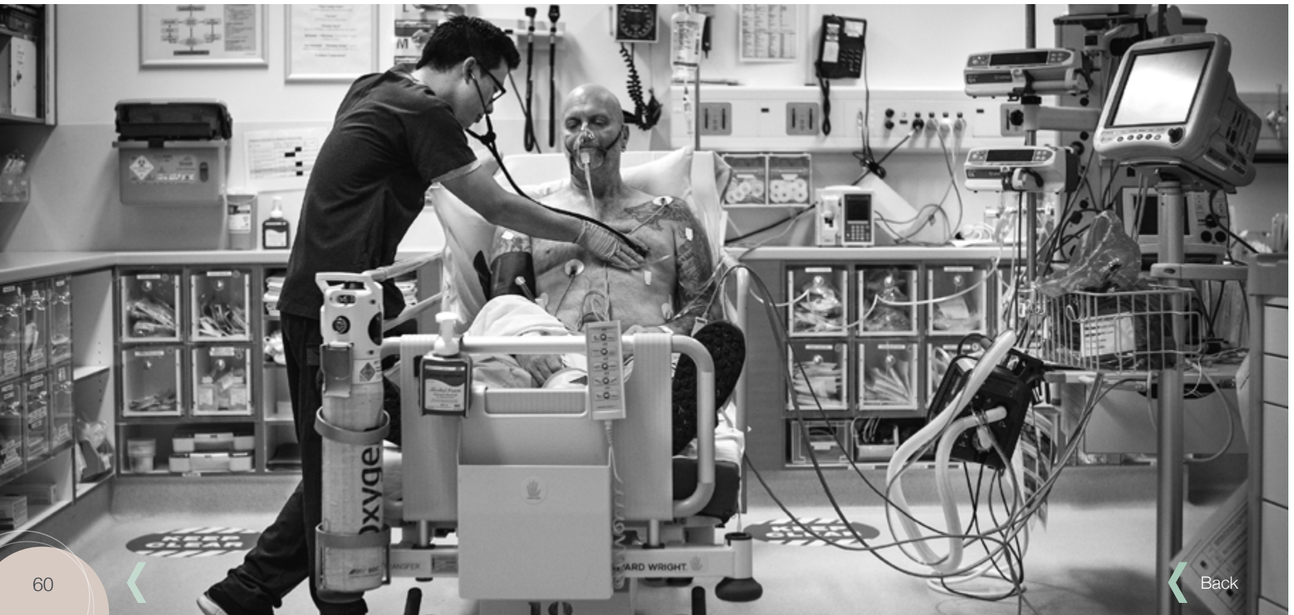


Table 1: 2017-18 targets for each triage category

Triage category	Presentation	Treatment activity	Target (per cent)
1	Immediately life-threatening	Immediate (within 2 minutes)	100
2	Imminently life-threatening	Within 10 minutes	80
3	Potentially life-threatening, important time-critical treatment required or severe pain	Within 30 minutes	75
4	Potentially life-serious, situational urgency or significant complexity	Within 60 minutes	70
5	Less urgent	Within 120 minutes	70

Monitoring the indicators related to treatment occurring within clinically recommended timeframes assists to manage the demand on ED services. By measuring the effectiveness of service provision, it assists in the facilitation of decision-making for our clinical teams and allows them to determine the most appropriate location for ongoing treatment and care, whether that be within the hospital facility or within the community setting.

In 2017-18, EMHS achieved target for triage category one and two. In addition, although under target, EMHS has seen consistent improvement in performance to target for triage category three.

This improvement is particularly evident at AH. The implementation of the ED Rapid Assessment Team (RAT) has contributed to a more streamlined assessment and treatment process, allowing for improved patient flow through the ED.

Performance to target for category four patients has steadily improved since September 2017 and reached the target in the final quarter of the financial year. Additionally EMHS has consistently achieved above 85 per cent each month (over target) for category five.

An expansion of the Emergency Medical Ward (EMW) at RPH improved collaboration between ED and the Acute Medical Ward (AMW). Together with the development of a lead triage role, this has contributed to improved flow through ED, allowing for the earlier assessment of waiting patients.

The EMHS Winter Collaborative Program which commenced in 2017 saw representatives from each EMHS site and service, as well as external organisations, come together to design and develop strategies to address patient flow in the busy winter months. Strategies addressed improving coordination and communication among sites, as well as between EMHS and St John Ambulance to enhance timely access to care for patients.

Figure 1: Triage category 1

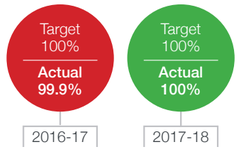


Figure 2: Triage category 2

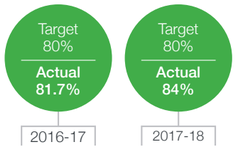


Figure 3: Triage category 3

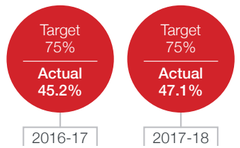


Figure 4: Triage category 4

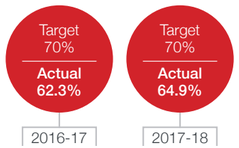
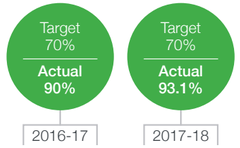


Figure 5: Triage category 5



EMHS contributing sites: Armadale Hospital, Royal Perth Hospital, St John of God Midland Public Hospital.
Data period: 2016-17 and 2017-18 financial years.
Data source: Emergency Department Data Collection.

Continuing to deliver safe and high quality care

EMHS is very proud of the significant improvements we continue to make in providing safe and high quality care for our patients and consumers. This is our number one priority. It is recognised however that in such a complex and challenging industry, sometimes things can go wrong. We are committed to providing an open and transparent environment that includes supporting staff to report incidents in the event that something does not go according to plan.

Learning from incidents

During 2017-18, 145 239 patients were admitted to EMHS hospitals. In addition, 203 013 patients were seen in our EDs and another 517 027 patients were seen in an outpatient clinic or setting. To the testament of our professional and skilled workforce, the overwhelming majority of these interactions occurred without incident. However, for a very small percentage of patients, errors did regrettably occur during their care and in some cases, these errors resulted in unintended harm.

In the interests of transparency, we are sharing the number of serious clinical incidents that occurred in 2017-18 at our hospitals and health services. Every incident provides a critical learning opportunity towards ensuring that we put in place strategies to prevent others from being harmed.

During 2017-18, there were 155 incidents reported with a Severity Assessment Code rating of '1' (SAC1s). A SAC1 event is defined as an event or circumstance resulting from healthcare that led to, or had the potential to lead to, unintended and/or unnecessary serious harm or death of a patient/consumer. This excludes 22 incidents that were originally reported as serious, however were declassified following thorough investigation and a finding that healthcare did not adversely contribute to the event. This is an increase compared with 135 SAC1s reported in the same period last year. All SAC1s are fully investigated in line with the WA Clinical Incident Management Policy and are scrutinised by members of the EMHS Executive, as well as the EMHS Board Safety and Quality Committee.

The increase during 2017-18 should not be taken as a direct indication that safety is compromised. It is internationally recognised that healthcare systems that are proactive in notifying clinical incidents and undertaking in-depth investigations are more likely to reduce avoidable harm to patients. Upon analysis, the increase during 2017-18 is largely attributable to an increased vigilance on patient safety outcomes by the organisation.

In 2017-18 EMHS focused on strengthening its reporting and learning associated with the following areas:

- Adoption of standard business rules for the reporting and investigation of unexpected deaths of mental health clients in the community, leading to an increase in the number of cases reported as SAC1s during the year. This is reflective of a change in definition and process rather than an increase in actual numbers of deaths. These events are now consistently reported and investigated by all EMHS services.
- Adoption of increased scrutiny of pressure injuries of the highest level of severity. In particular, a decision to adopt a root cause analysis investigation to all high stage (3 and 4) pressure injuries saw an increase in reporting of this incident type as a SAC1 event. Staging is determined by the severity of the pressure damage with stages 3 and 4 indicating more invasive tissue damage and consequently more severe harm to the patient. The increased scrutiny and more rigorous investigation style has led to the adoption of additional strategies for prevention of pressure injuries. In addition, EMHS commissioned an external review of its systems and processes for the prevention of pressure injuries and is in the process of completing actions arising from this review process. Eliminating pressure injuries altogether remains challenging. Improved training and education, combined with the introduction of patient-led handover and ward leader rounding, will help towards prevention in the future.
- Adoption of increased scrutiny relating to healthcare acquired infections. In order to facilitate improved learning, a decision was made to notify and investigate cases of bacteraemia occurring as a result of infection from staphylococcus aureus as a SAC1 incident. This type of bacteria can lead to serious harm for a patient and may be transferred as a result of poor hand hygiene practices. Management and clinical staff remain focused on the prevention of infection and rates of this type of infection are monitored closely and investigated rigorously through the services clinical incident management system.

Of the 155 serious incidents, the patient outcome was noted as:

Patient outcome*	Number
Death	24
Serious harm	112
Moderate harm	1
Minor harm	10
No harm	8

*The outcome does not necessarily equate as a direct cause of the incident, as other factors, other than healthcare related, may have contributed to the patient's outcome.

The delivery of healthcare is undertaken within a highly complex healthcare system. When system processes break down, the quality of care can be compromised. Mitigating these risks can greatly assist in preventing similar incidents in the future.

Michelle, nurse at AH, with Milly

Learnings from a SAC1 incident

Situation

An unwell and malnourished man was admitted to the ICU after being found unresponsive on the floor of his home. During his stay in ICU, the patient was noted to have developed pressure injuries on two parts of his body.

Clinical incident

The Incident Investigation Panel conducted a thorough assessment of the incident and concluded that the patient's risk of developing pressure injuries was not identified during screening on admission and subsequent shift changes.

Contributing factors

The panel determined that the patient should have had preventative measures put in place, such as the use of a special air mattress to minimise the risk of pressure injuries forming while he was receiving care in ICU. The assessment process was not fully adhered to.

Recommendations

1. The ICU to align their practice with best practice guidelines for the prevention and management of pressure injury as published by the Australian Commission on Safety and Quality in Health Care.
2. Staff education to be provided by the Wound Clinical Nurse Consultant and pressure injury champions.
3. Pressure injury staging lanyards to be provided to all nursing staff in the ICU to assist in the identification and appropriate staging of pressure injuries.

Lessons learned

All areas that care for patients, particularly critical care areas, must have ways to ensure that patients are adequately assessed for their risk of developing pressure injuries. Staff training and education is vital to ensuring that patients at high risk are identified and are provided with appropriate means to minimise the risk of these injuries occurring.

East Metropolitan Health Service

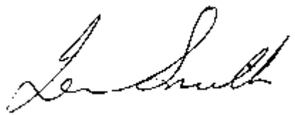
Key Performance Indicators

Certification of KPIs

East Metropolitan Health Service

Certification of Key Performance Indicators for the year ended 30 June 2018

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



Ian Smith PSM
Board Chair
East Metropolitan Health Service
11 September 2018

Peter Forbes
Chair, EMHS Board Finance Committee
East Metropolitan Health Service
11 September 2018

Audit opinion

Please see the full audit opinion in the financial statements section on page 93.

Outcomes

KPIs assist EMHS to assess and monitor achievement of the following DoH outcomes.

Outcome one:

Public hospital based services that enable effective treatment and restorative healthcare for Western Australians.

Outcome two:

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

KPI data legend

Please note the following for KPI data:

* Please note: As EMHS was established on 1 July 2016, comparative data for calendar year KPIs is only inclusive of 1 July to 31 December 2016.

Unplanned hospital readmissions of public hospital patients within 28 days for selected surgical procedures

Outcome one: effectiveness KPI

Description

Unplanned and unexpected hospital readmissions to the same or another public hospital or as a public patient in Contracted Health Entities (CHEs) within 28 days for selected surgical procedures:

(a) knee replacement
(b) hip replacement
(c) tonsillectomy and adenoidectomy
(d) hysterectomy
(e) prostatectomy
(f) cataract surgery
(g) appendicectomy.

Rationale

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

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

Good intervention, appropriate treatment together with good discharge planning will decrease the likelihood of unplanned hospital readmissions. A low unplanned readmission rate suggests that good clinical practice is in operation within our health system, and lessons can be learnt from a higher than target unplanned readmission rate through the creation of a variety of improvement strategies.

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

Target

Table 2 outlines the 2016 and 2017 targets for each surgical procedure.

Table 2: 2016 and 2017 targets for surgical procedures

Surgical procedure	2016 target (per 1000)	2017 target (per 1000)
knee replacement	22	26.2
hip replacement	21	17.2
tonsillectomy & adenoidectomy	71	61
hysterectomy	47	41.3
prostatectomy	34	38.8
cataract surgery	1	1.1
appendicectomy	39	32.9

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

Results

Please note: comparative data within this KPI has been provided for the period of July to December 2016 (as EMHS was established on 1 July 2016). Although a comparison is included, methodology for counting of data for this KPI has changed this year, with all readmissions included in the 2017 data, as opposed to only the first readmission in 2016.

The 2017 performance targets are based on the best state-wide results achieved within the previous five calendar years, excluding the most recent calendar year.

EMHS strives to provide safe, high quality care to its patients at all times and in 2017, has exceeded the target for four of the seven selected surgical procedures. Where performance of EMHS does not meet the target, the cases are reviewed for service improvement opportunities.

EMHS performance to target for appendicectomy, hip replacement and prostatectomy has shown continued improvement since 2016 and knee replacement continues to achieve the performance target.

Performance for cataract surgery was slightly over target and is representative of a small number of readmissions (five) from 4180 surgeries undertaken across three hospital sites.

In total, there were eight readmissions for hysterectomy procedures across three sites. Case review demonstrates appropriate admission and treatment of recognised complications that are not always preventable, although each readmission will continue to be reviewed for any system wide learnings.

EMHS continues to monitor and address performance for tonsillectomy and adenoidectomy and has implemented measures to minimise post-operative complications.

Figure 6: Knee replacement

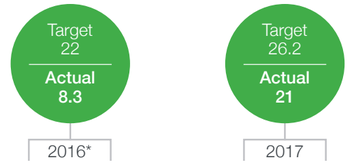


Figure 7: Hip replacement

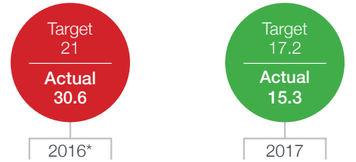


Figure 8: Tonsillectomy and adenoidectomy

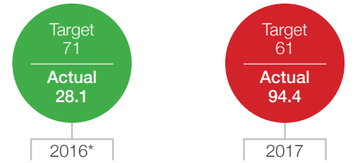


Figure 9: Hysterectomy

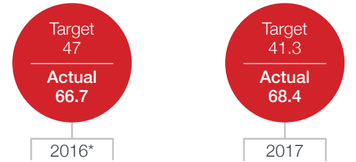


Figure 10: Prostatectomy

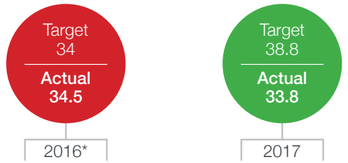


Figure 11: Cataract surgery

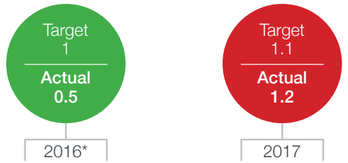
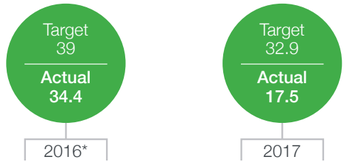


Figure 12: Appendicectomy



EMHS contributing sites: Armadale Health Service, Bentley Hospital, Kalamunda Hospital, Royal Perth Hospital, St John of God Midland Public Hospital.
Data period: *2016 data: July – December 2016 only
2017 data: full calendar year.
Data source: Hospital Morbidity Data Collection.

Physiotherapist Hayley with patients at RPH

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

Outcome one: effectiveness KPI

Description

Proportion of all elective patients on the wait list whose waiting time is over the clinically recommended time for their urgency category at census date, reported by urgency category. Reported as an average of weekly census data for the financial year.

Rationale

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

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

On 1 April 2016, the WA health system introduced a new state-wide performance target for the provision of elective services. The new target requires no patients (zero per cent) on the elective waiting lists wait longer than the clinically recommended time for their procedure, according to their urgency category.

Reportable cases are defined as all waiting list cases that are not listed on the Elective Services Wait List Data Collection (ESWLDC) Commonwealth Non-Reportable Procedures list.

This list is consistent with the Australian Institute of Health and Welfare (AIHW) list of Code 2 (other) procedures that do not meet the definition of elective surgery. It also includes additional procedure codes that are intended to better reflect the procedures identified in the AIHW Code 2 list.

Target

The 2017-18 target for patients waiting over boundary for all urgency categories is zero per cent. This target has not changed from 2016-17.

A result equal to target is desired.

Results

Figures 13-15 demonstrate the proportion of cases over boundary in comparison to the 2016-17 financial year in all categories.

Initiatives have been put in place to actively manage the Elective Surgery Waiting List (ESWL) with emphasis on patients waiting over boundary.

Recognising challenges with significant waitlists for urology and gastroenterology, EMHS worked with their visiting medical practitioners at SJGMPH and AKG to reach an agreement for the transfer of appropriate referrals on the RPH waitlists, to assist in reducing surgical wait times.

In addition to this, to further alleviate pressure on the RPH waitlists, any vacant theatre lists (due to planned leave) were backfilled by available RPH surgeons to ensure efficient use of theatres across EMHS.

Deloitte was engaged by EMHS in 2018 to conduct an independent review into contributing factors on ESWL performance. They observed that average waiting times and surgery cancellations had improved over the period of October 2016 to March 2018. The review made recommendations on improving processes and data quality which are in the process of implementation across EMHS hospitals.

EMHS has also recognised the need to continually work to improve the efficiency of theatres, with the commencement of the Quality, Efficiency, and Safety in Theatres (QuEST) project at AKG.

Figure 13: Category 1

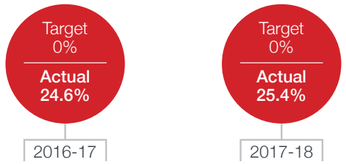


Figure 14: Category 2

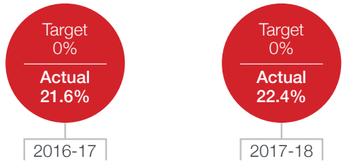


Figure 15: Category 3

EMHS contributing sites: Armadale Health Service, Bentley Hospital, Royal Perth Hospital, St John of God Midland Public Hospital.
Data period: 2016-17 and 2017-18 financial years.
Data source: Elective Services Wait List Data Collection (ESWLDC).

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

Outcome one: effectiveness KPI

Description

Hospital infection rates (Healthcare-associated *staphylococcus aureus* bloodstream infections (HA-SABSI) per 10 000 occupied bed-days in public hospitals that provide acute healthcare).

Rationale

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

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

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

Target

The 2017 target rate for HA-SABSI infections is 1 per 10 000 occupied bed-days.

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

Results

For the 2017 calendar year EMHS performed favourably compared with the target for Healthcare-associated staphylococcus aureus bloodstream infections (HA-SABSI) per 10 000 occupied bed-days.

Initiatives that have been developed to contribute to this result include an active aseptic technique educational and competency program to improve staff skills and knowledge, and the 'March 8 Cannulate' pilot project, which was a targeted strategy focussing on the insertion of Peripheral Intravenous Cannulas (PIVC). 'March 8 Cannulate' was successful in reducing the number of Healthcare-associated staphylococcus aureus bloodstream infections and was a WA Health Excellence Awards finalist.

Figure 16: HA-SABSI rates per 10 000 occupied bed-days

Please note: this is a new KPI for 2017 and therefore there is no comparative data from 2016.

EMHS contributing sites: Armadale Health Service, Bentley Hospital, Kalamunda Hospital, Royal Perth Hospital.
Data period: 2017 calendar year.
Data source: Healthcare Infection Surveillance WA (HISWA) Data Collection.

Survival rates for sentinel conditions

Outcome one: effectiveness KPI

Description

Percentage of public patients who, for stroke, acute myocardial infarction, or fractured neck of femur, are discharged as 'alive' from a public hospital.

By reviewing and analysing survival rates, targeted strategies can be developed that aim to increase patient survival after being admitted for a sentinel condition. Therefore, this indicator can potentially assist hospitals in monitoring changes over time to facilitate effective restoration of patients' health.

Rationale

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

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

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

Target

Please see the targets for each condition noted in the results section.

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

Results

Stroke

For the 2017 calendar year, EMHS exceeded targets for survival rate for stroke in all age groups.

A program of active engagement and education by the neurology team with the Emergency Department and Acute Medical Unit teams on stroke management, the implementation of the WA Stroke Plan and increase in thrombectomy rates across WA has contributed to this result.

Figure 17: Survival rate for stroke by age group (years)

Figure 17: Survival rate for stroke by age group (years) (continued)

Acute Myocardial Infarction (AMI)

For the 2017 calendar year, EMHS exceeded targets for survival rate for AMI in the majority of age groups.

The development and implementation of ST-Elevated Myocardial Infarction (STEMI) and Acute Coronary Syndrome (ACS) pathways has ensured that these patients have formalised and appropriate management plans. There is ongoing review of STEMI door to balloon times with involvement of the St John Ambulance Service, RPH Emergency Department, AHS and SJGMPH. The establishment of a service to transfer ACS patients from AHS and SJGMPH to RPH for treatment and return back to their hospital has improved access to invasive coronary diagnostic and interventional procedures.

Figure 18: Survival rate for Acute Myocardial Infarction (AMI) by age group (years)

EMHS contributing sites: Armadale Health Service, Bentley Hospital, Kalamunda Hospital, Royal Perth Hospital, St John of God Midland Public Hospital.
Data period: *2016 data: July – December 2016 only.
2017 data: full calendar year.
Data source: Hospital Morbidity Data Collection.

Figure 18: Survival rate for Acute Myocardial Infarction (AMI) by age group (years) (continued)

Fractured Neck of Femur

For the 2017 calendar year, EMHS exceeded the target for survival rate for fractured neck of femur in the 80 years plus age group and was close to target for the 70 to 79 year age group. This was an improvement on performance from the preceding year that has been influenced by the development and implementation of a fractured neck of femur pathway which has standardised holistic care provision.

Figure 19: Survival rate for fractured neck of femur by age group (years)

EMHS contributing sites: Armadale Health Service, Bentley Hospital, Kalamunda Hospital, Royal Perth Hospital, St John of God Midland Public Hospital.
Data period: *2016 data: July – December 2016 only.
2017 data: full calendar year.
Data source: Hospital Morbidity Data Collection.

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

Outcome one: effectiveness KPI

Description

The percentage of admitted Aboriginal and non-Aboriginal patients who left against medical advice.

Rationale

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

Patients who left against medical advice (also called DAMA or discharged against medical advice) have been found to cost the health system 50 per cent more than the cost of patients who are discharged by physicians.[5] Published data contends that high DAMA rates reflect the need for improved responses by the health system to the needs of Aboriginal patients and provides a measure of the safety, quality and cultural security of the services provided.

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

[5] Aliyu ZY. Discharge against medical advice: sociodemographic, clinical and financial perspectives. International journal of clinical practice 2002;56(5):325-27.

Target

The 2017 target for admitted patients who discharged against medical advice is 0.77 per cent.

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

Results

The results for 2017 show EMHS is not achieving desired results for this indicator with DAMA rates for Aboriginal patients significantly over the target and Non-Aboriginal patients also over target.

EMHS has implemented a number of initiatives to improve DAMA rates including improved referral pathways for Aboriginal patients and active management of patients into general practice and support for outpatient appointments post discharge.

EMHS continues to work with community and GP services in transitioning patients between non-metropolitan and metropolitan locations and across primary and hospital based care.

An additional strategy employed to address this KPI includes clearly informing patients about their medical issues. Where required, interpreters are offered to ensure that communication is understood. Patient's dignity and cultural differences are respected to make their hospital stay as pleasant as possible.

Figure 20: Percentage of admitted Aboriginal patients who discharged against medical advice

Figure 21: Percentage of admitted non-Aboriginal patients who discharged against medical advice

Please note: this is a new KPI for 2017 and therefore there is no comparative data from 2016.

Improving the cultural appropriateness of the RPH menu for Aboriginal patients

As part of a recent quality improvement project performed by the Nutrition and Dietetics Department at RPH to assess the cultural appropriateness of the RPH menu for Aboriginal patients, we identified that fulfilling this criteria is more complex than offering some bush tucker.

Patients expressed that the general hospital environment impacted negatively on their health status as it is foreign and unwelcoming. However, their faces would light up as they described their community and preference to eat outdoors in a group setting. It is this group setting that is so important (and is often lacking in metropolitan hospitals) as it facilitates conversation/yarning, strengthening of community bonds, as well as connecting them to the land as they cook on a fire.

Given this feedback and the significant disparity in the health status of Aboriginal and non-Aboriginal individuals throughout WA, RPH are planning to build a unique health space created with cultural sensitivity in mind. It is hoped that providing a dedicated and safe space for Aboriginal patients to meet, yarn and feel as if they belong (all within the safety of the hospital) will promote positive experiences and improved health outcomes.

EMHS contributing sites: Armadale Health Service, Bentley Hospital, Kalamunda Hospital, Royal Perth Hospital, St John of God Midland Public Hospital.
Data period: 2017 calendar year.
Data source: Hospital Morbidity Data Collection.

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

Outcome one: effectiveness KPI

Description

The proportion of infants liveborn at or after term (from 37 completed weeks gestational age) with an Apgar score of less than seven at five minutes after birth.

Rationale

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

The Apgar score is an assessment of an infant's health at birth based on breathing, heart rate, colour, muscle tone and reflex irritability. An Apgar score is applied at one, five and possibly ten minutes after delivery to determine how well the infant is adapting outside the mother's womb. Apgar scores range from zero to two for each condition with a maximum final total score of ten. The higher the Apgar score the better the health of the newborn infant.

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

The indicator aligns to the National Core Maternity Indicators (2016) Health, Standard 02/02/2016.

Target

The 2017 target is 1.8 per cent (as per 2016).

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

Results

For the 2017 calendar year, EMHS achieved a positive rate that remains below the target rate. This outcome is indicative of the quality of care and skilled workforce providing obstetric and neonatal services in our hospitals.

Figure 22: Percentage of liveborn term infants with an Apgar score of less than seven at five minutes post delivery

EMHS contributing sites: Armadale Health Service, Bentley Hospital, St John of God Midland Public Hospital.
Data period: *2016 data: July – December 2016 only.
2017 data: full calendar year.
Data source: Midwives Notification System.

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

Outcome one: effectiveness KPI

Description

The rate of total hospital readmissions within 28 days to an acute designated mental health inpatient unit.

Rationale

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

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

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

Target

The 2017 target for this KPI is 12 per cent.

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

Results

EMHS has been consistently trending close to the target of 12 per cent of patients having an unplanned readmission.

A number of strategies have been put in place across EMHS services, to ensure patients continue to receive care in the community therefore preventing the need for readmission. These include improving the timeliness of the discharge summary at the point of discharge to ensure continuity of information between service providers; greater involvement of the community teams during the patient's admission; inclusion of a crisis plan in the treatment, support and discharge plan for patients at high risk of readmission; and comprehensive seven day follow up after discharge from hospital. These strategies aim to ensure patients are supported in their transition from hospital to community.

Figure 23: Rate of total hospital readmissions within 28 days to an acute designated mental health inpatient unit

Please note: this is a new KPI for 2017 and therefore there is no comparative data from 2016.

EMHS contributing sites: Armadale Health Service, Bentley Hospital, Royal Perth Hospital, St John of God Midland Public Hospital, St John of God Mount Lawley contracted services.
Data period: 2017 calendar year.
Data source: Hospital Morbidity Data Collection.

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

Outcome one: effectiveness KPI

Description

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

Rationale

In 2014-15 there were 4.0 million Australians (17.5 per cent) who reported having a mental or behavioural condition.[8] Therefore, it is crucial to ensure effective and appropriate care is provided not only in a hospital setting but also in the community.

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

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

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

[8] National Health Survey 2014-15.

Target

The 2017 target for this KPI is 75 per cent (as per 2016).

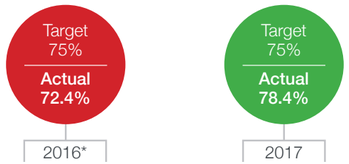
Improved or maintained performance is demonstrated by a result equal to or exceeding the target.

Results

EMHS has improved and achieved above its target for timely contacts with community based mental health services.

A number of strategies were implemented at Bentley Hospital in an effort to improve performance. This included the allocation of one position with the responsibility of completing follow up phone calls within 48 hours of discharge, improved communication with the patient in regards to what to expect post discharge and a process for which to follow in the case of not being able to make contact with a patient.

Figure 24: Percentage of contacts with community-based public mental health non-admitted services within seven days post discharge from an acute public mental health inpatient unit



EMHS contributing sites: Armadale Health Service, Bentley Hospital, Royal Perth Hospital, St John of God Midland Public Hospital, St John of God Mount Lawley contracted services.
Data period: *2016 data: July – December 2016 only.
2017 data: full calendar year.
Data source: Mental Health Information System Data Collection (MHIS), Hospital Morbidity Data Collection.

Average admitted cost per weighted activity unit

Outcome one: efficiency KPI
Service one: public hospital admitted services

Description

Measures the costs of admitted patients against a common unit of activity, termed the estimated Weighted Activity Unit (WAU).

Rationale

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

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

Target

The 2017-18 target for average admitted cost per weighted activity unit is $7285[1].

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

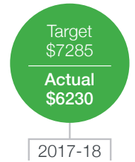
Results

The EMHS average admitted cost per weighted activity unit is $6230 which is $1055 below the target of $7285.

The target was developed at a WA health level for all Health Service Providers. The lower KPI result indicates that EMHS has performed more efficiently than the WA health target.

[1]The original 2017-18 target as published in budget paper 2 is $6868. The revised target includes budget for Teaching Training and Research (TT and R) and PathWest Resources Received Free of Charge (RRFoC) expenses that have been excluded from the original target.

Figure 25: Average admitted cost per weighted activity unit



Please note: this is a new KPI for 2017-18 and therefore there is no comparative data from 2016-17.

EMHS contributing sites: Armadale Health Service, Bentley Hospital, Kalamunda Hospital, Royal Perth Hospital, St John of God Midland Public Hospital.
Data period: 2017-18 financial year.
Data source: OBM Allocation Application, Oracle 11i Financial System, Hospital Morbidity Data Collection extracts, TOPAS, HCARe, webPAS and SJGMPH discharge extracts.

Danny, patient at SJGMPH

Average Emergency Department cost per weighted activity unit

Outcome one: efficiency KPI
Service two: public hospital emergency services

Description

Measures the costs of Emergency Department activity against a common unit of activity, termed the Weighted Activity Unit (WAU).

Rationale

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

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

Target

The 2017-18 target for average ED cost per weighted activity unit is $7043[1].

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

Results

EMHS average Emergency Department cost per weighted activity unit is $6842 which is $201 below the target of $7043.

The target was developed at a WA health level for all Health Service Providers. The KPI result for 2017-18 indicates that EMHS has performed more efficiently than the WA health target.

[1]The original 2017-18 target as published in budget paper 2 is $6642. The revised target includes budget for Teaching Training and Research (TT and R) and PathWest RRFoC expenses that have been excluded from the original target.

Figure 26: Average Emergency Department cost per weighted activity unit

Please note: this is a new KPI for 2017-18 and therefore there is no comparative data from 2016-17.

EMHS contributing sites: Armadale Health Service, Royal Perth Hospital, St John of God Midland Public Hospital.
Data period: 2017-18 financial year.
Data source: OBM Allocation Application, Oracle 11i Financial System, Emergency Department Data Collection extract.

Average non-admitted cost per weighted activity unit

Outcome one: efficiency KPI
Service three: public hospital non-admitted services

Description

Measures the costs of non-admitted patients against a common unit of activity, termed the Weighted Activity Unit (WAU).

Rationale

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

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

Target

The 2017-18 target for average non-admitted cost per weighted activity unit is $7160[1].

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

Results

EMHS average non-admitted cost per weighted activity unit is $7238 which is $78 above the target of $7160.

The target was developed at a WA health level for all Health Service Providers. The KPI result for 2017-18 indicates that EMHS has performed less efficiently to the WA health target.

[1]The original 2017-18 target as published in budget paper 2 is $6738. The revised target includes budget for Teaching Training and Research (TT and R) and PathWest RRFoC expenses that have been excluded from the original target.

Figure 27: Average non-admitted cost per weighted activity unit

Please note: this is a new KPI for 2017-18 and therefore there is no comparative data from 2016-17.

EMHS contributing sites: Armadale Health Service, Bentley Hospital, Kalamunda Hospital, Royal Perth Hospital, St John of God Midland Public Hospital.
Data period: 2017-18 financial year.
Data source: OBM Allocation Application, Oracle 11i Financial System, Non Admitted Patient Activity and Wait List Data Collection (NAPAAWL DC), Interim Collection of Aggregate Data (ICAD).

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

Outcome one: efficiency KPI
Service four: mental health services

Description

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

Rationale

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

Target

The 2017-18 target for average cost per bed-day in specialised mental health inpatient units is $1144[1].

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

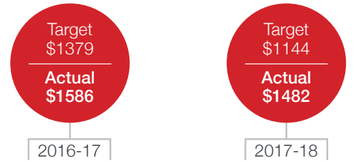
Results

EMHS average cost per bed-day in specialised mental health inpatient units for 2017-18 is $1482 which is $338 above the target of $1144.

Although the 2017-18 performance against the target is unfavourable, EMHS has maintained a safe environment for staff and patients in this highly complex environment while continuing to respond to increasing demand as evidenced by an increase in the number of mental health bed days recorded in 2017-18. When compared to costs incurred in 2016-17 for these services, the average cost per bed-day in specialised mental health inpatient units in 2017-18 has reduced. This further supports the continuing efforts by EMHS to work on enhancing processes and procedures to improve efficiency and minimise costs.

[1]The original 2017-18 target as published in budget paper 2 is $1082. The revised target includes budget for Teaching Training and Research (TT and R) and PathWest RRFoC expenses that have been excluded from the original target.

Figure 28: Average cost per bed-day in specialised mental health inpatient units



EMHS contributing sites: Armadale Health Service, Bentley Hospital, Royal Perth Hospital, St John of God Midland Public Hospital, St John of God Mt Lawley contracted services.
Data period: 2016-17 and 2017-18 financial years.
Data source: OBM Allocation Application, Oracle 11i Financial System, Mental Health Information System Data Collection (MHIS), BedState.

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

Outcome one: efficiency KPI
Service four: mental health services

Description
Average cost per treatment day of non-admitted care provided by public clinical mental health services.

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

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

Target
The 2017-18 target for average cost per treatment day of non-admitted care provided by public clinical mental health services is $409[1].

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

Results
The EMHS average cost per treatment day of non-admitted care provided by public clinical mental health services is $422 which is $13 above the target of $409.

The EMHS has continued to provide non-admitted services commensurate with a highly complex environment and demographic. The actual number of recorded treatment days was below the original level estimated, and clients serviced presented with greater levels of complexity than anticipated. This required EMHS services to respond accordingly by altering the mix and length of patient contact and service offerings to provide appropriate treatment and care.

[1] The original 2017-18 target as published in budget paper 2 is $1131. This target was amended by the Department of Health in February 2018, after analysis established that an inaccurate denominator was used in the original calculation of the target.

Figure 29: Average cost per treatment day of non-admitted care provided by public clinical mental health services

Please note: this is a new KPI for 2017-18 and therefore there is no comparative data from 2016-17.

EMHS contributing sites: Armadale Health Service, Bentley Hospital, Royal Perth Hospital, St John of God Midland Public Hospital.
Data period: 2017-18 financial year.
Data source: OBM Allocation Application, Oracle 11i Financial System, Mental Health Information System Data Collection (MHIS).

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

Outcome two: efficiency KPI
Service six: public and community health services

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

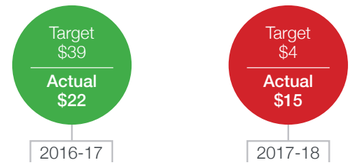
Rationale
Population health units support individuals, families and communities to increase control over and improve their health. With the aim of improving health, population health works to integrate all activities of the health sector and link them with broader social and economic services and resources by utilising the WA Health Promotion Strategic Framework 2017–21. This is based on the growing understanding of the social, cultural and economic factors that contribute to a person's health status.

Target
The 2017-18 target for average cost per person of delivering population health programs is $4.

Results
EMHS average cost per person of delivering population health programs by population health units for 2017-18 was $15 which is above the target of $4.

This increased cost is primarily related to the inclusion of expenses for services provided by EMHS to other Health Service Providers. These expenses were not included when the target for 2017-18 was derived, but were included in the derivation of the 2016-17 target. When this is taken into consideration, the EMHS performance in 2017-18 compares more favourably with its performance in 2016-17.

Figure 30: Average cost per person of delivering population health programs by population health units



Please note: the total population used in the calculation of this KPI is based on the WA Health Epidemiology Branch from 2012-2016 estimates using the FORECAST function of Microsoft Excel 2010.

EMHS contributing sites: Armadale Health Service, Bentley Hospital, Kalamunda Hospital, Royal Perth Hospital.
Data period: 2016-17 and 2017-18 financial years.
Data source: OBM Allocation Application, Oracle 11i Financial System, 2012-2016 population extracted from EpiCalc version 1.0 (beta), Epidemiology Branch, Public Health, WA Department of Health, 2017 population projected by the Epidemiology Branch from 2012-2016 estimates using the FORECAST function of Microsoft Excel 2010.

EMHS finance staff Shilen and Rike.

East Metropolitan Health Service

Financials

Certification of financial statements

East Metropolitan Health Service

Certification of finacial statements for the year ended 30 June 2018

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

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

Ian Smith PSM
Board Chair
East Metropolitan Health Service
11 September 2018

Peter Forbes
Chair, EMHS Board Finance Committee
East Metropolitan Health Service
11 September 2018

Graeme Jones
Chief Finance Officer
East Metropolitan Health Service
11 September 2018

Auditor General

INDEPENDENT AUDITOR'S REPORT

To the Parliament of Western Australia

EAST METROPOLITAN HEALTH SERVICE

Report on the Financial Statements

Opinion
I have audited the financial statements of the East Metropolitan Health Service which comprise the Statement of Financial Position as at 30 June 2018, the Statement of Comprehensive Income, Statement of Changes in Equity, Statement of Cash Flows for the year then ended, and Notes comprising a summary of significant accounting policies and other explanatory information.

In my opinion, the financial statements are based on proper accounts and present fairly, in all material respects, the operating results and cash flows of the East Metropolitan Health Service for the year ended 30 June 2018 and the financial position at the end of that period. They are in accordance with Australian Accounting Standards, the *Financial Management Act 2006* and the Treasurer's Instructions.

Basis for Opinion
I conducted my audit in accordance with the Australian Auditing Standards. My responsibilities under those standards are further described in the *Auditor's Responsibilities for the Audit of the Financial Statements* section of my report. I am independent of the Health Service in accordance with the *Auditor General Act 2006* and the relevant ethical requirements of the Accounting Professional and Ethical Standards Board's APES 110 *Code of Ethics for Professional Accountants* (the Code) that are relevant to my audit of the financial statements. I have also fulfilled my other ethical responsibilities in accordance with the Code. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Auditor General

Responsibility of the Board for the Financial Statements
The Board is responsible for keeping proper accounts, and the preparation and fair presentation of the financial statements in accordance with Australian Accounting Standards, the *Financial Management Act 2006* and the Treasurer's Instructions, and for such internal control as the Board determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Board is responsible for assessing the agency's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Western Australian Government has made policy or funding decisions affecting the continued existence of the Health Service.

Auditor's Responsibility for the Audit of the Financial Statements
As required by the *Auditor General Act 2006*, my responsibility is to express an opinion on the financial statements. The objectives of my audit are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with Australian Auditing Standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

As part of an audit in accordance with Australian Auditing Standards, I exercise professional judgment and maintain professional scepticism throughout the audit. I also:

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for my opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.

Back Contents

Auditor General

- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the agency's internal control.

- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Board.

- Conclude on the appropriateness of the Board's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the agency's ability to continue as a going concern. If I conclude that a material uncertainty exists, I am required to draw attention in my auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify my opinion. My conclusions are based on the audit evidence obtained up to the date of my auditor's report.

- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

I communicate with the Board regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

Report on Controls

Opinion
I have undertaken a reasonable assurance engagement on the design and implementation of controls exercised by the East Metropolitan Health Service. The controls exercised by the Health Service are those policies and procedures established by the Board to ensure that the receipt, expenditure and investment of money, the acquisition and disposal of property, and the incurring of liabilities have been in accordance with legislative provisions (the overall control objectives).

My opinion has been formed on the basis of the matters outlined in this report.

Auditor General

In my opinion, in all material respects, the controls exercised by the East Metropolitan Health Service are sufficiently adequate to provide reasonable assurance that the receipt, expenditure and investment of money, the acquisition and disposal of property and the incurring of liabilities have been in accordance with legislative provisions during the year ended 30 June 2018.

The Board's Responsibilities
The Board is responsible for designing, implementing and maintaining controls to ensure that the receipt, expenditure and investment of money, the acquisition and disposal of property, and the incurring of liabilities are in accordance with the *Financial Management Act 2006*, the Treasurer's Instructions and other relevant written law.

Auditor General's Responsibilities
As required by the *Auditor General Act 2006*, my responsibility as an assurance practitioner is to express an opinion on the suitability of the design of the controls to achieve the overall control objectives and the implementation of the controls as designed. I conducted my engagement in accordance with Standard on Assurance Engagements ASAE 3150 *Assurance Engagements on Controls* issued by the Australian Auditing and Assurance Standards Board. That standard requires that I comply with relevant ethical requirements and plan and perform my procedures to obtain reasonable assurance about whether, in all material respects, the controls are suitably designed to achieve the overall control objectives and the controls, necessary to achieve the overall control objectives, were implemented as designed.

An assurance engagement to report on the design and implementation of controls involves performing procedures to obtain evidence about the suitability of the design of controls to achieve the overall control objectives and the implementation of those controls. The procedures selected depend on my judgement, including the assessment of the risks that controls are not suitably designed or implemented as designed. My procedures included testing the implementation of those controls that I consider necessary to achieve the overall control objectives.

I believe that the evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Auditor General

Limitations of Controls
Because of the inherent limitations of any internal control structure it is possible that, even if the controls are suitably designed and implemented as designed, once the controls are in operation, the overall control objectives may not be achieved so that fraud, error, or noncompliance with laws and regulations may occur and not be detected. Any projection of the outcome of the evaluation of the suitability of the design of controls to future periods is subject to the risk that the controls may become unsuitable because of changes in conditions.

Report on the Key Performance Indicators

Opinion
I have undertaken a reasonable assurance engagement on the key performance indicators of the East Metropolitan Health Service for the year ended 30 June 2018. The key performance indicators are the key effectiveness indicators and the key efficiency indicators that provide performance information about achieving outcomes and delivering services.

In my opinion, in all material respects, the key performance indicators of the East Metropolitan Health Service are relevant and appropriate to assist users to assess the Health Service's performance and fairly represent indicated performance for the year ended 30 June 2018.

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

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

The approval was conditional on its inclusion as an unaudited performance indicator in the Annual Report and that it be reinstated as an audited KPI following the implementation of a new Emergency Department data collection system. A new system had not been developed at 30 June 2018. Consequently, the KPI has not been included in the audited KPIs for the year ended 30 June 2018. My opinion is not modified in respect of this matter.

Auditor General

The Board's Responsibility for the Key Performance Indicators
The Board is responsible for the preparation and fair presentation of the key performance indicators in accordance with the *Financial Management Act 2006* and the Treasurer's Instructions and for such internal control as the Board determines necessary to enable the preparation of key performance indicators that are free from material misstatement, whether due to fraud or error.

In preparing the key performance indicators, the Board is responsible for identifying key performance indicators that are relevant and appropriate having regard to their purpose in accordance with Treasurer's Instruction 904 *Key Performance Indicators*.

Auditor General's Responsibility
As required by the *Auditor General Act 2006*, my responsibility as an assurance practitioner is to express an opinion on the key performance indicators. The objectives of my engagement are to obtain reasonable assurance about whether the key performance indicators are relevant and appropriate to assist users to assess the agency's performance and whether the key performance indicators are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. I conducted my engagement in accordance with Standard on Assurance Engagements ASAE 3000 *Assurance Engagements Other than Audits or Reviews of Historical Financial Information* issued by the Australian Auditing and Assurance Standards Board. That standard requires that I comply with relevant ethical requirements relating to assurance engagements.

An assurance engagement involves performing procedures to obtain evidence about the amounts and disclosures in the key performance indicators. It also involves evaluating the relevance and appropriateness of the key performance indicators against the criteria and guidance in Treasurer's Instruction 904 for measuring the extent of outcome achievement and the efficiency of service delivery. The procedures selected depend on my judgement, including the assessment of the risks of material misstatement of the key performance indicators. In making these risk assessments I obtain an understanding of internal control relevant to the engagement in order to design procedures that are appropriate in the circumstances.

I believe that the evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Back Contents

Auditor General

My Independence and Quality Control Relating to the Reports on Controls and Key Performance Indicators
I have complied with the independence requirements of the *Auditor General Act 2006* and the relevant ethical requirements relating to assurance engagements. In accordance with ASQC 1 *Quality Control for Firms that Perform Audits and Reviews of Financial Reports and Other Financial Information, and Other Assurance Engagements*, the Office of the Auditor General maintains a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

Matters Relating to the Electronic Publication of the Audited Financial Statements and Key Performance Indicators
This auditor's report relates to the financial statements and key performance indicators of the East Metropolitan Health Service for the year ended 30 June 2018 included on the Health Service's website. The Health Service's management is responsible for the integrity of the Health Service's website. This audit does not provide assurance on the integrity of the Health Service's website. The auditor's report refers only to the financial statements and key performance indicators described above. It does not provide an opinion on any other information which may have been hyperlinked to/from these financial statements or key performance indicators. If users of the financial statements and key performance indicators are concerned with the inherent risks arising from publication on a website, they are advised to refer to the hard copy of the audited financial statements and key performance indicators to confirm the information contained in this website version of the financial statements and key performance indicators.

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

East Metropolitan Health Service
Statement of comprehensive income
For the year ended 30 June 2018

	Note	2018 $000	2017 $000
Cost of services			
Expenses			
Employee benefits expense	3.1(a)	791,277	744,622
Fees for visiting medical practitioners	3.4	25,200	24,596
Contracts for services	3.2	274,334	242,257
Patient support costs	3.3	214,528	222,502
Finance costs	3.4	65	95
Depreciation and amortisation expense	5.3	44,258	39,165
Asset revaluation decrement	3.4	3,130	3,831
Loss on disposal of non-current assets	3.4	85	314
Repairs, maintenance and consumable equipment	3.4	26,257	27,553
Other supplies and services	3.4	6,707	11,250
Other expenses	3.4	81,572	85,024
Total cost of services		**1,467,413**	**1,401,209**
Income			
Revenue			
Patient charges	4.4	64,787	63,698
Other fees for services	4.5	52,481	63,797
Commonwealth grants and contributions	4.2	451,887	410,855
Other grants and contributions	4.3	123,985	128,334
Donation revenue	4.6	2,075	399
Commercial activities	4.7	98	2,537
Other revenue	4.8	8,146	11,072
Total income other than income from State Government		**703,459**	**680,692**
Net cost of services		**763,954**	**720,517**
Income from State Government			
Service appropriations	4.1	714,341	705,935
Assets assumed	4.1	97	228
Services received free of charge	4.1	56,196	64,658
Total income from State Government		**770,634**	**770,821**
Surplus for the period		**6,680**	**50,304**
Other comprehensive income			
Items not reclassified subsequently to profit or loss			
Changes in asset revaluation reserve	8	14,183	74,893
Total other comprehensive income		**14,183**	**74,893**
Total comprehensive income for the period		**20,863**	**125,197**

The statement of comprehensive income should be read in conjunction with the accompanying notes
See also note 2.2 'Schedule of income and expenses by service'

East Metropolitan Health Service
Statement of financial position
As at 30 June 2018

	Note	2018 $000	2017 $000
Assets			
Current assets			
Cash and cash equivalents	7.3	108,797	83,848
Restricted cash and cash equivalents	7.3	27,584	26,395
Receivables	6.1	31,893	32,288
Inventories	6.3	5,091	5,585
Other current assets	6.4	876	765
Total current assets		174,241	148,881
Non-current assets			
Restricted cash and cash equivalents	7.3	6,359	2,976
Amounts receivable for services	6.2	435,334	391,092
Property, plant and equipment	5.1	915,969	939,313
Intangible assets	5.2	2,027	2,885
Other non-current assets	6.4	150	263
Total non-current assets		1,359,839	1,336,529
Total assets		**1,534,080**	**1,485,410**
Liabilities			
Current liabilities			
Payables	6.5	74,486	70,186
Borrowings	7.1, 7.2	819	792
Employee benefits provisions	3.1(b)	155,913	142,319
Other current liabilities	6.6	190	220
Total current liabilities		231,408	213,517
Non-current liabilities			
Employee benefits provisions	3.1(b)	35,329	33,674
Borrowings	7.1, 7.2	839	1,658
Total non-current liabilities		36,168	35,332
Total liabilities		**267,576**	**248,849**
Net assets		**1,266,504**	**1,236,561**
Equity			
Contributed equity	8	1,120,444	1,111,364
Reserves	8	89,076	74,893
Accumulated surplus		56,984	50,304
Total equity		**1,266,504**	**1,236,561**

The statement of financial position should be read in conjunction with the accompanying notes.

East Metropolitan Health Service
Statement of changes in equity
For the year ended 30 June 2018

	Note	2018 $000	2017 $000
Contributed equity	8		
Balance at start of period		1,111,364	-
Transactions with owners in their capacity as owners:			
Capital appropriations		13,613	18,048
Other contributions by owners		37	1,096,199
Distributions to owners		(4,570)	(2,883)
Balance at end of period		**1,120,444**	**1,111,364**
Reserves	8		
Asset revaluation reserve			
Balance at start of period		74,893	-
Other comprehensive income for the period		14,183	74,893
Balance at end of period		**89,076**	**74,893**
Accumulated surplus			
Balance at start of period		50,304	-
Surplus for the period		6,680	50,304
Balance at end of period		**56,984**	**50,304**
Total equity			
Balance at start of period		1,236,561	-
Total comprehensive income for the period		20,863	125,197
Transactions with owners in their capacity as owners		9,080	1,111,364
Balance at end of period		**1,266,504**	**1,236,561**

The statement of changes in equity should be read in conjunction with the accompanying notes.

East Metropolitan Health Service
Statement of cash flows
For the year ended 30 June 2018

	Note	2018 $000 Inflows/(Outflows)	2017 $000 Inflows/(Outflows)
Cash flows from State Government	7.3.3		
Service appropriations		670,035	661,508
Capital appropriations		12,890	17,321
Cash and cash equivalents transferred from the Metropolitan Health Service (abolished)		-	27,264
Net cash provided by State Government		**682,925**	**706,093**
Utilised as follows:			
Cash flows from operating activities			
Payments			
Employee benefits		(776,312)	(724,222)
Supplies and services		(559,172)	(539,877)
Finance costs		(3)	(6)
Receipts			
Receipts from customers		60,703	59,597
Commonwealth grants and contributions		451,887	410,855
Other grants and contributions		123,985	128,333
Donations received		187	292
Other receipts		59,774	87,380
Net cash used in operating activities	7.3.2	**(638,951)**	**(577,648)**
Cash flows from investing activities			
Payments			
Purchase of non-current assets		(14,423)	(15,195)
Net cash used in investing activities		**(14,423)**	**(15,195)**
Cash flows from financing activities			
Payments			
Repayment of finance lease liabilities		(30)	(31)
Net cash used in financing activities	7.3.4	**(30)**	**(31)**
Net increase in cash and cash equivalents		29,521	113,219
Cash and cash equivalents at the beginning of the period		113,219	-
Total cash and cash equivalents at the end of the period		**142,740**	**113,219**

The statement of cash flows should be read in conjunction with the accompanying notes.

East Metropolitan Health Service
Notes to the financial statements
As at 30 June 2018

Note 1 Basis of preparation

East Metropolitan Health Service (the Health Service) is a Western Australian Government entity and is controlled by the State of Western Australia, which is the ultimate parent. The Health Service is a not-for-profit entity (as profit is not its principal objective). A description of the nature of its operations and its principal activities have been included in the 'Governance/Overview' which does not form part of these financial statements.

These annual financial statements were authorised for issue by the Accountable Authority of the Health Service on 11 September 2018.

Statement of compliance

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

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

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

Basis of preparation

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

Judgements and estimates

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

East Metropolitan Health Service
Notes to the financial statements
As at 30 June 2018

Note 1 Basis of preparation (continued)

Contributed equity

AASB Interpretation 1038 Contributions by Owners Made to Wholly-Owned Public Sector Entities requires transfers in the nature of equity contributions, other than as a result of a restructure of administrative arrangements, to be designated by the Government (the owner) as contributions by owners (at the time of, or prior, to transfer) before such transfers can be recognised as equity contributions. Capital appropriations have been designated as contributions by owners by *TI 955 Contributions by Owners made to Wholly Owned Public Sector Entities* and have been credited directly to Contributed Equity.
The transfers of net assets to/from other agencies, other than as a result of a restructure of administrative arrangements, are designated as contributions by owners where the transfers are non-discretionary and non-reciprocal.

Comparative figures

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

Note 2 Health Service outputs

How the Health Service operates

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

	Note
Health Service objectives	2.1
Schedule of income and expenses by service	2.2

2.1 Health Service objectives

Services

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

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

East Metropolitan Health Service
Notes to the financial statements
As at 30 June 2018

2.1 Health Service objectives (continued)

Public hospital admitted services

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

Public hospital emergency services

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

Public hospital non-admitted services

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

Mental health services

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

East Metropolitan Health Service
Notes to the financial statements
As at 30 June 2018

2.1 Health Service objectives (continued)

Aged and continuing care services

The provision of aged and continuing care services. Aged and continuing care services include programs that assess the care needs of older people, provide functional interim care or support for older, frail, aged and younger people with disabilities to continue living independently in the community and maintain independence.

Public and community health services

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

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

Note 2 Health Service outputs (continued)

2.2 Schedule of income and expenses by service

	Public hospital admitted	Public hospital emergency	Public hospital non-admitted	Mental health	Aged and continuing care	Public and community health	Total
	2018 $000	2018 $000	2018 $000	2018 $000	2018 $000	2018 $000	2018 $000
Cost of services							
Expenses							
Employee benefits expense	456,624	96,472	99,482	121,850	6,864	9,985	791,277
Fees for visiting medical practitioners	21,852	1,548	1,720	80	-	-	25,200
Contracts for services	162,546	54,889	18,722	28,266	9,905	6	274,334
Patient support costs	137,426	18,446	40,701	7,118	2,052	8,785	214,528
Finance costs	40	5	16	4	-	-	65
Depreciation and amortisation expense	27,260	5,848	5,990	4,898	213	49	44,258
Asset revaluation decrement	1,747	229	894	260	-	-	3,130
Loss on disposal of non-current assets	34	13	38	-	-	-	85
Repairs, maintenance and consumable equipment	15,282	3,322	3,757	3,153	518	225	26,257
Other supplies and services	3,622	611	802	1,305	154	213	6,707
Other expenses	48,159	9,035	7,770	14,642	905	1,061	81,572
Total cost of services	**874,592**	**190,418**	**179,892**	**181,576**	**20,611**	**20,324**	**1,467,413**
Income							
Patient charges	56,741	3,240	4,806	-	-	-	64,787
Other fees for services	30,250	1,997	14,287	1,316	29	4,602	52,481
Commonwealth grants and contributions	274,768	56,909	66,754	49,422	3,777	257	451,887
Other grants and contributions	753	106	145	121,286	1,359	336	123,985
Donation revenue	1,744	140	148	40	2	1	2,075
Commercial activities	67	11	17	3	-	-	98
Other revenue	5,493	705	1,120	761	40	27	8,146
Total income other than income from State Government	**369,816**	**63,108**	**87,277**	**172,828**	**5,207**	**5,223**	**703,459**
Net cost of services	**504,776**	**127,310**	**92,615**	**8,748**	**15,404**	**15,101**	**763,954**
Income from State Government							
Service appropriations	474,187	119,594	87,002	4,902	14,470	14,186	714,341
Assets assumed	85	5	7	-	-	-	97
Services received free of charge	35,500	7,093	5,084	7,925	338	256	56,196
Total income from State Government	509,772	126,692	92,093	12,827	14,808	14,442	770,634
Surplus for the period	**4,996**	**(618)**	**(522)**	**4,079**	**(596)**	**(659)**	**6,680**

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

Note 2 Health Service outputs (continued)

2.2 Schedule of income and expenses by service (continued)

	Public hospital admitted	Public hospital emergency	Public hospital non-admitted	Mental health	Prevention, promotion and protection	Total
	2017 $000	2017 $000	2017 $000	2017 $000	2017 $000	2017 $000
Cost of services						
Expenses						
Employee benefits expense	450,827	89,489	104,646	93,138	6,522	744,622
Fees for visiting medical practitioners	14,891	2,956	3,457	3,077	215	24,596
Contracts for services	146,673	29,114	34,046	30,302	2,122	242,257
Patient support costs	136,382	26,817	32,113	25,436	1,754	222,502
Finance costs	58	11	13	12	1	95
Depreciation and amortisation expense	23,712	4,707	5,504	4,899	343	39,165
Asset revaluation decrement	2,319	461	538	479	34	3,831
Loss on disposal of non-current assets	190	38	44	39	3	314
Repairs, maintenance and consumable equipment	16,682	3,311	3,872	3,446	242	27,553
Other supplies and services	6,811	1,352	1,581	1,407	99	11,250
Other expenses	50,784	10,218	11,949	11,328	745	85,024
Total cost of services	**849,329**	**168,474**	**197,763**	**173,563**	**12,080**	**1,401,209**
Income						
Patient charges	56,243	3,185	4,270	-	-	63,698
Other fees for services	44,147	8,763	10,248	-	639	63,797
Commonwealth grants and contributions	256,943	51,003	59,642	39,550	3,717	410,855
Other grants and contributions	3,313	658	769	123,546	48	128,334
Donation revenue	276	55	64	-	4	399
Commercial activities	1,774	352	411	-	-	2,537
Other revenue	7,662	1,521	1,779	-	110	11,072
Total income other than income from State Government	**370,358**	**65,537**	**77,183**	**163,096**	**4,518**	**680,692**
Net cost of services	**478,971**	**102,937**	**120,580**	**10,467**	**7,562**	**720,517**
Income from State Government						
Service appropriations	472,890	101,631	119,049	4,899	7,466	705,935
Assets assumed	158	31	37	-	2	228
Services received free of charge	40,816	7,847	9,930	5,692	373	64,658
Total income from State Government	**513,864**	**109,509**	**129,016**	**10,591**	**7,841**	**770,821**
Surplus for the period	**34,893**	**6,572**	**8,436**	**124**	**279**	**50,304**

The comparative figures provided are based on the services and activity based costing methodology used prior to the adoption of the OBM framework on 1 July 2017. (See note 2.1 'Health Service objectives').

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

	2018 $000	2017 $000
Note 3 Use of our funding		

Expenses incurred in the delivery of services

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

	Note		
Employee benefits expense	3.1(a)	791,277	744,622
Employee benefits provisions	3.1(b)	191,242	175,993
Contracts for services	3.2	274,334	242,257
Patient support costs	3.3	214,528	222,502
Other expenses	3.4	143,016	152,663

3.1(a) Employee benefits expense

Salaries and wages	725,002	681,331
Superannuation - defined contribution plans (a)	66,275	63,291
Total employee benefits expense	791,277	744,622

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

Salaries and wages: Employee expenses include all costs related to employment including wages and salaries, fringe benefits plus the fringe benefits tax component, leave entitlements including superannuation contribution components and redundancy expenses of $2.4 million (2017: $2.8 million).

Employment on-costs expenses (workers' compensation insurance) are not employee benefits and are included with note 3.4 'Other expenses'.

Superannuation: The amount recognised in profit or loss of the statement of comprehensive income comprises employer contributions paid to the GSS (concurrent contributions), the WSS, the GESBs, or other superannuation funds. The employer contribution paid in respect of the GSS is paid back into the Consolidated Account by the Government Employees Superannuation Board (GESB).

	2018 $000	2017 $000

3.1(a) Employee benefits expense (continued)

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

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

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

3.1(b) Employee benefits provisions

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

Current		
Annual leave (a)	65,793	62,538
Time off in lieu leave (a)	32,392	28,718
Long service leave (b)	57,224	50,253
Deferred salary scheme (c)	504	810
	155,913	142,319
Non-current		
Long service leave (b)	35,329	33,674
Total employee benefits provisions	191,242	175,993

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

	2018 $000	2017 $000
3.1(b) Employee benefits provisions (continued)		

(a) Annual leave liabilities and time off in lieu leave liabilities are classified as current as there is no unconditional right to defer settlement for at least 12 months after the end of the reporting period.

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

Within 12 months of the end of the reporting period	70,405	62,678
More than 12 months after the end of the reporting period	27,780	28,578
	98,185	91,256

(b) Long service leave liabilities are classified as current where there is no unconditional right to defer settlement for at least 12 months after the end of the reporting period. Pre-conditional and conditional long service leave provisions are classified as non-current liabilities because the Health Service has an unconditional right to defer the settlement of the liability until the employee has completed the requisite years of service.

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

Within 12 months of the end of the reporting period	13,774	11,648
More than 12 months after the end of the reporting period	78,779	72,279
	92,553	83,927

Annual leave, time off in lieu leave and long service leave are not expected to be settled wholly within 12 months after the end of the reporting period and therefore considered to be 'other long-term employee benefits'. The leave liability is recognised and measured at the present value of amounts expected to be paid when the liabilities are settled using the remuneration rate expected to apply at the time of settlement.

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

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

	2018 $000	2017 $000
3.1(b) Employee benefits provisions (continued)		

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

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

Within 12 months of the end of the reporting period	144	222
More than 12 months after the end of the reporting period	360	588
	504	810

Key sources of estimation uncertainty - long service leave
Key estimates and assumptions concerning the future are based on historical experience and various other factors that have a significant risk of causing a material adjustment to the carrying amount of assets and liabilities within the next financial year. Several estimates and assumptions are used in calculating the agency's long service leave provision. These include expected future salary rates, discount rates, employee turnover rates and usage rates of leave in service or at termination. Changes in these estimations and assumptions may impact on the carrying amount of the long service leave provision.

Any gain or loss following revaluation of the present value of long service leave liabilities is recognised as employee benefits expense.

Sick Leave
Liabilities for sick leave are recognised when it is probable that sick leave paid in the future will be greater than the entitlement that will accrue in the future. Past history indicates that on average, sick leave taken each reporting period is less than the entitlement accrued. This is expected to continue in future periods. Accordingly, it is unlikely that existing accumulated entitlements will be used by employees and no liability for unused sick leave entitlements is recognised. As sick leave is non-vesting, an expense is recognised in the statement of comprehensive income for this leave as it is taken.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

	2018 $000	2017 $000
3.2 Contracts for services		
Public patients services (a)	247,425	211,559
Mental health services (a)	26,853	30,635
Other contracts	56	63
Total contracts for services	274,334	242,257

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

3.3 Patient support costs		
Drug supplies	61,303	70,711
Pathology	37,433	44,193
Prosthesis	24,127	21,852
Other medical supplies and services	60,687	57,658
Domestic charges	13,346	12,584
Fuel, light and power	8,547	7,265
Food supplies	5,991	5,674
Patient transport costs	2,674	2,316
Research, development and other grants	420	249
Total patient support costs	214,528	222,502

3.4 Other expenses		
Fees for visiting medical practitioners		
Clinical	19,392	18,615
Radiology	5,808	5,981
Total fees for visiting medical practitioners	25,200	24,596

Visiting medical practitioners (VMPs), both general practitioners and specialists, are contracted to provide medical services to a hospital via a Medical Services Agreement. VMPs are independent contractors operating medical businesses and are not Health Service employees.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

	2018 $000	2017 $000
3.4 Other expenses (continued)		
Finance costs		
Interest expense	62	89
Finance lease charges	3	6
Total finance costs	65	95

Finance costs include costs incurred in connection with the borrowing of funds and the interest component of finance lease repayments.

Asset revaluation decrement		
Land	3,130	3,831
Total asset revaluation decrement	3,130	3,831

Land revaluation decrement recognised as an expense on the statement of comprehensive income. (See note 5.1 'Property, plant and equipment').
For building revaluation increment credited to the asset revaluation reserve, see note 8 'Equity'.

Loss on disposal of non-current assets		
Carrying amount of non-current assets disposed:		
Property, plant and equipment	180	314
Proceeds from disposal of non-current assets:		
Property, plant and equipment	(95)	-
Net loss on disposal	85	314

Repairs, maintenance and consumable equipment		
Repairs and maintenance	18,656	19,608
Consumable equipment	7,601	7,945
Total repairs, maintenance and consumable equipment	26,257	27,553

Repairs and maintenance costs are recognised as expenses as incurred, except where they relate to the replacement of a significant component of an asset. In that case the costs are capitalised and depreciated. Consumable equipment costing less than $5,000 is recognised as an expense (see note 5.1 'Property, plant and equipment').

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

	2018 $000	2017 $000
3.4 Other expenses (continued)		
Other supplies and services		
Sanitisation and waste removal services	1,350	1,429
Administration and management services	1,125	1,030
Interpreter services	1,180	934
Security services	505	166
Rehabilitation and complex needs services	-	4,993
Library subscription	1,284	1,285
Contract management	153	930
Patient experience survey	295	-
Outsourced health promotion	131	33
Outsourced engineering	194	102
Other	490	348
Total other supplies and services	6,707	11,250

Supplies and services are recognised as an expense as incurred.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

	2018 $000	2017 $000
3.4 Other expenses (continued)		
Other expenses		
Services provided by Health Support Services: (a)		
ICT services	28,662	22,748
Supply chain services	4,490	7,776
Financial services	2,778	4,734
Human resources services	5,829	7,344
Workers compensation insurance	13,361	17,124
Operating lease expenses	1,899	1,328
Other insurances	7,456	5,294
Consultancy fees	2,242	1,264
Printing and stationery	2,291	2,236
Doubtful debts expense (b)	5,684	7,467
Communications	1,993	1,612
Other employee related expenses	1,570	1,132
Write-down of assets (c)	6	3,513
Motor vehicle expenses	510	582
Computer services	548	433
Other	2,253	437
Total other expenses	81,572	85,024

(a) Services received free of charge. (See note 4.1 'Income from State Government')
(b) Recognised as the movement in the provision for doubtful debts. (See note 6.1 'Receivables').
(c) See note 5.1 'Property, plant and equipment'.

Note 4 Our funding sources

How we obtain our funding

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

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

		2018 $000	2017 $000
Note 4 Our funding sources (continued)			
	Note		
Income from State Government	4.1	770,634	770,821
Commonwealth grants and contributions	4.2	451,887	410,855
Other grants and contributions	4.3	123,985	128,334
Patient charges	4.4	64,787	63,698
Other fees for services	4.5	52,481	63,797
Donation revenue	4.6	2,075	399
Commercial activities	4.7	98	2,537
Other revenue	4.8	8,146	11,072

4.1 Income from State Government

Appropriation received during the year:		
Service appropriation (funding via the Department of Health) (a)	714,341	705,935
	714,341	705,935
Assets transferred from/(to) other State government agencies during the year (b):		
- Transfer of software from South Metropolitan Health Service	-	168
- Transfer of medical equipment from South Metropolitan Health Service	-	49
- Transfer of medical equipment from North Metropolitan Health Service	203	25
- Transfer of equipment from the Department of Health	-	7
- Transfer of artwork from South Metropolitan Health Service	-	5
- Transfer of medical equipment to WA Country Health Service	(66)	(10)
- Transfer of furniture and fittings to South Metropolitan Health Service	-	(16)
- Transfer of medical equipment to South Metropolitan Health Service	(40)	-
Total assets transferred	97	228
Services received free of charge from other State government agencies during the year (c):		
Health Support Services - shared services	41,759	42,602
Pathwest - indirect costs	14,434	22,056
Department of Finance - rental lease management	3	-
Total services received free of charge	56,196	64,658
Total income from State Government	770,634	770,821

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

	2018 $000	2017 $000
4.1 Income from State Government (continued)		

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

Service appropriations fund the net cost of services delivered (as set out in note 2.2 'Schedule of income and expenses by service'). Appropriation revenue comprises a cash component and a receivable (asset). The receivable (Holding Account – note 6.2 'Amounts receivable for services (Holding Account)') comprises the budgeted depreciation expense for the year and any agreed increase in leave liabilities.

(b) Discretionary transfers of net assets (including grants) between State government agencies free of charge, are measured at the fair value of those net assets that the Health Service would otherwise pay for, and are reported under Income from State Government. Transfers of assets and liabilities in relation to a restructure of administrative arrangements are recognised as distribution to owners by the transferor and contribution by owners by the transferee under *AASB 1004*. Other non-discretionary non-reciprocal transfers of assets and liabilities designated as contributions by owners under *TI 955* are also recognised directly to equity.

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

4.2 Commonwealth grants and contributions

Capital grants:		
Bentley Rehabilitation Beds (National Partnership Agreement)	-	28
Recurrent grants:		
National Health Reform Agreement (funding via the Department of Health) (a)	393,294	367,999
National Health Reform Agreement (funding via the Mental Health Commission)	49,422	39,550
Other - Commonwealth Specific Grants (Recurrent)	9,171	3,278
Total commonwealth grants and contributions	451,887	410,855

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

	2018 $000	2017 $000
4.2 Commonwealth grants and contributions (continued)		

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

4.3 Other grants and contributions		
Mental Health Commission - service delivery agreement	117,293	120,013
Mental Health Commission - other	3,991	3,532
Disability Services Commission - community aids and equipment program	1,696	2,001
Lotteries Commission	-	18
Road Trauma Program - Injury Prevention	759	357
Other	246	2,413
Total other grants and contributions	123,985	128,334

4.4 Patient charges		
Inpatient bed charges	53,671	52,437
Inpatient other charges	6,057	6,766
Outpatient charges	5,059	4,495
Total patient charges	64,787	63,698

4.5 Other fees for services		
Recoveries from the Pharmaceutical Benefits Scheme (PBS)	42,792	51,209
Health Technology Management Services	5,132	5,106
Business Intelligence Services	4,043	4,243
Non clinical services to other health organisations	476	3,190
Other	38	49
Total other fees for services	52,481	63,797

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

	2018 $000	2017 $000
4.6 Donation revenue		
Body scanner donated to Royal Perth Hospital	1,300	-
General public donations	775	399
Total donations	2,075	399

4.7 Commercial activities		
Sales:		
Cafeteria sales revenue	3,390	3,277
Car parking fees revenue	2,069	2,268
Total sales	5,459	5,545
Cost of sales	(5,361)	(3,008)
Gross profit	98	2,537

4.8 Other revenue		
RiskCover insurance premium rebate	3,501	5,813
Abatements	376	1,522
Royalty revenues	766	1,043
Rent from commercial properties	937	766
Parking	377	424
Commissions	251	282
Sponsorship	584	213
Training and education	336	4
Clinical trial revenue	247	-
Use of hospital facilities	92	99
Other	679	906
Total other revenue	8,146	11,072

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

	2018 $000	2017 $000

4.8 Other revenue (continued)

Revenue recognition

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

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

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

Grants, donations, gifts and other non-reciprocal contributions
Revenue is recognised at fair value when the Health Service obtains control over the assets comprising the contributions, usually when cash is received. Other non-reciprocal contributions that are not contributions by owners are recognised at their fair value. Contributions of services are only recognised when a fair value can be reliably determined and the services would be purchased if not donated.

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

Note 5 Key assets

Assets the Health Service utilises for economic benefit or service potential

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

	Note		
Property, plant and equipment	5.1	915,969	939,313
Intangible assets	5.2	2,027	2,885
Depreciation and amortisation expense	5.3	44,258	39,165

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

	2018 $000	2017 $000

5.1 Property, plant and equipment

Land		
Gross carrying amount	90,938	98,638
Reconciliation:		
Carrying amount at start of period	98,638	-
Transfers from the Metropolitan Health Service (abolished) (a)	-	81,109
Transfers from/(to) other reporting entities	(4,570)	21,360
Revaluation increments/(decrements)	(3,130)	(3,831)
Carrying amount at end of period	90,938	98,638
Buildings		
Gross carrying amount	709,654	697,889
Reconciliation:		
Carrying amount at start of period	697,889	-
Transfers from the Metropolitan Health Service (abolished) (a)	-	639,517
Additions	2,622	1,881
Transfers from/(to) other reporting entities	-	5,566
Transfers from works in progress	4,208	-
Revaluation increments/(decrements)	14,183	74,893
Transfers between asset classes	19,184	-
Depreciation	(28,432)	(23,968)
Carrying amount at end of period	709,654	697,889

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

	2018 $000	2017 $000
5.1 Property, plant and equipment (continued)		
Site infrastructure		
Gross carrying amount	45,787	64,971
Accumulated depreciation	(4,204)	(2,302)
	41,583	62,669
Reconciliation:		
Gross carrying amount at start of period	64,971	-
Accumulated depreciation	(2,302)	-
Carrying amount at start of period	62,669	-
Transfers from the Metropolitan Health Service (abolished) (a)	-	63,664
Transfers from/(to) other reporting entities	-	1,307
Transfers between asset classes	(19,184)	-
Depreciation	(1,902)	(2,302)
Carrying amount at end of period	41,583	62,669
Leasehold improvements		
Gross carrying amount	2,709	2,709
Accumulated depreciation	(553)	(259)
	2,156	2,450
Reconciliation:		
Gross carrying amount at start of period	2,709	-
Accumulated depreciation	(259)	-
Carrying amount at start of period	2,450	-
Transfers from the Metropolitan Health Service (abolished) (a)	-	2,253
Additions	-	456
Depreciation	(294)	(259)
Carrying amount at end of period	2,156	2,450

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

	2018 $000	2017 $000
5.1 Property, plant and equipment (continued)		
Computer equipment		
Gross carrying amount	2,354	2,360
Accumulated depreciation	(1,412)	(706)
	942	1,654
Reconciliation:		
Gross carrying amount at start of period	2,360	-
Accumulated depreciation	(706)	-
Carrying amount at start of period	1,654	-
Transfers from the Metropolitan Health Service (abolished) (a)	-	2,390
Additions	-	6
Write-down of assets (b) (c)	(6)	(24)
Write-off of assets	-	(12)
Depreciation	(706)	(706)
Carrying amount at end of period	942	1,654
Furniture and fittings		
Gross carrying amount	4,813	4,651
Accumulated depreciation	(1,159)	(558)
	3,654	4,093
Reconciliation:		
Gross carrying amount at start of period	4,651	-
Accumulated depreciation	(558)	-
Carrying amount at start of period	4,093	-
Transfers from the Metropolitan Health Service (abolished) (a)	-	4,370
Additions	419	770
Transfers from/(to) other reporting entities	-	(24)
Other disposals	-	(48)
Transfers between asset classes	(257)	-
Write-down of assets (b)	-	(415)
Depreciation	(601)	(560)
Carrying amount at end of period	3,654	4,093

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

	2018 $000	2017 $000
5.1 Property, plant and equipment (continued)		
Motor vehicles		
Gross carrying amount	13	13
Accumulated depreciation	(10)	(5)
	3	8
Reconciliation:		
Gross carrying amount at start of period	13	-
Accumulated depreciation	(5)	-
Carrying amount at start of period	8	-
Transfers from the Metropolitan Health Service (abolished) (a)	-	13
Depreciation	(5)	(5)
Carrying amount at end of period	3	8
Medical equipment		
Gross carrying amount	57,820	51,207
Accumulated depreciation	(17,957)	(8,746)
	39,863	42,461
Reconciliation:		
Gross carrying amount at start of period	51,207	-
Accumulated depreciation	(8,746)	-
Carrying amount at start of period	42,461	-
Transfers from the Metropolitan Health Service (abolished) (a)	-	48,000
Additions	6,819	5,610
Transfers from/(to) other reporting entities	97	495
Other disposals	(180)	(205)
Write-down of assets (b)	-	(2,624)
Write-off of assets	-	(47)
Depreciation	(9,334)	(8,768)
Carrying amount at end of period	39,863	42,461

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

	2018 $000	2017 $000
5.1 Property, plant and equipment (continued)		
Other plant and equipment		
Gross carrying amount	25,261	24,812
Accumulated depreciation	(3,862)	(1,736)
	21,399	23,076
Reconciliation:		
Gross carrying amount at start of period	24,812	-
Accumulated depreciation	(1,736)	-
Carrying amount at start of period	23,076	-
Transfers from the Metropolitan Health Service (abolished) (a)	-	19,034
Additions	192	6,154
Transfers from/(to) other reporting entities	-	43
Transfers between asset classes	257	-
Write-down of assets (b)	-	(421)
Depreciation	(2,126)	(1,734)
Carrying amount at end of period	21,399	23,076
Artworks		
Gross carrying amount	2,045	2,031
Reconciliation:		
Carrying amount at start of period	2,031	-
Transfers from the Metropolitan Health Service (abolished) (a)	-	2,026
Additions	14	-
Transfers from/(to) other reporting entities	-	5
Carrying amount at end of period	2,045	2,031

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

5.1 Property, plant and equipment (continued)

	2018 $000	2017 $000
Works in progress		
Gross carrying amount	3,732	4,344
Reconciliation:		
Carrying amount at start of period	4,344	-
Transfers from the Metropolitan Health Service (abolished) (a)	-	258
Additions	3,596	4,115
Capitalised to asset classes	(4,208)	-
Write-down of assets (c)	-	(29)
Carrying amount at end of period	3,732	4,344
Total property, plant and equipment		
Gross carrying amount	945,126	953,625
Accumulated depreciation	(29,157)	(14,312)
	915,969	939,313
Reconciliation:		
Gross carrying amount at start of period	953,625	-
Accumulated depreciation	(14,312)	-
Carrying amount at start of period	939,313	-
Transfers from the Metropolitan Health Service (abolished) (a)	-	862,634
Additions	13,662	18,992
Transfers from/(to) other reporting entities	(4,473)	28,752
Other disposals	(180)	(253)
Revaluation increments/(decrements)	11,053	71,062
Write-down of assets (b) (c)	(6)	(3,513)
Write-off of assets	-	(59)
Depreciation	(43,400)	(38,302)
Carrying amount at end of period	915,969	939,313

(a) See note 8 'Equity'.
(b) Assets under $5,000 transferred to the Health Service on 1 July 2016 upon establishment of the Health Service under the *Health Services Act 2016*, were expensed. (See note 3.4 'Other expenses').
(c) Expenses capitalised in the previous financial year, expensed in the current financial year. See note 3.4 'Other expenses'.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

5.1 Property, plant and equipment (continued)

Initial recognition
Items of property, plant and equipment costing $5,000 or more are recognised as assets and measured at cost. Items of property, plant and equipment costing less than $5,000 are immediately expensed directly to the statement of comprehensive income (other than where they form part of a group of similar items which are significant in total).

Assets acquired for nil or nominal cost are initially measured at their fair value.

The cost of a leasehold improvement is capitalised and depreciated over the shorter of the remaining term of the lease or the estimated useful life of the leasehold improvement.

Assets leased under a finance lease are initially recognised at the lower of the fair value of the asset and the present value of the minimum lease payments, each determined at the inception of the lease.

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

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

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

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

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

5.1 Property, plant and equipment (continued)

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

Land and buildings were revalued as at 1 July 2017 by the Western Australian Land Information Authority (Valuations and Property Analytics). The valuations were performed during the year ended 30 June 2018 and recognised at 30 June 2018. In undertaking the revaluation, fair value was determined by reference to market values for land: $20.1 million (2017: $25.5 million) and buildings: $2.7 million (2017: $2.9 million). For the remaining balance, fair value of buildings was determined on the basis of current replacement cost and fair value of land was determined on the basis of comparison with market evidence for land with low level utility (high restricted use land).

The most significant assumptions and judgements in estimating fair value are made in assessing whether to apply the existing use basis to assets and in determining estimated economic life. Professional judgement by the valuer is required where the evidence does not provide a clear distinction between market type assets and existing use assets. In order to estimate fair value on the basis of existing use, the current replacement costs are determined on the assumption that the buildings will be used for the same functions in the future. A major change in utilisation of the buildings may result in material adjustment to the carrying amounts.

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

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

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

5.1 Property, plant and equipment (continued)

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

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

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

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

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

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

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

	2018 $000	2017 $000
5.2 Intangible assets		
Computer software		
Gross carrying amount	3,761	3,761
Accumulated amortisation	(1,734)	(876)
	2,027	2,885
Reconciliation:		
Gross carrying amount at start of the period	3,761	-
Accumulated amortisation	(876)	-
Carrying amount at start of the period	2,885	-
Transfers from the Metropolitan Health Service (abolished) (a)	-	3,546
Additions	-	35
Transfers from/(to) other reporting entities	-	168
Depreciation	(858)	(864)
Carrying amount at end of the period	2,027	2,885

(a) See note 8 'Equity'.

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

Initial recognition
Acquisitions of intangible assets costing $5,000 or more and internally generated intangible assets costing $5,000 or more are capitalised and measured at cost. Costs incurred below these thresholds are immediately expensed directly to the statement of comprehensive income.

Intangible assets acquired for nil or nominal cost are initially measured at their fair value.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

	2018 $000	2017 $000
5.2 Intangible assets (continued)		

Initial recognition (continued)
An internally generated intangible asset arising from development (or from the development phase of an internal project) is recognised if, and only if, all of the following are demonstrated:
(a) the technical feasibility of completing the intangible asset so that it will be available for use or sale
(b) an intention to complete the intangible asset and use or sell it
(c) the ability to use or sell the intangible asset
(d) the intangible asset will generate probable future economic benefit
(e) the availability of adequate technical, financial and other resources to complete the development and to use or sell the intangible asset
(f) the ability to measure reliably the expenditure attributable to the intangible asset during its development

Costs incurred in the research phase of a project are immediately expensed.

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

See note 5.1 'Property, plant and equipment' for testing assets for impairment.

5.3 Depreciation and amortisation expense		
Depreciation and amortisation charge for the period		
Buildings	28,432	23,967
Medical equipment	9,334	8,768
Site infrastructure	1,902	2,302
Leasehold improvements	294	259
Computer equipment	706	706
Furniture and fittings	601	560
Motor vehicles	5	5
Other plant and equipment	2,126	1,734
Total depreciation for the period	43,400	38,301

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

	2018 $000	2017 $000
5.3 Depreciation and amortisation expense (continued)		
Computer software	858	864
Total amortisation for the period	858	864
Total depreciation and amortisation for the period	44,258	39,165

Finite useful lives

All property, plant and equipment having a limited useful life are systematically depreciated over their estimated useful lives in a manner that reflects the consumption of their future economic benefits. The exceptions to this rule include assets held for sale, land and works of art. Amortisation of finite life intangible assets is calculated on a straight line basis at rates that allocate the asset's value over its estimated useful life. All intangible assets controlled by the agency have a finite useful life and zero residual value.

Estimated useful lives for each class of depreciable asset (including intangibles) are:

Buildings	50 years
Site infrastructure	50 years
Leasehold improvements	Term of the lease
Computer equipment	2 to 20 years
Furniture and fittings	2 to 20 years
Motor vehicles	3 to 10 years
Medical equipment	2 to 25 years
Other plant and equipment	3 to 50 years
Computer software	5 to15 years

The estimated useful lives, residual values and depreciation or amortisation method are reviewed at the end of each annual reporting period, and adjustments should be made where appropriate.

Leasehold improvements are depreciated over the shorter of the lease term and their useful lives.

The Health Service's policy is to depreciate all items of property, plant and equipment on a straight line basis. The exception to this is land and works of art, which are considered to have an indefinite life. Depreciation is not recognised in respect of these assets because their service potential has not, in any material sense, been consumed during the reporting period.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

	2018 $000	2017 $000
5.3 Depreciation and amortisation expense (continued)		

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

Note 6 Other assets and liabilities

This section sets out the Health Service's other assets utilised for economic benefits and liabilities incurred during normal operations.

	Note		
Assets			
Receivables	6.1	31,893	32,288
Amounts receivable for services (Holding Account)	6.2	435,334	391,092
Inventories	6.3	5,091	5,585
Other assets	6.4	1,026	1,028
Liabilities			
Payables	6.5	74,486	70,186
Other liabilities	6.6	190	220

6.1 Receivables

Current		
Patient fee debtors (a)	35,356	42,196
Other receivables	6,222	6,004
Less: Allowance for impairment of receivables	(23,314)	(28,553)
Accrued revenue	10,645	9,942
GST receivable	2,984	2,699
Total current	31,893	32,288

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

(a) Under the Private Patient Scheme approved by the State Government, the Department of Health provides ex-gratia payments towards private patient fees not paid in full by health insurance funds. The Health Service has received $1.5 million in ex-gratia payments for the 2017-18 period (2016-17: $2.7 million).

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

	2018 $000	2017 $000

6.1 Receivables (continued)

Receivables are recognised at original invoice amount less any allowances for uncollectible amounts (i.e. impairment). The carrying amount is equivalent to fair value as it is due for settlement within 30 days.

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

6.1.1 Movement of the allowance for impairment of receivables

Balance at start of period	28,553	-
Transfers from the Metropolitan Health Service (abolished) (a)		25,547
Doubtful debts expense (note 3.4 'Other expenses')	5,684	7,467
Amounts written off during the period	(9,433)	(4,380)
Debt waivers during the period (b)	(1,490)	
Adjustment to opening balance	-	(81)
Balance at end of period	23,314	28,553

(a) See note 8 'Equity'.
(b) Debt waivers are discretionary in nature and under justifiable and reasonable circumstances, can be used by the Accountable Authority to permanently forgive a debt.

The collectibility of receivables is reviewed on an ongoing basis. Any receivables identified as uncollectible are written-off against the allowance account. The allowance for uncollectible amounts (doubtful debts) is raised when there is objective evidence that the Health Service will not be able to collect the debts.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

	2018 $000	2017 $000

6.1.1 Movement of the allowance for impairment of receivables (continued)

Key sources of estimation uncertainty - Provision for doubtful debt
Historical debt collection trends are used to estimate impairment of receivables. Changes in the economic, political and legislative environment can affect debt collection rates. These changes may impact the carrying amount of receivables.

6.2 Amounts receivable for services (Holding Account)

Current	-	-
Non-current	435,334	391,092
Total amounts receivable for services	435,334	391,092

Amounts receivable for services represent the non-cash component of service appropriations. It is restricted in that it can only be used for asset replacement or payment of leave liability.

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

6.3 Inventories

Current		
Pharmaceutical stores - at cost	4,579	4,686
Engineering stores - at cost	512	899
Total inventories	5,091	5,585

Inventories are measured at the lower of cost and net realisable value. Costs are assigned on a weighted average cost basis. Inventories not held for resale are measured at cost unless they are no longer required, in which case they are measured at net realisable value.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

	2018 $000	2017 $000
6.4 Other assets		
Current		
Prepayments	876	765
Non-current		
Prepayments	150	263
Total other assets	1,026	1,028

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

6.5 Payables		
Current		
Accrued expenses	44,243	41,158
Trade creditors	11,675	13,326
Accrued salaries	12,773	10,088
Other creditors	5,791	5,607
Accrued interest	4	7
Total current	74,486	70,186

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

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

The accrued salaries suspense account (see note 7.3.1 'Reconciliation of cash') consists of amounts paid annually, from Health Service appropriations for salaries expense, into a Treasury suspense account to meet the additional cash outflow for employee salary payments in reporting periods with 27 pay days instead of the normal 26. No interest is received on this account.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

	2018 $000	2017 $000
6.6 Other liabilities		
Current		
Refundable deposits	133	134
Paid parental leave scheme	55	86
Other current liabilities	2	-
Total current	190	220

Note 7 Financing

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

	Note		
Borrowings	7.1	1,658	2,450
Finance leases	7.2	22	52
Cash and cash equivalents	7.3	142,740	113,219
Commitments	7.4	5,492,465	5,455,116

7.1 Borrowings		
Current		
Department of Treasury loans (a)	797	762
Finance lease liabilities (b)	22	30
Total current	819	792
Non-current		
Department of Treasury loans (a)	839	1,636
Finance lease liabilities (b)	-	22
Total non-current	839	1,658
Total borrowings	1,658	2,450

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

	2018 $000	2017 $000

7.1 Borrowings (continued)

(a) This debt was taken up by the Health Service on 1 July 2016 and relates to a loan provided by the Department of Treasury for capital works. Principal repayments and related interest costs are paid to the Department of Treasury by the Department of Health on behalf of the Health Service. Interest rates are linked to the State Government's debt servicing costs.

(b) The finance lease relates to cleaning equipment at Royal Perth Hospital. See note 7.2 'Finance leases'.

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

7.2 Finance leases

Finance lease commitments
Minimum lease payment commitments in relation to finance leases are payable as follows:

Within 1 year	23	33
Later than 1 year, and not later than 5 years	-	23
Minimum finance lease payments	23	56
Less future finance charges	(1)	(4)
Present value of finance lease liabilities	22	52
The present value of finance leases payable is as follows:		
Within 1 year	22	30
Later than 1 year, and not later than 5 years	-	22
Present value of finance lease liabilities	22	52
Included in the financial statements as:		
Current	22	30
Non-current	-	22
	22	52

	2018 $000	2017 $000

7.2 Finance leases (continued)

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

7.3 Cash and cash equivalents

7.3.1 Reconciliation of cash

Current		
Cash and cash equivalents	108,797	83,848
Restricted cash and cash equivalents (b)	27,584	26,395
	136,381	110,243
Non-current		
Accrued salaries suspense account (a)	6,359	2,976
Total cash assets	142,740	113,219

(a) Funds held in the suspense account for the purpose of meeting the 27th pay in a reporting period that occurs every 11th year. This account is classified as non-current for 10 out of the 11 years.

(b) Restricted cash and cash equivalents are assets, the uses of which are restricted by specific legal or other externally imposed requirements. These include medical research grants, donations for the benefits of patients, medical education, scholarships, capital projects, employee contributions and staff benevolent funds.

For the purpose of the statement of cash flows, cash and cash equivalent (and restricted cash and cash equivalent) assets comprise of cash on hand and cash at bank.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

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

	Note	2018 $000	2017 $000
Net cost of services (statement of comprehensive income)		(763,954)	(720,517)
Non-cash items			
Depreciation and amortisation expense	5.3	44,258	39,165
Doubtful debt expense	3.4	5,684	7,467
Services received free of charge	4.1	56,196	64,658
Net (gain)/loss on disposal of non-current assets	3.4	85	314
Donation of non-current assets	4.6	(1,888)	(107)
Write down of property, plant and equipment	3.4	6	3,513
Interest paid by the Department of Health	3.4	64	91
Asset revaluation decrement	3.4	3,130	3,831
Adjustment for other non-cash items		2,741	(1,901)
Write off of receivables	6.1.1	(10,923)	(4,380)
(Increase)/decrease in assets			
GST receivable	6.1	(285)	54
Other current receivables	6.1	5,919	8,254
Inventories	6.3	495	(218)
Prepayments and other current assets	6.4	(111)	381
Other non-current assets	6.4	113	(263)
Increase/(decrease) in liabilities			
Current payables	6.5	4,300	9,927
Current employee benefits provisions	3.1(b)	13,594	9,588
Other current liabilities	6.6	(30)	69
Non-current employee benefits provisions	3.1(b)	1,655	2,426
Net cash used in operating activities (statement of cash flows)		(638,951)	(577,648)

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

7.3.3 Cash flows from State Government

	2018 $000	2017 $000
Service appropriations (statement of comprehensive income)	714,341	705,935
Capital contributions credited directly to Contributed equity (note 8)	13,650	18,048
Cash and cash equivalents transferred from the Metropolitan Health Service (abolished) (note 8)	-	27,264
	727,991	751,247
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:		
Accrual appropriations	(44,240)	(44,335)
Repayment of interest-bearing liabilities to Department of Treasury	(762)	(728)
Interest paid to Department of Treasury	(64)	(91)
Total notional cash flows	(45,066)	(45,154)
Cash flows from State Government (statement of cash flows)	682,925	706,093

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

7.3.4 Reconciliation of liabilities arising from financing activities

	Loan $000	Finance lease $000	Total (a) $000
2018			
Balance at beginning of period	2,398	52	2,450
Repayment of principal:			
Cash	-	(30)	(30)
Non-cash (b)	(762)	-	(762)
Balance at end of period	1,636	22	1,658
2017			
Transfers from the Metropolitan Health Service (abolished) (c)	3,126	21	3,147
New borrowing (non-cash)		62	62
Repayment of principal:			
Cash	-	(31)	(31)
Non-cash (b)	(728)	-	(728)
Balance at end of period	2,398	52	2,450

(a) See note 7.1 'Borrowings'.
(b) Principal and interest payments are paid by the Department of Health to the Department of Treasury on behalf of the Health Service. (See note 8 'Equity').
(c) See note 8 'Equity'.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

	2018 $000	2017 $000

7.4 Commitments

7.4.1 Operating lease commitments

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

Within 1 year	572	585
Later than 1 year, and not later than 5 years	1,895	1,827
Later than 5 years	1,170	1,671
Balance at end of period	3,637	4,083

The totals presented for operating lease commitments are inclusive of GST.

Operating lease commitments predominantly consist of contractual agreements for office accommodation. The basis of which contingent operating lease payments are determined is the value for each lease agreement under the contract terms and conditions at current values.

Judgements made by management in applying accounting policies - operating lease commitments
The Health Service has entered into a number of leases for buildings. Some of these leases relate to buildings of a temporary nature and it has been determined that the lessor retains substantially all the risks and rewards incidental to ownership. Accordingly, these leases have been classified as operating leases.

7.4.2 Capital commitments

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

Within 1 year	9,148	8,894
Later than 1 year, and not later than 5 years	-	263
Balance at end of period	9,148	9,157

The totals presented for capital commitments are inclusive of GST.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

	2018 $000	2017 $000
7.4.3 Private sector contracts for the provision of health services commitments		

Expenditure commitments in relation to private sector organisations contracted for at the end of the reporting period but not recognised as liabilities, are payable as follows:

Within 1 year	302,183	283,789
Later than 1 year, and not later than 5 years	1,212,645	1,131,457
Later than 5 years, and not later than 10 years	1,567,391	1,457,494
Later than 10 years	2,383,212	2,548,427
Balance at end of period	5,465,431	5,421,167

The totals presented for private sector contracts for the provision of health services commitments are inclusive of GST.

7.4.4 Other commitments

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

Within 1 year	13,659	19,895
Later than 1 year, and not later than 5 years	590	651
Later than 5 years	-	163
Balance at end of period	14,249	20,709

The totals presented for other commitments are inclusive of GST.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

	2018 $000	2017 $000
Note 8 Equity		

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

Contributed equity		
Balance at start of the period	1,111,364	-
Contributions by owners (a)		
Transfer of net assets from the Metropolitan Health Service (abolished) (b)	-	1,057,176
Capital appropriation (c)	13,613	18,048
Transfer of assets from the Department of Health	-	15,033
Transfer of assets and liabilities from North Metropolitan Health	-	23,140
Transfer of assets and liabilities from South Metropolitan Health	37	850
Total contributions by owners	1,125,014	1,114,247
Distributions to owners (a)		
Transfer of assets and liabilities to South Metropolitan Health	-	(2,012)
Transfer of assets and liabilities to North Metropolitan Health	-	(871)
Transfer of land to the Ministerial Body	(4,570)	-
Total distributions to owners	(4,570)	(2,883)
Balance at end of the period	1,120,444	1,111,364

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

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

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

	2018 $000	2017 $000

Note 8 Equity (continued)

(b) The *Health Services Act 2016* was enacted to replace the *Hospitals and Health Services Act 1927* from 1 July 2016. The old Metropolitan Health Service as a statutory authority was abolished and their assets and liabilities were transferred to five health service providers (Child and Adolescent Health Service, East Metropolitan Health Service, North Metropolitan Health Service, South Metropolitan Health Service and Health Support Services) that are separate statutory authorities.

The assets and liabilities transferred to East Metropolitan Health Service are outlined below:

	Balances at 1 July 2016 $000
Assets	
Cash and cash equivalents	27,264
Receivables	381,438
Inventories	5,368
Property, plant and equipment	862,634
Intangible assets	3,546
Other current assets	1,148
	1,281,398
Liabilities	
Payables	56,945
Borrowings	3,147
Provisions	163,979
Other liabilities	151
	224,222
Net Contribution	1,057,176

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

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

	2018 $000	2017 $000

Note 8 Equity (continued)

Asset revaluation reserve		
Balance at start of the period	74,893	-
Net revaluation increments/(decrements):		
Buildings	14,183	74,893
Balance at end of the period	89,076	74,893

The asset revaluation reserve is used to record increments and decrements on the revaluation of non-current assets on a class of assets basis. Any increment is credited directly to the asset revaluation reserve, except to the extent that any increment reverses a revaluation decrement previously recognised as an expense (see note 5.1 'Property, plant and equipment').
For land revaluation decrement recognised as an expense, see note 3.4 'Other expenses'.

Note 9 Risks and contingencies

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

	Note
Financial risk management	9.1
Contingent assets and contingent liabilities	9.2
Fair value measurements	9.3

9.1 Financial risk management

Financial instruments held by the Health Service are cash and cash equivalents, restricted cash and cash equivalents, borrowings, finance leases, receivables and payables. The Health Service has limited exposure to financial risks. The Health Service's overall risk management program focuses on managing the risks identified below.

All financial assets and liabilities recognised in the statement of financial position, whether they are carried at cost or fair value, are recognised at amounts that represent a reasonable approximation of fair value unless otherwise stated in the applicable notes.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

9.1 Financial risk management (continued)

a) Summary of risks and risk management

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

The maximum exposure to credit risk at the end of the reporting period in relation to each class of recognised financial assets is the gross carrying amount of those assets inclusive of any allowance for impairment as shown in the table at note 9.1 (c) 'Credit risk and ageing analysis of financial assets' and note 6.1 'Receivables'.

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

In circumstances where a third party is responsible for payment, or there are legal considerations, payment of accounts can be delayed considerably. Unpaid debts are referred to an external debt collection service on a case by case basis, considering financial election and reasons for non-payment.

Allowance for impairment of financial assets is calculated based on objective evidence such as observable data and historical trends. For financial assets that are either past due or impaired, refer to note 9.1 (c) 'Credit risk and ageing analysis of financial assets'.

Liquidity risk
Liquidity risk arises when the Health Service is unable to meet its financial obligations as they fall due. The Health Service is exposed to liquidity risk through its normal course of operations.

The Health Service has appropriate procedures to manage cash flows including drawdowns of appropriations by monitoring forecast cash flows to ensure that sufficient funds are available to meet its commitments.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

	2018 $000	2017 $000

9.1 Financial risk management (continued)

Market risk
Market risk is the risk that changes in market prices such as foreign exchange rates and interest rates will affect the Health Service's income or the value of its holdings of financial instruments. The Health Service does not trade in foreign currency and is not materially exposed to other price risks. The Health Service's exposure to market risk for changes in interest rates relates primarily to the long-term debt obligations. The Health Service's borrowings include the Department of Treasury loans and finance leases (fixed rates with varying maturities). The interest rate risk for the loans is managed by the Department of Treasury through portfolio diversification and variation in maturity dates.

b) Categories of financial instruments

The carrying amounts of each of the following categories of financial assets and financial liabilities at the end of the reporting period are:

	2018 $000	2017 $000
Financial Assets		
Cash and cash equivalents	108,797	83,848
Restricted cash and cash equivalents	33,943	29,371
Receivables (a)	28,909	29,589
Amounts receivable for services	435,334	391,092
Total financial assets	606,983	533,900
Financial Liabilities		
Financial liabilities measured at amortised cost	76,144	72,636
Total financial liabilities	76,144	72,636

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

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

9.1 Financial risk management (continued)

c) Credit risk and ageing analysis of financial assets

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

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

Ageing analysis of financial assets

	Carrying amount	Not past due and not impaired	Past due but not impaired				Impaired financial assets
			1 - 3 months	3 - 12 months	1 - 5 years	More than 5 years	
	$000	$000	$000	$000	$000	$000	$000
2018							
Cash and cash equivalents	108,797	108,797	-	-	-	-	-
Restricted cash and cash equivalents	33,943	33,943	-	-	-	-	-
Receivables (a)	28,909	14,747	6,893	5,609	1,660	-	-
Amounts receivable for services	435,334	435,334	-	-	-	-	-
	606,983	592,821	6,893	5,609	1,660	-	-
2017							
Cash and cash equivalents	83,848	83,848	-	-	-	-	-
Restricted cash and cash equivalents	29,371	29,371	-	-	-	-	-
Receivables (a)	29,589	18,003	5,209	5,210	1,167	-	-
Amounts receivable for services	391,092	391,092	-	-	-	-	-
	533,900	522,314	5,209	5,210	1,167	-	-

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

d) Liquidity risk and interest rate exposure

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

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018
9.1 Financial risk management (continued)

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

		Interest rate exposure				Maturity dates			
	Weighted average effective interest rate	Carrying amount	Fixed interest rate	Variable interest rate	Non-interest bearing	Nominal amount	Up to 3 months	3 months to 1 year	1 - 5 years	More than 5 years
	%	$000	$000	$000	$000	$000	$000	$000	$000	$000
2018										
Financial Assets										
Cash and cash equivalents		108,797	-	-	108,797	108,797	108,797	-	-	-
Restricted cash and cash equivalents		33,943	-	-	33,943	33,943	33,943	-	-	-
Receivables - non interest bearing (a)		28,909	-	-	28,909	28,909	28,909	-	-	-
Receivables - interest bearing		-	-	-	-	-	-	-	-	-
Amounts receivable for services		435,334	-	-	435,334	435,334	-	-	-	435,334
		606,983	-	-	606,983	606,983	171,649	-	-	435,334
Financial Liabilities										
Payables	-	74,486	-	-	74,486	74,486	74,486	-	-	-
Department of Treasury Loans	3.18%	1,636	-	1,636	-	1,686	209	627	850	-
Finance lease liabilities - Royal Perth	3.62%	22	22	-	-	23	8	15	-	-
		76,144	22	1,636	74,486	76,195	74,703	642	850	-
2017										
Financial Assets										
Cash and cash equivalents		83,848	-	-	83,848	83,848	83,848	-	-	-
Restricted cash and cash equivalents		29,371	-	-	29,371	29,371	29,371	-	-	-
Receivables - non interest bearing (a)		29,589	-	-	29,589	29,589	29,589	-	-	-
Receivables - interest bearing		-	-	-	-	-	-	-	-	-
Amounts receivable for services		391,092	-	-	391,092	391,092	-	-	-	391,092
		533,900	-	-	533,900	533,900	142,808	-	-	391,092
Financial Liabilities										
Payables	-	70,186	-	-	70,186	70,186	70,186	-	-	-
Department of Treasury Loans	3.17%	2,398	-	2,398	-	2,513	206	619	1,688	-
Finance lease liabilities - Royal Perth	7.98%	52	52	-	-	56	8	25	23	-
		72,636	52	2,398	70,186	72,755	70,400	644	1,711	-

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

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

9.1 Financial risk management (continued)

e) Interest rate sensitivity analysis

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

	Carrying amount	-100 basis points		+100 basis points	
		Surplus	Equity	Surplus	Equity
	$000	$000	$000	$000	$000
2018					
Financial assets					
Receivables	-	-	-	-	-
Financial liabilities					
Department of Treasury loans	1,636	16	16	(16)	(16)
Total increase/(decrease)	1,636	16	16	(16)	(16)
2017					
Financial assets					
Receivables	-	-	-	-	-
Financial liabilities					
Department of Treasury loans	2,398	24	24	(24)	(24)
Total increase/(decrease)	2,398	24	24	(24)	(24)

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

9.2 Contingent assets and contingent liabilities

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

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

9.2.1 Contingent assets

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

9.2.2 Contingent liabilities

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

Litigation in progress
There are six claims pending litigation not recoverable from RiskCover insurance that may affect the financial position of the Health Service. These claims total $182,000.

Hospital cladding
The Department of Health is conducting a review of the Health Service's hospitals that have aluminium composite panels (ACPs), following concerns about the potential fire risk associated with the use of some ACP cladding products. The review has identified two sites where ACPs may not meet the requirements of the building code of Australia. The cladding at these sites is undergoing additional testing to determine the need for remediation work. Any costs associated with potential remediation work at either of these sites has not been reliably estimated.

Public holiday time off in lieu (PH TOIL)
Due to an inconsistent interpretation of employee industrial awards and configuration of the payroll system, it has been identified by the Health Support Services (HSS) that incorrect calculations of PH TOIL leave have occurred at the Health Service. A system resolution has been implemented for the nursing cohort and the net effect of this ($1.45m) has been recognised in these financial statements. HSS is working through other employment classes that also earn TOIL and the cost of this cannot as yet be reliably estimated.

Contaminated sites
Under the *Contaminated Sites Act 2003*, the Health Service is required to report known and suspected contaminated sites to the Department of Water and Environmental Regulation (DWER). In accordance with the Act, DWER classifies these sites on the basis of the risk to human health, the environment and environmental values. Where sites are classified as *contaminated – remediation required* or *possibly contaminated – investigation required*, the Health Service may have a liability in respect of investigation or remediation expenses.

At the reporting date, the Health Service does not have any suspected contaminated sites reported under the Act.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

9.3 Fair value measurements

Assets measured at fair value 2018	Level 1 $000	Level 2 $000	Level 3 $000	Total $000
Land (note 5.1 'Property, plant and equipment')				
Vacant land	-	920	-	920
Specialised land	-	19,180	70,838	90,018
Buildings (note 5.1 'Property, plant and equipment')				
Residential and commercial carpark	-	2,720	-	2,720
Specialised buildings	-	-	706,934	706,934
	-	22,820	777,772	800,592

Assets measured at fair value 2017	Level 1 $000	Level 2 $000	Level 3 $000	Total $000
Land (note 5.1 'Property, plant and equipment')				
Vacant land	-	5,780	-	5,780
Specialised land	-	19,750	73,108	92,858
Buildings (note 5.1 'Property, plant and equipment')				
Residential and commercial carpark	-	2,860	-	2,860
Specialised buildings	-	-	695,029	695,029
	-	28,390	768,137	796,527

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

Level 1 inputs - quoted prices (unadjusted) in active markets for identical assets.

Level 2 inputs - input other than quoted prices included within level 1 that are observable for the asset, either directly or indirectly.

Level 3 inputs - input not based on observable market data.

There were no transfers between levels 1, 2 or 3 during the current and previous periods.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

9.3 Fair value measurements (continued)

Valuation techniques to derive level 2 and level 3 fair values

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

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

The best evidence of fair value is current prices in an active market for similar properties. Where such information is not available, Western Australian Land Information Authority (Valuations and Property Analytics) considers current prices in an active market for properties of different nature or recent prices of similar properties in less active markets, and adjusts the valuation for differences in property characteristics and market conditions.

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

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

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

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

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

9.3 Fair value measurements (continued)

Cost approach (continued)

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

The Health Service's hospitals and community centres are specialised buildings and their fair value is determined by reference to the cost of replacing the remaining future economic benefits embodied in the asset (i.e. current replacement cost). Current replacement cost is generally determined by estimating the current cost of reproduction or replacement of the building, on its current site, adjusted for physical deterioration and all relevant forms of obsolescence and optimisation. Obsolescence encompasses physical deterioration, functional (technological) obsolescence and economic (external) obsolescence. Current replacement cost is unlikely to be materially different from depreciated replacement cost as a measure of value in use of specialised assets that are rarely sold.

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

a) Review and updating of the 'as-constructed' drawing documentation.
b) Categorisation of the drawings using the Building Utilisation Categories (BUC's) which designate the functional areas typically provided by the following types of clinical facilities. Each BUC has different cost rates which are calculated from the historical construction costs of similar clinical facilities and are adjusted for the year-to-year change in building costs using building cost index.
   - Nursing Posts and Medical Centres
   - Metropolitan Secondary, Specialist and General Hospitals
   - Tertiary Hospitals
c) Measurement of the general floor areas.
d) Application of the BUC cost rates per square metre of general floor areas.

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

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

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

9.3 Fair value measurements (continued)

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

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

Fair value measurements using significant unobservable inputs (Level 3)

	Land $000	Buildings $000
2018		
Fair value at beginning of period	73,108	695,029
Additions	-	26,015
Revaluation increments/(decrements) recognised in profit or loss	(2,270)	-
Revaluation increments/(decrements) recognised in other comprehensive income	-	14,265
Depreciation	-	(28,375)
Fair value at end of period	70,838	706,934

	Land $000	Buildings $000
2017		
Fair value of balances transferred from the Metropolitan Health Service (abolished) (a)	54,989	636,657
Additions	21,360	7,447
Revaluation increments/(decrements) recognised in profit or loss	(3,241)	-
Revaluation increments/(decrements) recognised in other comprehensive income		74,835
Depreciation	-	(23,910)
Fair value at end of period	73,108	695,029

(a) See note 8 'Equity'.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

9.3 Fair value measurements (continued)

Valuation processes
Western Australian Land Information Authority (Valuation and Property Analytics) determines the fair values of the Health Service's land and buildings. A quantity surveyor is engaged by the Health Service to provide an update of the current construction costs for specialised buildings. Western Australian Land Information Authority (Valuation and Property Analytics) may endorse the current construction costs calculated by the quantity surveyor for specialised buildings and calculates the current replacement costs.

Note 10 Other disclosures

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

10.1 Events occuring after the end of the reporting period

The Health Service is unaware of any event occurring after the reporting date that would materially affect the financial statements.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

10.2 Future impact of Australian Accounting Standards issued not yet operative

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

Title	Operative for reporting periods beginning on/after
AASB 9 Financial Instruments	1 Jan 2018
This Standard supersedes *AASB 139 Financial Instruments: Recognition and Measurement*, introducing a number of changes to accounting treatments. The Health Service has assessed that recognition of expected credit losses will increase the amount of impairment losses recognised as other expenses in the statement of comprehensive income by $0.4 million, and thus have an adverse impact on the Health Service's surplus/(deficit) for the period.	
AASB 15 Revenue from Contracts with Customers	1 Jan 2019
This Standard establishes the principles that the Health Service shall apply to report useful information to users of financial statements about the nature, amount, timing and uncertainty of revenue and cash flows arising from a contract with a customer. The mandatory application date of this Standard is currently 1 January 2019 after being amended by *AASB 2016-7*. The Health Service's revenues from State Government will not be affected by this change and will be measured under *AASB 1058*. The Health Service has not yet determined the potential impact of the Standard on revenues other than revenues from State Government.	
AASB 16 Leases	1 Jan 2019
This Standard introduces a single lessee accounting model and requires a lessee to recognise assets and liabilities for all leases with a term of more than 12 months, unless the underlying asset is of low value. Whilst the impact of *AASB 16* has not yet been quantified, the entity currently has commitments for $3.6 million worth of non-cancellable operating leases which will mostly be brought onto the statement of financial position. Interest and amortisation expense will increase and rental expense will decrease.	

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

10.2 Future impact of Australian Accounting Standards issued not yet operative (continued)

Title	Operative for reporting periods beginning on/after
AASB 1058 Income for Not-for-Profit Entities	1 Jan 2019
This Standard clarifies and simplifies the income recognition requirements that apply to not-for-profit (NFP) entities, more closely reflecting the economic reality of NFP entity transactions that are not contracts with customers. Timing of income recognition is dependent on whether such a transaction gives rise to a liability or other performance obligation (a promise to transfer a good or service), or a contribution by owners, related to an asset (such as cash or another asset) received by an agency. The Health Service anticipates that the application will not materially impact appropriation or untied grant revenues.	
AASB 1059 Service Concession Arrangements: Grantors	1 Jan 2019
This Standard addresses the accounting for a service concession arrangement (a type of public private partnership) by a grantor that is a public sector entity by prescribing the accounting for the arrangement from the grantor's perspective. Timing and measurement for the recognition of a specific asset class occurs on commencement of the arrangement and the accounting for associated liabilities is determined by whether the grantee is paid by the grantor or users of the public service provided. The Health Service has not yet determined the impact of the Standard.	
AASB 2010-7 Amendments to Australian Accounting Standards arising from AASB 9 (December 2010) [AASB 1, 3, 4, 5, 7, 101, 102, 108, 112, 118, 120, 121, 127, 128, 131, 132, 136, 137, 139, 1023 & 1038 and Int 2, 5, 10, 12, 19 & 127]	1 Jan 2018
This Standard makes consequential amendments to other Australian Accounting Standards and Interpretations as a result of issuing *AASB 9* in December 2010. The mandatory application date of this Standard has been amended by *AASB 2012-6* and *AASB 2014-1* to 1 January 2018. Other than the exposures to *AASB 9* noted above, the Health Service is only insignificantly impacted by the application of the Standard.	

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

10.2 Future impact of Australian Accounting Standards issued not yet operative (continued)

Title	Operative for reporting periods beginning on/after
AASB 2014-1 Amendments to Australian Accounting Standards	1 Jan 2018
Part E of this Standard makes amendments to *AASB 9* and consequential amendments to other Standards. These changes have no impact as Appendix E has been superseded and the Health Service was not permitted to early adopt *AASB 9*.	
AASB 2014-5 Amendments to Australian Accounting Standards arising from AASB 15	1 Jan 2018
This Standard gives effect to the consequential amendments to Australian Accounting Standards (including Interpretations) arising from the issuance of *AASB 15*. The mandatory application date of this Standard has been amended by *AASB 2015-8* to 1 January 2018. The Health Service has not yet determined the application or the potential impact of the Standard.	
AASB 2014-7 Amendments to Australian Accounting Standards arising from AASB 9 (December 2014,	1 Jan 2018
This Standard gives effect to the consequential amendments to Australian Accounting Standards (including Interpretations) arising from the issuance of *AASB 9* (December 2014). The Health Service has not yet determined the application or the potential impact of the Standard.	
AASB 2015-8 Amendments to Australian Accounting Standards – Effective Date of AASB 15	1 Jan 2018
This Standard amends the mandatory application date of *AASB 15* to 1 January 2018 (instead of 1 January 2017). It also defers the consequential amendments that were originally set out in *AASB 2014-5*. There is no financial impact arising from this Standard.	
AASB 2016-3 Amendments to Australian Accounting Standards – Clarifications to AASB 15	1 Jan 2018
This Standard clarifies identifying performance obligations, principal versus agent considerations, timing of recognising revenue from granting a licence, and, provides further transitional provisions to *AASB 15*. The Health Service has not yet determined the application or the potential impact when the deferred *AASB 15* becomes effective from 1 January 2019.	

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

10.2 Future impact of Australian Accounting Standards issued not yet operative (continued)

Title	Operative for reporting periods beginning on/after
AASB 2016-7 Amendments to Australian Accounting Standards – Deferral of AASB 15 for Not-for-Profit Entities This Standard defers, for not-for-profit entities, the mandatory application date of *AASB 15* to 1 January 2019, and the consequential amendments that were originally set out in *AASB 2014-5*. There is no financial impact arising from this standard.	1 Jan 2018
AASB 2016-8 Amendments to Australian Accounting Standards – Australian Implementation Guidance for Not-for-Profit Entities This Standard inserts Australian requirements and authoritative implementation guidance for not-for-profit entities into *AASB 9* and *AASB 15*. This guidance assists not-for-profit entities in applying those Standards to particular transactions and other events. There is no financial impact.	1 Jan 2019

10.3 Key management personnel

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

The Board of East Metropolitan Health Service is the Accountable Authority for the Health Service.

Total compensation for key management personnel, comprising members and senior officers of the Accountable Authority for the period are presented within the following bands:

Compensation of members of the Accountable Authority

Compensation band ($)	2018	2017
$ 0 - $ 10,000 (a)	1	2
$ 20,001 - $ 30,000	1	-
$ 40,001 - $ 50,000	7	7
$ 70,001 - $ 80,000	1	1
Total:	10	10

(a) Includes members of the Accountable Authority with nil compensation.

	2018 $000	2017 $000

10.3 Key management personnel (continued)

Compensation of senior officers

Compensation band ($)	2018	2017
$ 50,001 - $ 60,000	1	1
$ 70,001 - $ 80,000	1	-
$ 80,001 - $ 90,000	1	-
$100,001 - $110,000	1	-
$120,001 - $130,000	1	-
$150,001 - $160,000	-	1
$170,001 - $180,000	2	2
$210,001 - $220,000	2	2
$220,001 - $230,000	-	1
$230,001 - $240,000	1	1
$480,001 - $490,000	1	-
$490,001 - $500,000	-	1
$500,001 - $510,000	1	-
$510,001 - $520,000	-	1
$550,001 - $560,000	1	1
Total:	13	11

Short-term employee benefits (a)	3,144	3,024
Post employment benefits	356	339
Other long-term benefits	(103)	34
Total compensation of key management personnel	3,397	3,397

(a) The short-term employee benefits include salary, motor vehicle benefits, district and travel allowances incurred by the Health Service in respect of senior officers.

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

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

10.4 Related party transactions

The Health Service is a wholly owned public sector entity that is controlled by the State of Western Australia.

Related parties of the Health Service include:

- all senior officers and their close family members, and their controlled or jointly controlled entities
- all members of the Accountable Authority, and their close family members, and their controlled or jointly controlled entities
- all cabinet ministers and their close family members, and their controlled or jointly controlled entities
- other departments and statutory authorities, including related bodies, that are included in the whole of government consolidated financial statements (i.e. wholly-owned public sector entities)
- the Government Employees Superannuation Board (GESB)

In conducting its activities, the Health Service is required to transact with the State and entities related to the State. These transactions are generally based on the standard terms and conditions that apply to all agencies. Such transactions include:

	Note
Service appropriations	4.1
Capital appropriation	8
Services received free of charge	4.1
Superannuation payments to GESB	3.1(a)
Insurance payments to the Insurance Commission and RiskCover fund	3.4
Remuneration for services provided by Office of the Auditor General	10.8
Motor vehicle fleet management payments to State Fleet	3.4

Material transactions with other related parties:

Outside of normal citizen type transactions with the Health Service, there were no other related party transactions that involved key management personnel and/or their close family members and/or their controlled (or jointly controlled) entities.

10.5 Related bodies

A related body is a body that receives more than half of its funding and resources from an agency and is subject to operational control by that agency.

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

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

	2018 $000	2017 $000

10.6 Affiliated bodies

An affiliated body is a body that receives more than half its funding and resources from an agency but is not subject to operational control by that agency.

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

10.7 Special purpose accounts

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

Balance at start of period (a)	124	-
Receipts		
Commonwealth contributions (note 4.2)	49,422	39,550
State contributions (note 4.3)	117,293	120,013
Other (note 4.3)	3,991	3,532
	170,830	163,095
Payments	(170,198)	(162,971)
Balance at end of period	632	124

(a) The Mental Health Commission Fund (East Metropolitan Health Service) Account was established in June 2016, with no transactions in the 2015-16 financial year. Therefore, the opening balance at 1 July 2016 was zero.

The special purpose accounts are established under section 16(1)(d) of the *Financial Management Act 2006*.

10.8 Remuneration of auditors

Remuneration paid or payable to the Auditor General in respect of the audit for the current financial year is as follows:

Auditing the accounts, financial statement controls, and key performance indicators	217	155

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

	2018 $000	2017 $000
10.9 Supplementary financial information		
a) Write-offs		
Debts written off under the authority of the Accountable Authority	6,971	3,808
Public and other property written off under the authority of the Accountable Authority	-	59
Debts written off under the authority of the Minister	2,462	572
	9,433	4,439
b) Debt waivers		
Debts waived under the authority of the Accountable Authority	1,490	-
	1,490	-

Debt waivers are discretionary in nature and under justifiable and reasonable circumstances, can be used by the Accountable Authority to permanently forgive a debt.

10.10 Administered trust accounts

Funds held in these trust accounts are not controlled by the Health Service and are therefore not recognised in the financial statements.

a) The Health Service administers trust accounts for the purpose of holding patients' private moneys.

A summary of the transactions for these trust accounts are as follows:

Balance at start of period	29	24
Add receipts	89	88
	118	112
Less payments	(84)	(83)
Balance at end of period	34	29

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

	2018 $000	2017 $000
10.10 Administered trust accounts (continued)		
b) Other trust accounts not controlled by the Health Service:		
A summary of the transactions for this trust account is as follows:		
RPH Private Trust Account		
Balance at start of period	293	292
Add receipts	1	1
	294	293
Less payments	-	-
Balance at end of period	294	293

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

Note 11 Explanatory statement

All variances between actual results for 2018 and estimates (original budget) and are shown below. Narratives are provided for key major variances, which are generally greater than:

5% and $25 million for the statements of comprehensive income and cash flows
5% and $25 million for the statements financial position and changes in equity

Statement of comprehensive income	Note	Estimates 2018 $000	Actuals 2018 $000	Variance between actual and estimate $000
Expenses				
Employee benefits expense		786,274	791,277	5,003
Fees for visiting medical practitioners		22,186	25,200	3,014
Contracts for services	1	252,262	274,334	22,072
Patient support costs	2	182,914	214,528	31,614
Finance costs		67	65	(2)
Depreciation and amortisation expense		39,562	44,258	4,696
Asset revaluation decrement		-	3,130	3,130
Loss on disposal of non-current assets		-	85	85
Repairs, maintenance and consumable equipment		35,974	26,257	(9,717)
Other supplies and services		-	6,707	6,707
Other expenses		88,445	81,572	(6,873)
Total cost of services		**1,407,684**	**1,467,413**	**59,729**
Income				
Revenue				
Patient charges		65,505	64,787	(718)
Other fees for services		51,237	52,481	1,244
Commonwealth grants and contributions	3	386,489	451,887	65,398
Other grants and contributions	4	167,964	123,985	(43,979)
Donation revenue		-	2,075	2,075
Commercial activities		-	98	98
Other revenue		-	8,146	8,146
Total income other than income from State Government		**671,195**	**703,459**	**32,264**
Net cost of services		**736,489**	**763,954**	**27,465**
Income from State Government				
Service appropriations		694,762	714,341	19,579
Assets assumed		-	97	97
Services received free of charge		41,727	56,196	14,469
Total income from State Government		**736,489**	**770,634**	**34,145**
Surplus for the period		**-**	**6,680**	**6,680**

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

Note 11 Explanatory statement (continued)

Statement of comprehensive income (continued)	Estimates 2018 $000	Actuals 2018 $000	Variance between estimate and actual $000
Other comprehensive income			
Items not reclassified subsequently to profit or loss	-	-	-
Changes in asset revaluation reserve	-	14,183	14,183
Total other comprehensive income	**-**	**14,183**	**14,183**
Total comprehensive income for the period	**-**	**20,863**	**20,863**

Significant variances between estimates and actuals - statement of comprehensive income

1) Actual contracts for services are $22m (9%) higher than estimated. The initial budget increased subsequent to the preparation of the estimates.

2) Actual patient support costs are $32m (17%) higher than estimated. The initial expenditure target increased to accommodate an increase in price per purchased unit of activity. In addition, $14m of indirect pathology expenses from PathWest were not included in the original estimates and drug supplies increased by $5m over initial estimate (recovered from Pharmaceutical Benefits Scheme).

3) Actual commonwealth grants and contributions are $65m (17%) higher than estimated. $49m Mental Health funding was recognised in Commonwealth grants and contributions while included in other grants and contributions in the estimates, and $5m recognised as state appropriation was included in the Commonwealth grants and contributions in the estimates. In addition, there was a $20m increase in the NHRA funding budget during the financial year.

4) Actual other grants and contributions are $44m (26%) lower than estimated. $49m of Mental Health funding was recognised in Commonwealth grants and contributions actuals while included in the estimates for other grants and contributions. There are $3m in community aids and equipment program (CAEP) and other grants not in the original estimates. The final service agreement provided an additional $2m in Mental Health funding over the initial estimate.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

Note 11 Explanatory statement (continued)

Statement of financial position	Note	Estimates 2018 $000	Actuals 2018 $000	Variance between estimate and actual $000
Assets				
Current assets				
Cash and cash equivalents	1	83,848	108,797	24,949
Restricted cash and cash equivalents		26,395	27,584	1,189
Receivables		32,200	31,893	(307)
Inventories		5,585	5,091	(494)
Other current assets		1,028	876	(152)
Total current assets		**149,056**	**174,241**	**25,185**
Non-current assets				
Restricted cash and cash equivalents	1	-	6,359	6,359
Amounts receivable for services		430,654	435,334	4,680
Property, plant and equipment		915,322	915,969	647
Intangible assets		2,885	2,027	(858)
Other non-current assets		2,977	150	(2,827)
Total non-current assets		**1,351,838**	**1,359,839**	**8,001**
Total assets		**1,500,894**	**1,534,080**	**33,186**
Liabilities				
Current liabilities				
Payables		70,186	74,486	4,300
Borrowings		30	819	789
Employee benefits provisions		142,319	155,913	13,594
Other current liabilities		220	190	(30)
Total current liabilities		**212,755**	**231,408**	**18,653**
Non-current liabilities				
Employee benefits provisions		33,674	35,329	1,655
Borrowings		1,658	839	(819)
Total non-current liabilities		**35,332**	**36,168**	**836**
Total liabilities		**248,087**	**267,576**	**19,489**
Net assets		**1,252,807**	**1,266,504**	**13,697**
Equity				
Contributed equity		1,127,610	1,120,444	(7,166)
Reserves		74,893	89,076	14,183
Accumulated surplus		50,304	56,984	6,680
Total equity		**1,252,807**	**1,266,504**	**13,697**

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

Note 11 Explanatory statement (continued)

Significant variances between estimates and actuals - statement of financial position

1) Actual balances of cash and cash equivalents are $32m (29%) higher than estimated. Cash inflows from State Government were $12m higher than in original estimates and net cash outflows from operations were $16m lower than estimated.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

Note 11 Explanatory statement (continued)

Statement of changes in equity	Estimates 2018 $000	Actuals 2018 $000	Variance between estimate and actual $000
Contributed equity			
Balance at start of period	1,111,276	1,111,364	88
Transactions with owners in their capacity as owners:			
Capital appropriations	16,334	13,613	(2,721)
Other contributions by owners	-	37	37
Distributions to owners	-	(4,570)	(4,570)
Balance at end of period	**1,127,610**	**1,120,444**	**(7,166)**
Reserves			
Asset revaluation reserve			
Balance at start of period	74,893	74,893	-
Other comprehensive income for the period	-	14,183	14,183
Balance at end of period	**74,893**	**89,076**	**14,183**
Accumulated surplus			
Balance at start of period	50,304	50,304	-
Surplus for the period	-	6,680	6,680
Balance at end of period	**50,304**	**56,984**	**6,680**
Total equity			
Balance at start of period	1,236,473	1,236,561	88
Total comprehensive income for the period	-	20,863	20,863
Transactions with owners in their capacity as owners	16,334	9,080	(7,254)
Balance at end of period	**1,252,807**	**1,266,504**	**13,697**

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

Note 11 Explanatory statement (continued)

Statement of cash flows	Note	Estimates 2018 $000	Actuals 2018 $000	Variance between estimate and actual $000
Cash flows from State Government				
Service appropriations		655,133	670,035	14,902
Capital appropriations		15,572	12,890	(2,682)
Net cash provided by State Government		**670,705**	**682,925**	**12,220**
Utilised as follows:				
Cash flows from operating activities				
Payments				
Employee benefits		(786,274)	(776,312)	9,962
Supplies and services		(540,055)	(559,172)	(19,117)
Finance costs		-	(3)	(3)
Receipts				
Receipts from customers		65,505	60,703	(4,802)
Commonwealth grants and contributions	1	386,489	451,887	65,398
Other grants and contributions	2	167,965	123,985	(43,980)
Donations received		-	187	187
Other receipts		51,237	59,774	8,537
Net cash used in operating activities		**(655,133)**	**(638,951)**	**16,182**
Cash flows from investing activities				
Payments				
Purchase of non-current assets		(15,572)	(14,423)	1,149
Net cash used in investing activities		**(15,572)**	**(14,423)**	**1,149**
Cash flows from financing activities				
Payments				
Repayment of finance lease liabilities		-	(30)	(30)
Net cash used in financing activities		**-**	**(30)**	**(30)**
Net increase in cash and cash equivalents		-	29,521	29,521
Cash and cash equivalents at the beginning of the period		110,243	113,219	2,976
Total cash and cash equivalents at the end of the period		**110,243**	**142,740**	**32,497**

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

Note 11 Explanatory statement (continued)

Significant variances between estimates and actuals - statement of cash flows

1) Actual receipts from Commonwealth grants and contributions are $65m (17%) higher than estimated. $49m Mental Health funding was recognised as Commonwealth grants and contributions while included in other grants and contributions in the estimates, and $5m recognised as state appropriation was included in the Commonwealth grants and contributions in the estimates. In addition, there was a $20m increase in the NHRA funding budget during the financial year.

2) Actual receipts from other grants and contributions are $44m (26%) lower than estimated. $49m of Mental Health funding was recognised in commonwealth grants and contributions actuals while included in the estimates for other grants and contributions. There are $3m in CAEP and other grants not in the original estimates. The final service agreement provided an additional $2m in Mental Health funding over the initial estimate.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

Note 11 Explanatory statement (continued)

All variances between actual results for 2018 and 2017 are shown below. Narratives are provided for key major variances, which are generally greater than:
- 5% and $25 million for the statements of comprehensive income and cash flows
- 5% and $25 million for the statements financial position and changes in equity

Statement of comprehensive income	Note	Actuals 2018 $000	Actuals 2017 $000	Variance between 2018 and 2017 $000
Expenses				
Employee benefits expense	1	791,277	744,622	46,655
Fees for visiting medical practitioners		25,200	24,596	604
Contracts for services	2	274,334	242,257	32,077
Patient support costs		214,528	222,502	(7,974)
Finance costs		65	95	(30)
Depreciation and amortisation expense		44,258	39,165	5,093
Asset revaluation decrement		3,130	3,831	(701)
Loss on disposal of non-current assets		85	314	(229)
Repairs, maintenance and consumable equipment		26,257	27,553	(1,296)
Other supplies and services		6,707	11,250	(4,543)
Other expenses		81,572	85,024	(3,452)
Total cost of services		**1,467,413**	**1,401,209**	**66,204**
Income				
Revenue				
Patient charges		64,787	63,698	1,089
Other fees for services		52,481	63,797	(11,316)
Commonwealth grants and contributions	3	451,887	410,855	41,032
Other grants and contributions		123,985	128,334	(4,349)
Donation revenue		2,075	399	1,676
Commercial activities		98	2,537	(2,439)
Other revenue		8,146	11,072	(2,926)
Total income other than income from State Government		**703,459**	**680,692**	**22,767**
Net cost of services		**763,954**	**720,517**	**43,437**
Income from State Government				
Service appropriations		714,341	705,935	8,406
Assets assumed		97	228	(131)
Services received free of charge		56,196	64,658	(8,462)
Total income from State Government		**770,634**	**770,821**	**(187)**

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

Note 11 Explanatory statement (continued)

Statement of comprehensive income		Actuals 2018 $000	Actuals 2017 $000	Variance between 2018 and 2017 $000
Surplus for the period		**6,680**	**50,304**	**(43,624)**
Other comprehensive income				
Changes in asset revaluation reserve	4	14,183	74,893	(60,710)
Total other comprehensive income		**14,183**	**74,893**	**(60,710)**
Total comprehensive income for the period		**20,863**	**125,197**	**(104,334)**

Significant variances between 2018 and 2017 actuals - statement of comprehensive income

1) Employment expenses increased by $47m (6%), mainly due to an increase in FTEs associated with increased inpatient and emergency department activity and an average 1.5% cost of award increases. An additional $6m in employee benefits expense was recognised as a result of the actuarial valuation of the employee benefits provisions balances.

2) Contracts for services increased by $32m (13%). This reflects the increase in the payments to St. John of God for the services provided at St. John of God Midland Public Hospital and St. John of God Mt. Lawley.

3) Commonwealth grants and contributions increased by $41m (10%). Driven by $10m increase in Mental Health funding, $5 additional NHRA substituted funding and $24m of additional activity based funding primarily for inpatient activity ($17m) and non-admitted activity ($5m).

4) Changes in the movement of the asset revaluation reserve decreased by $61m (83%). 2017-18 building revaluations resulted in a $14m increase in value compared with a $75m increase in 2016-17.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

Note 11 Explanatory statement (continued)

Statement of financial position		Actuals 2018 $000	Actuals 2017 $000	Variance between 2018 and 2017 $000
Assets				
Current assets				
Cash and cash equivalents		108,797	83,848	24,949
Restricted cash and cash equivalents		27,584	26,395	1,189
Receivables		31,893	32,288	(395)
Inventories		5,091	5,585	(494)
Other current assets		876	765	111
Total current assets		**174,241**	**148,881**	**25,360**
Non-current assets				
Restricted cash and cash equivalents		6,359	2,976	3,383
Amounts receivable for services	1	435,334	391,092	44,242
Property, plant and equipment		915,969	939,313	(23,344)
Intangible assets		2,027	2,885	(858)
Other non-current assets		150	263	(113)
Total non-current assets		**1,359,839**	**1,336,529**	**23,310**
Total assets		**1,534,080**	**1,485,410**	**48,670**
Liabilities				
Current liabilities				
Payables		74,486	70,186	4,300
Borrowings		819	792	27
Employee benefits provisions		155,913	142,319	13,594
Other current liabilities		190	220	(30)
Total current liabilities		**231,408**	**213,517**	**17,891**
Non-current liabilities				
Employee benefits provisions		35,329	33,674	1,655
Borrowings		839	1,658	(819)
Total non-current liabilities		**36,168**	**35,332**	**836**
Total liabilities		**267,576**	**248,849**	**18,727**
Net assets		**1,266,504**	**1,236,561**	**29,943**
Equity				
Contributed equity		1,120,444	1,111,364	9,080
Reserves		89,076	74,893	14,183
Accumulated surplus		56,984	50,304	6,680
Total equity		**1,266,504**	**1,236,561**	**29,943**

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

Note 11 Explanatory statement (continued)

Significant variances between 2018 and 2017 actuals - statement of financial position

1) Amounts receivable for services increased by $44m (11%). This reflects the total state appropriation received to fund depreciation expense for 2017-18.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018
Note 11 Explanatory statement (continued)

Statement of changes in equity	Note	Actuals 2018 $000	Actuals 2017 $000	Variance between 2018 and 2017 $000
Contributed equity				
Balance at start of period		1,111,364	-	1,111,364
Transactions with owners in their capacity as owners:				
Capital appropriations		13,613	18,048	(4,435)
Other contributions by owners	1	37	1,096,199	(1,096,162)
Distributions to owners		(4,570)	(2,883)	(1,687)
Balance at end of period		**1,120,444**	**1,111,364**	**9,080**
Reserves				
Asset revaluation reserve				
Balance at start of period		74,893	-	74,893
Other comprehensive income for the period	2	14,183	74,893	(60,710)
Balance at end of period		**89,076**	**74,893**	**14,183**
Accumulated surplus				
Balance at start of period		50,304	-	50,304
Surplus for the period	3	6,680	50,304	(43,624)
Balance at end of period		**56,984**	**50,304**	**6,680**
Total equity				
Balance at start of period		1,236,561	-	1,236,561
Total comprehensive income for the period		20,863	125,197	(104,334)
Transactions with owners in their capacity as owners		9,080	1,111,364	(1,102,284)
Balance at end of period		**1,266,504**	**1,236,561**	**29,943**

Significant variances between 2018 and 2017 actuals - statement of changes in equity

1) Other contributions by owner for the 2017-18 period are $1b less than in 2016-17 because the net assets and liabilities were transferred to the Health Service upon establishment through equity on 1 July 2016. There were no large contributions by owner in the 2017-18 financial year.

2) Other comprehensive income for the period decreased by $61m (81%). The revaluation of buildings in 2017-18 resulted in a $14m increase in value compared with a $75m increase in 2016-17.

3) Surplus for the period decreased by $44m (88%). This is driven by a $65m increase in expenses (mainly employee benefits expense and contracts for services), partially offset by a $23m increase in revenues.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

Note 11 Explanatory statement (continued)

Statement of cash flows	Note	Actuals 2018 $000	Actuals 2017 $000	Variance between 2018 and 2017 $000
Cash flows from State Government				
Service appropriations		670,035	661,508	8,527
Capital appropriations		12,890	17,321	(4,431)
Cash and cash equivalents transferred from the Metropolitan Health Service (abolished)		-	27,264	(27,264)
Net cash provided by State Government		**682,925**	**706,093**	**(23,168)**
Utilised as follows:				
Cash flows from operating activities				
Payments				
Employee benefits	1	(776,312)	(724,222)	(52,090)
Supplies and services		(559,172)	(539,877)	(19,295)
Finance costs		(3)	(6)	3
Receipts				
Receipts from customers		60,703	59,597	1,106
Commonwealth grants and contributions	2	451,887	410,855	41,032
Other grants and contributions		123,985	128,333	(4,348)
Donations received		187	292	(105)
Other receipts	3	59,774	87,380	(27,606)
Net cash used in operating activities		**(638,951)**	**(577,648)**	**(61,303)**
Cash flows from investing activities				
Payments				
Purchase of non-current assets		(14,423)	(15,195)	772
Net cash used in investing activities		**(14,423)**	**(15,195)**	**772**
Cash flows from financing activities				
Payments				
Repayment of finance lease liabilities		(30)	(31)	1
Net cash used in financing activities		**(30)**	**(31)**	**1**
Net increase in cash and cash equivalents		29,521	113,219	(83,698)
Cash and cash equivalents at the beginning of the perioc		113,219	-	113,219
Total cash and cash equivalents at the end of the period		**142,740**	**113,219**	**29,521**

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2018

Note 11 Explanatory statement (continued)

Significant variances between 2018 and 2017 actuals - statement of cash flows

1) Cash outflows from employee benefits increased by $52m (7%). Employee benefits expense for the year increased by $45m and an additional $6m in employee related liabilities were settled in 2017-18.

2) Cash inflows from Commonwealth grants and contributions increased by $41m (10%). Driven by $10m increase in Mental Health funding, $5 additional NHRA substituted funding and $24m of additional activity based funding primarily for inpatient activity ($17m) and non-admitted activity ($5m).

3) Other receipts decreased by $28m (31%). This is due to lower revenues from the Pharmaceutical Benefits Scheme, RiskCover insurance rebates and other miscellaneous revenues. In addition, $10m less revenue accruals were settled in 2017-18.

Mary Ann, patient from Broome, at RPH

East Metropolitan Health Service

Disclosure and legal compliance

Important note

All information within the disclosure and legal compliance section pertaining to staff is inclusive of staff working within EMHS corporate areas, AKG and RPBG. This data does not include staff employed at SJGMPH or SJGML campuses (with the exception of clinical staff who work on a rotational basis, such as medical interns) as they are employed privately by SJGHC.

Ministerial directives

Treasurer's Instructions 903(12) require disclosing information on any Ministerial directives relevant to the setting or achievement of desired outcomes or operational objectives, or operational objectives, investment activities and financing activities.

In 2017-18, the Minister for Health provided a Statement of Expectation outlining his expectations regarding the priorities and accountabilities of the EMHS Board, and in response, the EMHS Board released a Statement of Intent. Both of these are publicly available on the EMHS website www.eastmetropolitan.health.wa.gov.au.

The Statement of Expectation included the progression of the Government's election commitments allocated to EMHS. These include the establishment of an Innovation Hub, Mental Health Observation Area (MHOA), Urgent Care Clinic (UCC) and Medihotel, as well as measures to support the workforce, including the protection of frontline staff.

The Innovation Hub, to be located at RPH, will be a co-working space for start-ups, incubators and accelerators. Following consultation with a range of stakeholders, an initial proposal has been developed to inform the implementation of the Innovation Hub.

A MHOA Plus service has been determined as the best option for RPH. This will see the establishment of a purpose-built eight bed MHOA to allow for psychiatric assessment and brief treatment of less acute patients presenting to the ED, in addition to a 12 bed authorised Mental Health Unit (MHU). The MHU will provide higher acuity therapy and will be authorised to detain and treat involuntary patients. The MHOA Plus is expected to be completed by late 2019.

From left: Deputy Premier; Minister for Health; Mental Health, Hon. Roger Cook MLA and Premier, Hon. Mark McGowan MLA, with EMHS Chief Executive Liz MacLeod, opening the Urgent Care Clinic at RPH

The UCC provides a clinical service for recovery of patients with acute behavioural disturbance, usually in the context of drug and alcohol intoxication and overdose, with an expected length of stay of less than 24 hours. Formally titled the UCC (Toxicology), the clinic was officially opened and commenced receiving patients on 22 May 2018.

The Government committed to the establishment of Medihotels adjacent to Perth's tertiary hospitals, including RPH. Medihotels have been defined as specialist accommodation to support patients discharged from hospital who are still recovering from illness or treatment and/or being monitored or undergoing testing, while avoiding the full cost of inpatient care. Stakeholder engagement has commenced and a range of models are currently being considered for a Medihotel at RPH.

Following a range of measures implemented in 2016-17 to address the management of aggression in the workplace, EMHS continues to focus on strategies through its Stop the Violence initiative to support the protection of frontline staff. This program includes a range of staff and consumer engagement about the impact of violence in the workplace, supported by internal communications and education to staff about how to handle and de-escalate incidences of violence or aggression.

Summary of board and committee remuneration

The total annual remuneration for each board or committee is listed in the following table. For full details of individual board or committees, please see appendix on page 213.

Table 3 - Summary of board and committee remuneration 2017-18

Board/committee	Total remuneration $
East Metropolitan Health Service Board	365,607
Armadale Kalamunda Group Community Advisory Council	870
Bentley Hospital Community Advisory Committee	2760
Royal Perth Hospital Community Advisory Committee	3120
Royal Perth Bentley Group Lived Experience Advisory Group (mental health)	2220
Midland Mental Health Consumer Advisory Group	2880
Armadale Aboriginal Health Community Advisory Group	6900
Bentley Aboriginal Health Community Advisory Group	7220
Swan Hills / Midland Aboriginal Health Community Advisory Group	2295
Royal Perth Inner City Aboriginal Health Community Advisory Group	4530
Wungen Kartup Aboriginal Consumer and Carer Advisory Group (mental health)	2850
Aboriginal Health Advisory Council	1875
Royal Perth Hospital Animal Ethics Committee	28,740

Pricing policy

EMHS complies with the National Health Reform Agreement 2016 and the Department of Health Fees and Charges Manual regarding prices set for public hospital fees and charges.

As outlined in the National Health Reform Agreement 2016, an eligible person who receives services as a public patient in a public hospital or a publicly contracted bed in a private hospital is treated free of charge.

The Fees and Charges Manual sets out the rules and pricing in relation to fees and charges that EMHS may apply for health services, goods and other services. EMHS updates the fees they charge to patients on an annual basis to ensure they comply with the manual. As stated in the manual, EMHS is able to charge fees for the following patient categories:

- Privately insured patients: fees for private inpatients admitted to an EMHS hospital are charged as outlined in the Fees and Charges Manual. The same day and shared room fee is set according to the Commonwealth Minimum Benefit Table.
- Privately uninsured patients: fees for privately uninsured patients are set as above however the fees are charged directly to the patient.
- Ineligible overseas visitor: overseas visitors who are not Medicare-eligible or have a Reciprocal Health Care Agreement with Australia are charged fees as outlined in the Fees and Charges Manual. These fees are charged either directly to the patient or to their travel insurance.
- Overseas student: overseas students are required to have health insurance cover as part of their visa requirements to enter Australia. Fees are charged as outlined in the Fees and Charges Manual. Where students do not have appropriate insurance, they are treated as ineligible overseas visitors.
- Motor vehicle: there is a memorandum of understanding between the Department of Health and the Insurance Commission of WA (ICWA) which involves ICWA accepting upfront liability for medical expenses associated with legitimate motor vehicle accident (MVA) claims. Fees are charged directly to ICWA.
- Eastern States motor vehicle: in the event of a MVA involving only vehicles registered in other States, then the relevant interstate third party insurance authority is charged the applicable compensable patient rate.
- Australian Defence Force: patients who are members of the Australian Defence Force are classified as compensable and fees charged as outlined in the Fees and Charges Manual. Fees are charged directly to the Department of Defence as the liable insurer.
- Foreign Defence Force: patients who are members of a Foreign Defence Force are classified as compensable and fees charged as outlined in the Fees and Charges Manual. Invoices are issued in partnership with the Australian Defence Force.
- Department of Veterans' Affairs (DVA): hospital charges of eligible war service veterans are determined under a separate Commonwealth-State agreement with DVA. Under this agreement, EMHS does not charge medical treatment to eligible war service veterans. Instead, medical charges are fully recouped from DVA.
- Workers compensation: patients who are making a worker's compensation claim are classified as compensable and fees charged as outlined in the Fees and Charges Manual. Fees are charged directly to the patient's employer or related insurer.
- Shipping: patients who are a merchant seafarer are compensable and fees are charged directly to the shipping merchandiser.

Further information on the classification and charging of the patient categories listed above can be found in the Fees and Charges Manual 2017-18.

Capital works

EMHS has made a substantial investment in the improvement and development of its infrastructure during the 2017-18 financial year.

Table 4 - Capital works projects in 2017-18

Project title	Estimated total cost reported in 2016-17 ($000)	Estimated total cost in 2017-18 ($000)	Variance ($000)	Budget 2017-18 ($000)	Actual 2017-18 ($000)	Variance ($000)	Expected completion date	Estimated cost to complete ($000)
Armadale Health Service development	11,146	11,146	0	1,874	1,449	425	31/08/18	810
Kalamunda Hospital infrastructure upgrade	1,939	1,939	0	1,939	1,324	615	30/11/18	380
Royal Perth Hospital redevelopment stage one[2]	16,880	19,500	2,620	5,219	4,000	1,219	31/12/18	977
Royal Perth Hospital helipad	6,800	6,800	0	4,301	180	4,121	TBD	6,495
Royal Perth Hospital fire risk[1]	0	9,962	9,962	280	43	237	30/06/21	9,919
St John of God Midland Public Hospital[3]	348,603	360,200	11,597	619	279	340	TBD	340
Bentley Hospital development[1]	9,962	0	-9,962	0	0	0	N/A	N/A
Royal Perth Hospital Mental Health Observation Area[4]	0	11,785	11,785	200	0	200	30/06/20	11,785
Total	**395,330**	**421,332**	**26,002**	**14,432**	**7,275**	**7,157**		**30,706**

Notes:

1. The budget for the BH Development project was reallocated to the RPH Fire Risk project during 2017-18.
2. The variance represents budgeted expensed capital, which was omitted from the estimated total cost reported in 2016-17 but has now been correctly included in the estimated total cost of the project in 2017-18.
3. The variance represents budgeted expensed capital, which was omitted from the estimated total cost reported in 2016-17 but has now been correctly included in the estimated total cost of the project in 2017-18.
4. This project commenced in 2017-18. The variance represents recognition in the initial year of the full cost of the project.

Infrastructure

Many EMHS services are located within ageing facilities requiring significant maintenance and ongoing investment.

A $3.8 million program of construction and refurbishment works at AKG is currently reaching completion. At AH, construction works included the development of a new purpose-built neonatal nursery; a new staff lounge and central equipment store; and a staff room and medication room in the Medical Admissions Unit. Additional funded works include replacement of the hospital lifts which commenced in mid-2018, as well as the installation of an additional sixth lift.

Upgrades at KH included replacement of the roof; electrical upgrades, air conditioning upgrades, fire protection works and removal of hazardous substances. A second stage of development is planned to refurbish the hospital's main reception area with expected completion in late July 2018.

Within RPBG, $9.962 million of capital funds was reallocated from BH to RPH for upgrades to the fire protection system over a four year period. This is in addition to the previous $3.5 million spend on fire safety upgrades at the RPH campus over the past five years. Planning for a new helipad for RPH has also commenced, which will enable the hospital to accept larger helicopters once completed.

A Strategic Asset Management Plan (SAMP) is underway across the EMHS which is identifying building assets, plant, biomedical equipment, general equipment and departments that require consideration for a planned replacement/upgrade over the next ten years.

Government building training policy

The Works Procurement Policy stipulates that for all capital and maintenance works above $2 million (excluding GST), the Department of Finance, Building Management and Works (BMW) must be engaged to undertake the procurement of those works. In collaboration with a number of Group Training Organisations, the Apprentice Management Program (a business unit of BMW) manages the placement of apprentices with host employers undertaking government building and construction. BMW reports compliance with the Government building training policy in their annual report.

Unauthorised use of Western Australian Government purchasing cards

Western Australian Government purchasing cards can be issued by EMHS to employees where their functions warrant usage of this facility. These credit cards are not to be used for personal (unauthorised) purposes (i.e. a purpose that is not directly related to performing functions for the agency). All credit card purchases are reviewed by someone other than the cardholder to monitor compliance. If during a review it is determined that the credit card was used for unauthorised purchases, written notice must be given to the cardholder and the EMHS Board.

EMHS had two instances (total amount of $163) where a purchasing card was used for personal purposes in 2017-18. A review of these transactions confirmed they were both immaterial and the result of genuine and honest mistakes, and no further action was deemed necessary as prompt notification and full restitution was made by the individuals concerned.

Aggregate amount of personal use expenditure for the reporting period	$163
Aggregate amount of personal use expenditure settled by the due date (within five working days)	$163
Aggregate amount of personal use expenditure settled after the period (after five working days)	$0
Aggregate amount of personal use expenditure outstanding at balance date	$0

Expenditure on advertising

In 2017–18 in accordance with section 175Z of the *Electoral Act 1907* EMHS incurred a total advertising expenditure of $307,717.

Advertising (for recruitment and interest in consumer and community advisory participation) and market research (patient surveys) was procured and the amount paid to the following organisations:

Table 5 - Expenditure on advertising in 2017-18

Summary of advertising	Amount ($)
Advertising agencies	
Total	**0**
Market research organisations	
Press Ganey (patient survey)	294,559
Total	**294,559**
Polling organisations	
Total	**0**
Direct mail organisations	
Total	**0**
Media advertising organisations	
Adcorp Australia Limited	10,740
Australian and New Zealand College of Anaesthetists	1288
The Australasian College for Emergency Medicine	550
Australasian College of Health Service Management	500
Curtin University of Technology	80
Total	**13,158**
Total advertising expenditure	**307,717**

Industrial relations

The *HSA 2016* separated and clarified the industrial relations (IR) responsibilities of both the System Manager and the HSPs from 1 July 2016. As a HSP, EMHS is accountable for all IR matters within the statutory authority. The EMHS IR team provides support to EMHS including:

- advisory service for IR matters and disputes
- provision of specialist advice for disciplinary matters to human resources and line management
- advice on the application and interpretation of industrial agreements
- representation before industrial tribunals on issues relating to EMHS.

The System Manager is responsible for system-wide industrial relations matters including, but not limited to, negotiating and maintaining industrial agreements and classifying and determining the remuneration of health executive positions in the Health Executive Service. It provides central coordination and oversight of the interpretation and implementation of industrial instrument provisions and industrial disputes that have system wide implications.

Declarations of interest from senior officers

Senior officers of government agencies are required to declare any interest in an existing or proposed contract that has, or could result in, the member receiving financial benefits and/or present an actual, potential or perceived conflict of interest.

In 2017–18, members of the EMHS Board and Executive submitted annual declarations and were asked to declare potential conflicts of interest (in relation to agenda items) at every meeting. No board members held interests in an existing or proposed contract that has, or could result in, the member receiving financial benefits.

Staff development

The provision of ongoing staff development is an essential contributing factor to quality service delivery, employee engagement, performance and retention within EMHS.

EMHS has a dedicated team of education staff who provide training and support in evidence based practice, organisational learning and development, clinical audit and service improvement. With a strong focus on teamwork, communication and inter-professional awareness, EMHS staff from across all disciplines are provided with a range of development opportunities including:

- participation in information and education sessions, skills training, formal and informal upskilling programs
- clinical scenario training and innovative unit based specialty simulations aimed at developing technical and non-technical skills.

In addition, a range of team development training opportunities are provided to support service staff.

Workers' compensation

The Western Australian Workers' Compensation system was established by the State Government and exists under that statute of the *Workers' Compensation and Industry Management Act 1981.*

EMHS is committed to providing staff with a safe and healthy work environment in order to deliver effective and efficient healthcare services. In 2017-18, a total of 294 workers' compensation claims were made.

Table 6 - Total workers' compensation claims for the 2017-18 financial year

Category	2016-17 claims	2017-18 claims
Administration and clerical	35	31
Hotel services	80	92
Medical salaried	12	13
Medical support	26	25
Nursing	113	96
Site services	27	37
Other categories	0	0
Total	**299**	**294**

Ensuring EMHS staff and services are prepared and well-equipped to manage in the event of an emergency situation is of the utmost importance. In May 2018, our services participated in a multi-agency disaster preparedness exercise which assessed the health system's capacity to manage casualties in response to a major disaster situation.

As part of the exercise, three simulated coordinated terrorist attacks were staged across the Perth metropolitan area, producing more than 600 casualties. Both RPH and AH sent response teams to the "incident site", in addition to assembling hospital-based emergency operations teams to manage the flow of patients throughout the hospital.

This exercise was conducted successfully and was a valuable training opportunity for all involved, complementing our ongoing focus on emergency preparedness and management.

1347 staff are under 29 years of age

1907 staff are between 30-39 years of age

1789 staff are between 40-49 years of age

1760 staff are between 50-59 years of age

1036 staff are between 60-69 years of age

96 staff are over 70 years of age

Staff profile

Government agencies are required to report a summary of the number of employees for the financial year. As of 30 June 2018, EMHS employed a total of 7935 staff (individual staff head count), or 6005 full time equivalent (FTE).

Table 7 - Full-time equivalent (FTE) employees for 2017-18 financial year by category

Category	Definition	2016-17 FTE	2017-18 FTE
Administration	Includes all clerical-based occupations together with patient-facing (ward) clerical support staff.	904	956
Hotel services	Includes: • Catering • Cleaning • Stores/supply • Laundry • Transport occupations.	806	809
Medical	Includes all salary-based medical occupations including: • Interns • Registrars • Specialist medical practitioners • Specialist medical practitioners engaged on a sessional basis.	845	874
Medical support	Includes all allied health and scientific / technical related occupations.	789	838
Nursing	Includes all nursing occupations and agency nursing.	2269	2360
Maintenance	Includes: • Engineering • Grounds and garden • Security • Maintenance (infrastructure).	138	142
Other categories	Includes Aboriginal and ethnic health worker related occupations.	25	26
Total		**5776**	**6005**

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

Average age of our staff is 44 years

Disability access and inclusion plan outcomes

EMHS is committed to ensuring that people with disabilities, their families and carers are provided with the same opportunity, rights and responsibilities as other people in the community.

EMHS has a Disability Access and Inclusion Plan (DAIP) in accordance with the statutory responsibilities of the *Disability Services Act Regulations 2004* and other related legislation such as the *Equal Opportunity Act of 1984*, which is based on seven desired disability outcomes. This plan acknowledges the DoH's 2016-20 DAIP and the requirement for all staff to actively work towards progressing better access and inclusion in their workplaces.

EMHS works to ensure that no individual is discriminated against and will take into account their diverse needs. Examples of EMHS achievements in 2017-18 are listed below.

Access to services and events

EMHS held its first Public Board Meeting on 11 June 2018 which presented a unique opportunity for members of the public to find out first-hand how our healthcare services are planned and delivered. Planning and promotion of the event included consideration of the requirements of disability access, and key information about venue accessibility was included in promotional materials about the event to inform the public.

Access to buildings and facilities

During 2017-18, a range of modifications were made to existing facilities to provide better access for people with disabilities.

BH improved wheelchair access in its outpatients area through modification of existing desk height, while a new concierge service was also launched in the area to provide assistance to patients.

Accessibility to the BH outdoor areas on Wards 4, 5, 7 and 8 have also been upgraded, with outdoor gym equipment also having been installed in F block to help improve daily living activities for patients. Extensive updates to signage is also occurring across the hospital, and a new dedicated patient drop-off zone has been implemented at the hospital's main entrance, and the Ward 10 entrance.

RPH made modifications to its Victoria Square entrance reception area to improve visibility for consumers, and has refurbished the disabled toilet and installed an automatic door in the Level 3 high traffic area. Wider access doors within the RPH ED have been installed to enable safer access by ambulance trolleys, and a concierge service has commenced within the ED to assist patients. A review of existing requirements and availability of ACROD parking bays, particularly in the outpatient areas has also commenced. When revised, information about the availability of these parking bays will be made available to consumers and staff.

Access to KH's pathology service has also been modified to meet disability access requirements.

Access to information

All communication materials produced by EMHS meet accessibility guidelines and can be made available in alternative formats as required. Staff are provided with guidance, templates and style guides when producing consumer information to ensure that people with a disability are able to access information in an appropriate format. Consumer representatives are also consulted to ensure content is appropriate and easily understood. Surgical and Procedure Specific Information Sheets are also readily available for staff to download and provide to patients via the staff intranet.

Quality of service by staff

All EMHS staff are provided with information and training on the DAIP at staff orientation. This is supplemented by senior staff working across the organisation to increase staff awareness of disability and access issues and the importance of reporting areas of issue across the organisation. The DAIP and supporting information is made available to all staff via the intranet and through regular internal communications.

Opportunity to provide feedback

Staff and consumers have access to a range of ways to provide feedback to the organisation. Staff are made aware of the need to identify alternate communication mediums as required to enable people with a disability to provide feedback on our services.

Feedback shared through Patient Opinion is greatly valued and responded to in a timely matter. This feedback is tabled at all DAIP site meetings to share learnings and improvements.

Participation in public consultation

Opportunities for public consultation are advertised externally giving consideration to the requirements of people with a disability. The health service also seeks to ensure that venues used for public participation and consultation events are accessible and that information provided during consultation processes is made available in alternative formats as required.

A survey of outpatients/carers needs is currently being conducted to better assist attendees at RPH outpatient services.

AKG celebrated International Day of People with Disability on 4 December 2017, undertaking interactive public sessions.

Opportunities to obtain and maintain employment

EMHS is committed to assisting people with disability to obtain and maintain employment with the health service. This is supported through a number of initiatives as detailed below:

- The requirement to adhere to the *Equal Opportunity Act of 1984* is a standard duty in all EMHS positions. This is formalised in the EMHS job description form (JDF) template. Additionally, managers are required to identify their knowledge in relation to this legislation when addressing essential selection criteria within the recruitment process.
- The accessibility of the EMHS JDF is taken into consideration including formatting and the use of plain English and inclusive and non-discriminatory language.

Aboriginal Health Liaison Officer Tarnee and patient Patricia at RPH

- All recruitment processes include a statement to encourage applications from people with disabilities. Where positions are advertised on the WA Government jobs board, the WA Health diversity statement highlights our commitment to eliminating discrimination in the provision of our service and encourages applications from a number of diversity groups including people with disabilities.
- Where an employee discloses that they have a disability, EMHS Workforce Services are available to provide advice in relation to application of reasonable adjustments/modifications to the assessment process.
- During induction, education on employee responsibilities in relation to equal opportunity as well as information to improve awareness of the objectives of the WA Health Equity and Diversity Strategy 2015–2020 is provided.

Compliance with public sector standards and ethical codes

The following policies and guidelines cover EMHS and are consistent with the public sector standards and available to all employees on the EMHS and/or WA Health intranet sites.

- WA Health Employee Grievance Resolution Policy
- EMHS Employee Grievance Resolution Guidelines
- WA Health Recruitment Selection and Appointment Policy and Procedure
- WA Health Discipline Policy, explanatory notes and template letters
- EMHS Performance Development Policy and generic template
- EMHS Employee Separation Policy
- EMHS Expression of Interest Guidelines and template.

Information relating to the Public Sector Standards and a breach of standard claim process is available via:

- notification of a breach claim process and period as a part of the appointment process
- provision of information about grievance policy and reference to public sector standards in standard letter templates for formal grievance resolution processes
- notification of grievance resolution standard breach claim rights and period in formal grievance resolution outcome letters
- HSS Termination/Cessation Forms and checklists
- EMHS Employee Support Officer Network – trained employees available to provide information about processes/resources to employees with workplace concerns/queries.

During 2017-18, EMHS recruited, trained and appointed ten new Employee Support Officers to its network.

Human resources (HR) staff are also available to provide information and support to managers in relation to the implementation and compliance of the public sector standards.

Training is provided in relation to recruitment, selection and appointment and a HR Essentials course is available which includes information about procedural fairness and specific information about performance development and managing grievances and disciplinary matters.

The WA Health Code of Conduct has been developed to comply with the principles of appropriate behaviour outlined in the WA Public Sector Commission's Code of Ethics. All EMHS employees are responsible for ensuring that their behaviour reflects the standards of conduct embodied in the WA Health Code of Conduct. To assist staff to understand and comply with the principles of workplace behaviour and conduct, EMHS informs and educates employees through various communications including a requirement for new employees to acknowledge the code of conduct, site based induction programs, prevention of bullying training and the mandatory Accountable and Ethical Decision making training program.

Compliance with the public sector standards in HR management are monitored via review of breach claims. This includes claims for breaches lodged regarding recruitment, selection, appointment processes and management of an employee's performance.

During 2017-18, eight breach of standard claims were lodged against the employment standards. Of the claims, one was resolved internally and was withdrawn, and seven were referred to the Public Sector Commission (PSC) (four were dismissed, one was conciliated, PSC declined to deal with one claim, and one is ongoing). There were no claims against the grievance resolution, performance management, termination or redeployment standards.

Employee compliance with the WA Health Code of Conduct is monitored via reports of potential breaches of discipline. EMHS is required to review and investigate all complaints alleging non-compliance with the Code of Ethics or Code of Conduct. During 2017-18, EMHS had 149 reported cases of potential breaches of discipline (some of which involved misconduct). Of the claims that were closed during the financial year, 49 were substantiated.

Substantive equality

EMHS is committed to achieving substantive equality by eliminating systemic forms of discrimination in the provision of services and promoting awareness of the different needs of our client groups. EMHS seeks to ensure the WA Health Substantive Equality Policy Framework is reflected in all operational and strategic planning and policy development. A key focus for EMHS is to contribute towards substantive equality for the Aboriginal population which it serves by:

- Developing an Aboriginal Health Strategy for EMHS with input from the Aboriginal community and staff.
- Establishing strategic partnerships with Aboriginal people through the creation of four Aboriginal Health Community Advisory Groups and an Aboriginal Health Advisory Council. Nine working groups have been established to focus on key priorities identified by the Aboriginal community relating to the health journey, culture and workforce.
- Using the Aboriginal Impact Statement and Declaration process which aims to ensure that the needs, interests and circumstances of Aboriginal clients and employees are incorporated into the development of new and revised policies, programs, strategies and practices.
- Delivering community and population health programs specifically for Aboriginal people across the metropolitan region by appropriately trained Aboriginal staff, with the aim of education, prevention and management of chronic disease and illnesses.
- Engaging with Aboriginal patients and families to improve access and pathways for Aboriginal people in hospital through Aboriginal Health Liaison Officers located throughout EMHS sites.
- Delivering mandatory Aboriginal Cultural e-learning training for all EMHS staff, supported by the development of cultural learning plans to guide staff to develop their cultural competencies. Face to face Aboriginal cultural training is also available.
- Implementing cultural respect strategies which include engagement in activities and events of cultural significance in the Aboriginal community calendar and cultural protocols that respect and acknowledge Aboriginal ways of communicating and engaging in all aspects of health service delivery. This includes formal practice of Welcome to Country and Acknowledgement of Traditional Owners, flag raising ceremonies and smoking ceremonies.
- Engaging with the Aboriginal workforce in EMHS by establishing an Aboriginal Workforce Engagement Group. The aim of the group is to engage with Aboriginal staff, share information and seek their feedback to support development of strategies and initiatives that support attraction, retention and recruitment of Aboriginal people. This will ultimately contribute to culturally appropriate service delivery.
- Developing targeted employment strategies for Aboriginal people who are currently under-represented in the health workforce, including implementation of the s.51 Pilot Program and engaging three Aboriginal trainees.

EMHS is also committed to contributing to substantive equality for consumers with complex mental health issues and their carers and family. The inaugural 2017-18 RPBG Service 3 Mental Health Lived Experience Engagement and Participation (LEEP) Strategy was recently launched, which documents a strategy for embedding and supporting lived experience engagement and participation within the service. This will be achieved through the development of effective and meaningful partnerships with consumers, carers and families, in a culture with practices which truly accept, value and support lived experience participation in service planning, delivery and evaluation. By virtue of their lived experience, consumers, carers and family bring with them unique expertise, informed by their experiences of navigating the mental health system and the challenges of living with mental health issues.

Gningla, graduate nurse at AH

24 Lived Experience Representatives have been recruited and are supported to contribute to service improvement either individually, by representation on working groups/committees, co-facilitating staff training, resource review and staff recruitment or via participation in one of the three supported consumer advisory groups (Midland Consumer Advisory Group, RPBG Lived Experience Advisory Group and Wungen Kartup's Aboriginal Consumer and Carer Advisory Group).

A Peer Support Program to be delivered by employed Peer Support Workers with mental health issues and recovery is being developed across RPBG. A Peer Support Worker position is in place at the Midland Adult Community Mental Health Service with recruitment being finalised for an additional Peer Support Worker at the EMyU. The establishment and integration of a peer support service within the RPBG Mental Health Services is integral to achieving its vision and mission and in so doing, become a truly consumer-centred recovery-focused mental health service.

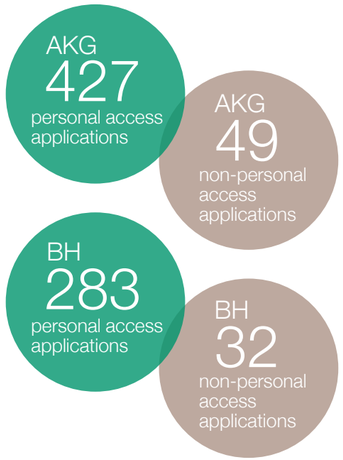
Freedom of information

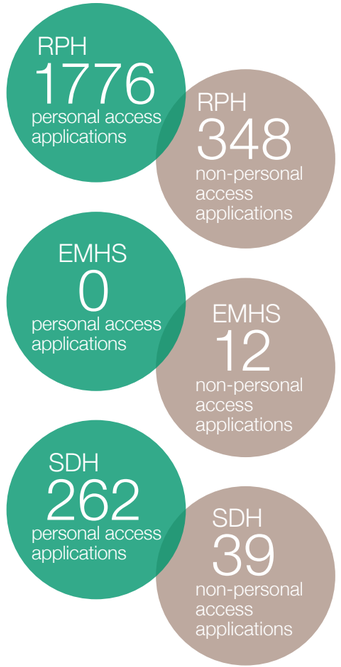
The *WA Freedom of Information Act 1992* gives all Western Australians a right of access to information held by EMHS.

Access to information can be made through a Freedom of Information (FOI) application which should be addressed to the FOI Office at the appropriate EMHS site. FOI applications can be granted full access, partial access or access may be refused in accordance with the *WA Freedom of Information Act 1992.*

Note: please see page 222 for site contact details.

In the 2017-18 financial year, EMHS received 3228 new applications under FOI legislation. This included:





For additional information about FOI, including application forms and information brochures please see:

Armadale Kalamunda Group. Also contact for FOI applications for Swan District Hospital (SDH), which closed in November 2015.
www.ahs.health.wa.gov.au/For-patients-and visitors/Freedom-of-Information.

Royal Perth Hospital
www.rph.health.wa.gov.au/For-patients-and-visitors/FOI.

Bentley Hospital
www.bhs.health.wa.gov.au/For-patients-and-visitors/Access-to-health-records.

East Metropolitan Health Service
www.eastmetropolitan.health.wa.gov.au.

Office of the Information Commissioner of Western Australia
www.foi.wa.gov.au/ThePublic.

Recordkeeping plans

The EMHS Recordkeeping Plan was developed to progress compliance against the *State Records Act 2000* and was approved by the State Records Commission (SRC) in April 2017. As part of this approval, the SRC acknowledged EMHS' commitment to improve recordkeeping practices within the timeframes contained in the plan.

The EMHS Recordkeeping Plan provides an accurate reflection of the current recordkeeping systems/programs within the organisation, including information regarding the organisations recordkeeping system(s), disposal arrangements, policies, practices and processes.

A Corporate Recordkeeping Working Group was formed to lead corporate recordkeeping across EMHS. The Working Group undertook a review and subsequently updated existing guidelines and a corporate recordkeeping policy. A health service wide survey was conducted to assess current corporate recordkeeping practices as well as the recordkeeping environment within EMHS, with a plan to implement an electronic document records management system over the next three to five years.

All EMHS staff are required to complete recordkeeping awareness training. With the implementation of an electronic recordkeeping system, further training will be conducted through online modules and education sessions.

Resources, advice and guidance regarding corporate recordkeeping is made available to all staff through the intranet, staff newsletters and training sessions.

Occupational safety, health and injury management

EMHS is committed to ensuring the safety, health and welfare of its staff, volunteers, students, contractors, patients and visitors through the following principles:

- compliance with all relevant Occupational Safety and Health (OSH) legislation, regulations and EMHS OSH policies, procedures and safe work practices
- enhancing the effectiveness of the OSH management system by consulting with employees, elected safety and health representatives and contractors on issues of health and safety
- improving our OSH performance by establishing measurable objectives and targets through OSH planning activities
- undertaking OSH risk management activities and reporting to adequately control risks to people in the work environment
- providing adequate facilities to protect the health, safety and welfare of all employees
- adequately communicating with all staff to enable safe work practices that minimise the risk to health
- promoting, training and supporting safety and health representatives to be a key safety resource and provide sufficient time to undertake their legislative responsibilities and duties.

The EMHS Executive OSH Steering Group is responsible for the ongoing monitoring and review of OSH management requirements and Area Strategic Occupational Health and Safety Plan initiatives and action plans. Future OSH strategy will include the outcomes and recommendations of the OSH service review, which is due to be finalised in mid-2018.

Employee consultation

Consultation with employees is undertaken by site OSH committee members at departmental meetings through standing agenda items. All EMHS sites have Workplace Safety and Health Committees. These relate to work areas where the size of the health service requires its own organisational structure.

Workplace Safety and Health Committees are responsible for:

- facilitating consultation and cooperation between the employer and employees in initiating, developing and implementing measures designed to ensure the safety and health of employees in the workplace
- ensuring its members are kept informed about current safety and health standards in comparable workplaces
- reviewing and providing recommendations to the employer about workplace rules and procedures in relation to the safety and health of its employees
- providing recommendations to the employer and employees about the establishment, maintenance and monitoring of programs, measures and procedures in the workplace that are related to the safety and health of the employees
- retaining any records and statistics supplied by the employer regarding the hazards to persons that arise or may arise at the workplace
- considering and making recommendations to the employer about any changes or intended changes in the workplace that could possibly affect the safety or health of employees at the workplace
- considering any matters referred to the Committee by an elected or otherwise recognised OSH representative
- performing any other functions that may be prescribed in the Regulations or given to the Committee, with its consent, by the employer.

Workplace Safety and Health Committees are evaluated at least bi-annually to ensure they meet their functional requirement and objectives. Each site has an active base of safety representatives, culminating to approximately 200 staff across all EMHS sites. All representatives are trained and provide timely advice for staff on OSH requirements and issues in the work environment.

Compliance with injury management

EMHS has a documented Injury Management System (IMS) that functions in accordance with the *Workers' Compensation and Injury Management Act 1981.*

The IMS provides for an early intervention approach to assist injured workers to return to work. The IMS also details how to conduct effective and efficient communication, clarification of policy and management practices and how to construct injury management programs, set goals and objectives for injured workers and how to establish, document, monitor and review those programs. There is a strong emphasis on regular consultation between the injured employee and employer.

EMHS has established a systematic approach to workplace-based injury management services for all employees following work-related injury, illness or disability, fostering an environment where it is normal practice for such employers to return to productive employment as soon as medically appropriate. Injured employees are allocated a site-based Injury Management Consultant (IMC) for support and guidance during recovery and return to work.

Best practice injury management strategies implemented across EMHS include:

- provision of return to work programs without delay to assist with recovery and consideration of alternative work areas where appropriate
- provision of exercise and treatment programs while on workers' compensation to facilitate recovery and return to work
- provision of counselling through the Employee Assistance Program or RiskCover-appointed counselling service
- injury management referrals to specialist doctors to facilitate diagnosis and treatment.

IMCs monitor and review external vocational rehabilitation providers ensuring they are in line with medical evidence and best practice.

RiskCover reporting, oversight and reporting of EMHS claims to Workcover WA ensures compliance of the return to work programs and injury management programs at EMHS. The organisation has been evaluated by RiskCover as fully compliant under the WA Workers Compensation and Injury Management Code of Practice.

Employee rehabilitation

EMHS has established a systematic approach to workplace-based injury management services for all employees following work-related injury, illness or disability. This includes:

- active IMS and injury management policies and guidelines
- fitness for work policy and program including occupational physician assessments
- Employee Assistance Program
- exercise, fitness and wellness programs whilst on workers' compensation
- graduated return to work plans in place for all workers with medical restrictions
- detailed claim pack containing information on claim process and injury management
- manager education regarding injury management and an easy to follow guide
- site-based IMCs to provide support and guidance throughout the claim process, ensuring that the IMCs remain in constant contact.

Assessment of the occupational safety and health management system and performance indicators

OSH management system audits have been completed at AHS and KH (2013), BH (2014) and RPH (2016) against AS/NZS 4801:2001 and the WorkSafe Plan as an assessment tool. AHS and BH action plans have been completed and the RPH action plan is currently monitored through OSH management committees. Action plans are available on request. The audits are undertaken in a five year cycle, with AKG due in 2018, BH in 2019 and RPH in 2021.

A chemical substances and compliance audit is undertaken every three years in order to maintain an up-to-date database of all chemicals and dangerous goods used in the organisation by site. This audit was last completed in October 2017. Action plans are monitored through each of the hospital's workplace health and safety committees.

EMHS monitors and manages any WorkSafe improvement notices through the site OSH Committees and centrally to ensure they are completed by the due date set by WorkSafe. Any WorkSafe notices received by any EMHS site are also reviewed by all other EMHS sites to ensure compliance.

Performance reported for EMHS for occupational safety, health and injury indicators for 2017-18 is summarised in figures 31-36 on page 206.

In liaison with SMHS, EMHS Work Health and Safety Strategic Unit continues to develop the Combined Hazard or Incident Reporting (CHoIR) system and produce reports for the sites to drive improved performance and visibility of trends.

EMHS work health and safety performance against Public Sector Commission Code of Practice: Occupational Safety and Health in the Western Australian Public Sector

Figure 31: fatalities

Figure 32: Lost Time Injury/ Diseases (LTI/D) incident rate (per 100)

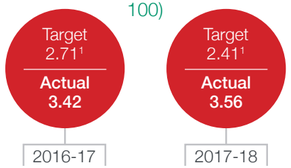


Figure 33: Lost Time Injury severity rate (percentage of LTI/D)

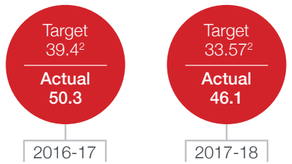


Figure 34: percentage of injured workers returned to work within 13 weeks

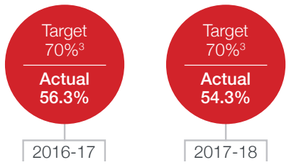


Figure 35: percentage of injured workers returned to work within 26 weeks

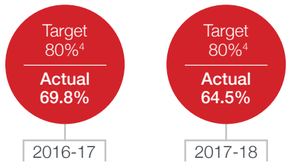
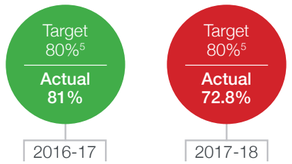


Figure 36: percentage of managers[6] trained in OSH and IM responsibilities



Please note: EMHS did not exist as an entity in 2015-16, therefore it has not been possible to provide performance base data for all indicators.

Notes:

[1]The Lost Time Injury and Disease (LTI/D) incidence rate is the number of lost time injury and disease claims lodged where one day or shift or more was lost from work. The number of employees is the agency's full-time equivalent (FTE) figure. The number of LTI/D is divided by the number of employees, then multiplied by 100. Incidence rate target is 10 per cent improvement on base year (1/7/15 - 30/6/16) performance.

[2]Severity rate is a measure of incident or accident prevention and effectiveness of injury management. The severity rate is to be reported as the number of severe LTI/D (actual or estimated 60 days or more lost from work) divided by the number of LTI/D claims multiplied by 100. Severity rate target is 10 per cent improvement on previous three years (1/7/13 - 30/6/14).

[3]The success and effectiveness of the agency's injury management practices in facilitating a sustainable return to work outcome for injured workers is measured using the percentage of injured workers (lost time claims) that returned to work within 13 weeks and 26 weeks. The calculation is [total LTI/Ds with a return to work outcome within 13 or 26 weeks divided by total LTI/Ds] multiplied by 100. The returned to work within 13 weeks measure is calculated based on: a) the number of injured workers with a LTI/D claim, where lost time commenced during the 12 month specified period; and b) the number of workers reported in (a) who returned to work to full hours and full duties (of a real job) on or before 13 weeks. This is an aspirational target determined internally as no formal target is stipulated.

[4]The returned to work within 26 weeks measure is calculated based on: a) the number of injured workers with a LTI/D claim, where lost time commenced during the 12 month specified period; and b) the number of workers reported in (a) who returned to work to full hours and full duties (of a real job) on or before 26 weeks.

[5]The occupational safety and health (OSH) and injury management (IM) training provided for management and supervisory staff is to be reported as the percentage of current manager who have received training in their responsibilities for OSH and IM. Managers include anyone who supervises staff. The frequency of refresher training should be at least every three years or sooner if the risk profile of the agency or work areas changes significantly, or when there are legislative changes.

[6]The denominator for the calculation of the percentage of managers trained was changed in December 2017 from Tiers 1-4 managers being required to complete the OSH and IM for Supervisors and Managers Training (126 staff members), to include all staff who supervise others in the workplace (1478 staff members).

Annual estimates for 2018-19

EMHS annual operational budget estimates for the following financial year are reported to the Minister for Health under Section 40 of the *Financial Management Act 2006* and Treasurer's Instruction 953.

The annual estimates for 2018–19, as approved by the Minister for Health, are:

Table 8 - Statement of comprehensive income

Statement of comprehensive income	2018-19 estimate ($000)
COST OF SERVICES	
Expenses	
Employee benefits expense	823,627
Fees for visiting medical practitioners	26,517
Contracts for services	284,878
Patient support costs	217,088
Finance costs	43
Depreciation and amortisation expense	46,488
Repairs, maintenance and consumable equipment	26,066
Other supplies and service	4,765
Other expenses	94,954
Total cost of services	**1,524,426**

Table 8 continued - Statement of comprehensive income

Statement of comprehensive income	2018-19 estimate ($000)
INCOME	
Revenue	
Patient charges	73,018
Other fees for services	63,495
Commonwealth grants and contributions	425,329
Other grants and contributions	178,550
Donation revenue	546
Other revenue	7,817
Total revenue	**748,755**
Total income other than income from State Government	**748,755**
NET COST OF SERVICES	**775,671**
Income from State Government	
Service appropriation	720,589
Services received free of charge	54,811
Total income from State Government	**775,400**
DEFICIT FOR THE PERIOD	**(271)**
OTHER COMPREHENSIVE PROFIT/(LOSS)	
Items not reclassified subsequently to profit or loss	
Changes in asset revaluation reserve	-
TOTAL COMPREHENSIVE LOSS FOR THE PERIOD	**(271)**

Note: the above figures are based on the approved Service Agreement with the Department of Health and the Mental Health Commission as at 30 June 2018.

Table 9 - Statement of financial position

Statement of financial position	2018-19 estimate ($000)
ASSETS	
Current assets	
Cash and cash equivalents	104,717
Restricted cash and cash equivalents	27,584
Receivables	31,830
Inventories	5,091
Other current assets	874
Total current assets	**170,096**
Non-current assets	
Restricted cash and cash equivalents	10,168
Amounts receivable for services	481,821
Property, plant and equipment	890,769
Intangible assets	2,027
Other non-current assets	150
Total non-current assets	**1,384,935**
Total assets	**1,555,031**

Table 9 continued - Statement of financial position

Statement of financial position	2018-19 estimate ($000)
LIABILITIES	
Current liabilities	
Payables	73,994
Borrowings	22
Provisions	163,176
Other current liabilities	188
Total current assets	**237,380**
Non-current liabilities	
Borrowings	839
Provisions	26,913
Total non-current liabilities	**27,752**
Total liabilities	**265,132**
NET ASSETS	**1,289,899**
EQUITY	
Contributed equity	1,143,830
Reserves	87,859
Accumulated surplus	58,210
TOTAL EQUITY	**1,289,899**

Note: the above figures are based on the approved Service Agreement with the Department of Health and the Mental Health Commission as at 30 June 2018.

Table 10 - Statement of cash flows

Statement of cash flows	2018-19 estimate ($000)
CASH FLOWS FROM STATE GOVERNMENT	
Service appropriations	674,058
Capital appropriations	22,587
Net cash provided by State Government	**696,645**
***Utilised* as follows:**	
CASH FLOWS FROM OPERATING ACTIVITIES	
Payments	
Employee benefits	(823,627)
Supplies and services	(595,861)
Receipts	
Receipts from customers	69,423
Commonwealth grants and contributions	425,329
Other grants and contributions	178,550
Donations	546
Other receipts	71,311
Net cash used in operating activities	**(674,329)**

Table 10 continued - Statement of cash flows

Statement of cash flows	2018-19 estimate ($000)
CASH FLOWS FROM INVESTING ACTIVITIES	
Payments	
Payment for purchase of non-current assets	(22,587)
Net cash used in investing activities	**(22,587)**
CASH FLOWS FROM FINANCING ACTIVITIES	**-**
Net decrease in cash and cash equivalents	**(271)**
Cash and cash equivalent at the beginning of the period	**108,797**
Restricted cash at the beginning of period	**33,943**
CASH AND CASH EQUIVALENTS AT THE END OF THE PERIOD	**142,469**

Note: the above figures are based on the approved Service Agreement with the Department of Health and the Mental Health Commission as at 30 June 2018.

Table 11 - Statement of changes in equity

Statement of changes in equity	2018-19 estimate ($000)
CONTRIBUTED EQUITY	
Balance at start of period	1,120,446
Transactions with owners in their capacity as owners:	
Contributions by owners	22,587
Other contributions by owners	797
Balance at end of period	**1,143,830**
RESERVES	
Asset revaluation reserve	
Balance at start of period	87,859
Other comprehensive income for the period	-
Balance at end of period	**87,859**
ACCUMULATED SURPLUS	
Balance at start of period	58,481
Deficit for the period	(271)
Balance at end of period	**58,210**
TOTAL EQUITY	
Balance at start of period	1,266,786
Total comprehensive loss for the year	(271)
Transactions with owners in their capacity as owners	23,384
Balance at end of period	**1,289,899**

Note: the above figures are based on the approved Service Agreement with the Department of Health and the Mental Health Commission as at 30 June 2018.

East Metropolitan Health Service

Appendix

Acronyms index

Acronym	In full
ABF	Activity based funding
ABS	Australian Bureau of Statistics
ACHS	Australian Council of Healthcare Standards
ACHSM	Australasian College of Health Service Management
AEG	Area Executive Group
AH	Armadale Hospital
AHPRA	Australian Health Practitioners Regulatory Agency
AHS	Armadale Health Service
AIHW	Australian Institute of Health and Welfare
AKG	Armadale Kalamunda Group
AM	Member of the Order of Australia
AMA	Australian Medical Association
AMI	Acute myocardial infarction
Apgar	Appearance, pulse, grimace, activity and respiration
BH	Bentley Hospital
BMW	Department of Finance, Building Management and Works
CAC	Consumer advisory council
CAG	Consumer advisory group
CALD	Culturally and linguistically diverse
CCTV	Closed-circuit television
CHEs	Contracted health entities
CHoIR	Combined Hazard or Incident Reporting
CWP	Capital works projects
DAIP	Disability access and inclusion plan
DAMA	Discharged against medical advice
DDI	Data and Digital Innovation
DNA	Did not arrive/attend
DoH	Department of Health
DVA	Department of Veterans Affairs
ED	Emergency Department
EMHS	East Metropolitan Health Service
EMR	Electronic Medical Record
EMyU	East Metropolitan Youth Unit
ENT	Ear, nose and throat
ESWLDC	Elective services wait list data collection
FACS	Food access and cost survey
FNoF	Fractured neck of femur
FOI	Freedom of Information
FTE	Full time equivalent
GBS	Government budget statements
GP	General practitioner
HACCP	Hazard analysis at critical control points
HA-SABSI	Healthcare-associated staphylococcus aureus bloodstream infections
HR	Human Resources
HSA 2016	Health Services Act 2016 WA
HSAP	Health service allocation price
HSP	Health service provider
HSS	Health Support Services
HTMU	Health Technology Management Unit
ICU	Intensive Care Unit
ICWA	Insurance Commission of WA
IMC	Injury management consultant
IMS	Injury management system
IR	Industrial Relations
ISD	Impact statement and declaration
JDF	Job description form
JLWD	Journey of living with diabetes
KH	Kalamunda Hospital
KPI	Key performance indicator
LEEP	Lived experience engagement and participation
LIFE	Living improvements for everyone
LTI/D	Lost time injury/disease
MET	Medical emergency team
MHOA	Mental Health Observation Area
MHU	Mental Health Unit
MLA	Member of the Legislative Assembly
MRF	Medical Research Foundation
NDIS	National Disability Insurance Scheme
NSQHS	National Safety and Quality Health Service
NSW	New South Wales
OBM	Outcome based management
OSH	Occupational safety and health
PARTY	Prevent Alcohol and Risk-related Trauma in Youth
PSC	Public Sector Commission
PSM	Public Service Medal
RGS	Research Governance System
RPBG	Royal Perth Bentley Group
RPH	Royal Perth Hospital
RPH HT	Royal Perth Hospital Homeless Team
RRCD	Rapid response to clinical deterioration
SAC	Severity assessment code
SCGH	Sir Charles Gairdner Hospital
SDH	Swan District Hospital
SJGHC	St John of God Health Care
SJGML	St John of God Mount Lawley
SJGMPH	St John of God Midland Public Hospital
SMHS	South Metropolitan Health Service
SQCE	Safety, Quality and Consumer Engagement
SRC	State Records Commission
STMU	State Major Trauma Unit
UCC	Urgent Care Clinic
UK	United Kingdom
UWA	University of Western Australia
WA	Western Australia
WACHI	WA Centre for Healthcare Innovation
WACHS	WA Country Health Service
WAPHA	Western Australian Primary Health Alliance
WAU	Weighted Activity Unit
WEAT	WA Emergency Access Target

Board and committee remuneration

Please see the following remuneration for EMHS boards and committees for the 2017-18 financial year:

East Metropolitan Health Service Board

Position	Name	Type of remuneration	Period of membership (within the financial year)	Gross/actual remuneration for 2017-18 financial year $
Board Chair	Ian Smith PSM	Annual	12 months	67,489
Board member	Suzanne May	Annual	12 months	39,647
Board member	Geraldine Ennis PSM	n/a	12 months	0
Board member	Kingsley Faulkner AM	Annual	12 months	39,647
Board member	Peter Forbes	Annual	12 months	39,647
Board member	Denise Glennon	Annual	12 months	37,360
Board member	Richard Guit	Annual	12 months	39,647
Board member	Ross Keesing	Annual	12 months	39,647
Board member	Stephanie Trust	Annual	7 months	22,874
Board member	Debra Zanella	Annual	12 months	39,647
			Total	**$365,607**

Consumer advisory committees (general)

Armadale Kalamunda Group Consumer Advisory Council

(formerly Armadale Health Service Community Advisory Council)

Position	Name	Type of remuneration	Period of membership (within the financial year)	Gross/actual remuneration for 2017-18 financial year $
Chair	Dorothy Harrison	Per meeting	12 months	300
Council member	Julie Hoey	Per meeting	12 months	270
Council member	Sheryl Little	Per meeting	12 months	270
Council member	Sarah Ladwig	Per meeting	12 months	30
Council member	Eric Wynne	Per meeting	12 months	0
			Total	**$870**

Bentley Hospital Community Advisory Committee

(formerly Bentley Health Service Community Advisory Council)

Position	Name	Type of remuneration	Period of membership (within the financial year)	Gross/actual remuneration for 2017-18 financial year $
Chair	Marie-Louise Matthews	Per meeting	12 months	660
Deputy chair	Alma Digweed	Per meeting	12 months	540
Committee member	Colin Stevenson	Per meeting	12 months	660
Committee member	Linda Beresford	Per meeting	12 months	660
Committee member	Phillip Lim	Per meeting	12 months	120
Committee member	Felicity Graham	Per meeting	8 months	120
			Total	**$2760**

Royal Perth Hospital Community Advisory Committee

Position	Name	Type of remuneration	Period of membership (within the financial year)	Gross/actual remuneration for 2017-18 financial year $
Chair	Robert McCormack	Per meeting	12 months	360
Deputy chair	Andrea Morgan	Per meeting	6 months	120
Committee member	Angie Dominish	Per meeting	12 months	120
Committee member	Eric Wynne	Per meeting	12 months	240
Committee member	Greg Swensen	Per meeting	6 months	300
Committee member	Joanne Treacy	Per meeting	6 months	60
Committee member	Maureen Meixner	Per meeting	6 months	300
Committee member	Patricia Canning	Per meeting	6 months	0
Committee member	Patricia Clark	Per meeting	6 months	240
Committee member	Peter Evans	Per meeting	12 months	480
Committee member	Peter Grocott	Per meeting	6 months	240
Committee member	Robert Matthews	Per meeting	12 months	0
Committee member	Suzanne Mathews	Per meeting	7 months	180
Committee member	Robyn Watts	Per meeting	12 months	0
Committee member	John Powdrill	Per meeting	3 months	240
Committee member	Marie Louise Allen	Per meeting	3 months	0
Committee member	Petrina Lawrence	Per meeting	6 months	120
Committee member	Susanne Burke	Per meeting	3 months	0
Committee member	Keith Morgan	Per meeting	3 months	120
			Total	**$3120**

Consumer advisory committees (Mental health)

Royal Perth Bentley Group Lived Experience Advisory Group

(formerly Bentley Health Service Mental Health Consumer Advisory Group and Psychiatry CAG: Royal Perth Hospital Psychiatry Department Consumer Advisory Group/Royal Perth Bentley Group Mental Health Consumer and Carer Advisory Group).

Position	Name	Type of remuneration	Period of membership (within the financial year)	Gross/actual remuneration for 2017-18 financial year $
Chair	Member 1	Per meeting	8 months	300
Deputy chair	Member 2	Per meeting	8 months	240
Group member	Member 3	Per meeting	8 months	300
Group member	Member 4	Per meeting	1 month	60
Group member	Member 5	Per meeting	8 months	360
Group member	Member 6	Per meeting	8 months	180
Group member	Member 7	Per meeting	8 months	60
Group member	Member 8	Per meeting	2 months	120
Group member	Member 9	Per meeting	8 months	300
Group member	Member 10	Per meeting	8 months	300
			Total	**$2220**

Midland Mental Health Consumer Advisory Group

(formerly Consumer Advisory Group Swan Mental Health Service)

Position	Name	Type of remuneration	Period of membership (within the financial year)	Gross/actual remuneration for 2017-18 financial year $
Co-Chair	Member 1	Per meeting	12 months	600
Co-Chair	Member 2	Per meeting	12 months	600
Group member	Member 3	Per meeting	12 months	480
Group member	Member 4	Per meeting	12 months	600
Group member	Member 5	Per meeting	8 months	300
Group member	Member 6	Per meeting	18 months	300
			Total	**$2880**

Aboriginal health advisory groups

Armadale Aboriginal Health Community Advisory Group

(formerly Armadale District Aboriginal Health Action Group)

Position	Name	Type of remuneration	Period of membership (within the financial year)	Gross/actual remuneration for 2017-18 financial year $
Chair	Eric Wynne	Per meeting	12 months	1620
Deputy chair	Leon Hayward	Per meeting	12 months	900
Group member	Mason Nicholson	Per meeting	12 months	675
Group member	Eunice Bynder	Per meeting	12 months	840
Group member	Raelene Hayward	Per meeting	12 months	1695
Group member	Madge Hill	Per meeting	12 months	300
Group member	Marlon Johns	Per meeting	12 months	120
Group member	Norman Pickett	Per meeting	6 months	210
Group member	Rhonda Pickett	Per meeting	6 months	210
Group member	Ian Taylor	Per meeting	4 months	240
Group member	Elizabeth Hayden	Per meeting	4 months	90
			Total	**$6900**

Bentley Aboriginal Health Community Advisory Group

(formerly Bentley District Aboriginal Health Action Group)

Position	Name	Type of remuneration	Period of membership (within the financial year)	Gross/actual remuneration for 2017-18 financial year $
Chair	Brenda Greenfield	Per meeting	12 months	950
Deputy chair	Charmaine Bartlett	Per meeting	12 months	1170
Group member	Albert Knapp	Per meeting	12 months	810
Group member	Penina (Nina) Chadd	Per meeting	12 months	1050
Group member	Shirley Voss	Per meeting	12 months	870
Group member	Joanne Hayward	Per meeting	12 months	450
Group member	Kerry Thorne	Per meeting	12 months	1350
Group member	Dorothy Winmar	Per meeting	12 months	570
			Total	**$7220**

Royal Perth Inner City Aboriginal Health Community Advisory Group

Position	Name	Type of remuneration	Period of membership (within the financial year)	Gross/actual remuneration for 2017-18 financial year $
Chair	Allira Clinch	Per meeting	12 months	450
Deputy chair	Dianne (Di) Ryder	Per meeting	12 months	900
Group member	Veronica Wallam	Per meeting	12 months	450
Group member	Vicki Blurton	Per meeting	12 months	150
Group member	Victor Ronan	Per meeting	12 months	120
Group member	Benedict (Ben) Taylor	Per meeting	12 months	420
Group member	Eric Wynne	Per meeting	12 months	240
Group member	Gilbert (Henry) Hansen	Per meeting	12 months	690
Group member	Lisa Morrison	Per meeting	11 months	390
Group member	Darren Kelly	Per meeting	11 months	390
Group member	Matthew Harris	Per meeting	11 months	210
Group member	Jim Morrison	Per meeting	2 months	120
			Total	**$4530**

Swan Hills/Midland Aboriginal Health Community Advisory Group

Position	Name	Type of remuneration	Period of membership (within the financial year)	Gross/actual remuneration for 2017-18 financial year $
Chair	Annette Dennis	Per meeting	12 months	510
Deputy chair	Denis Hayward	Per meeting	12 months	510
Group member	Shirley Harris-Kickett	Per meeting	12 months	450
Group member	Dianne (Di) Ryder	Per meeting	12 months	180
Group member	Clayton Prosser	Per meeting	12 months	585
Group member	Ceciley Phillips	Per meeting	12 months	60
			Total	**$2295**

Wungen Kartup Aboriginal Consumer and Carer Advisory Group (ACCAG)

Position	Name	Type of remuneration	Period of membership (within the financial year)	Gross/actual remuneration for 2017-18 financial year $
Chair	Member 1	Per meeting	12 months	480
Deputy chair	Member 2	Per meeting	12 months	390
Group member	Member 3	Per meeting	12 months	300
Group member	Member 4	Per meeting	12 months	630
Group member	Member 5	Per meeting	4 months	390
Group member	Member 6	Per meeting	4 months	390
Group member	Member 7	Per meeting	12 months	60
Group member	Member 8	Per meeting	4 months	90
Group member	Member 9	Per meeting	12 months	120
			Total	**$2850**

Aboriginal Health Advisory Council

Position	Name	Type of remuneration	Period of membership (within the financial year)	Gross/actual remuneration for 2017-18 financial year $
Chair	Eric Wynne	Per meeting	12 months	300
Council member	Leon Hayward	Per meeting	12 months	285
Council member	Brenda Greenfield	Per meeting	12 months	300
Council member	Charmaine Bartlett	Per meeting	12 months	360
Council member	Allira Clinch	Per meeting	12 months	120
Council member	Dianne (Di) Ryder	Per meeting	12 months	180
Council member	Annette Dennis	Per meeting	12 months	210
Council member	Denis Hayward	Per meeting	12 months	120
			Total	**$1875**

Royal Perth Hospital Animal Ethics Committee

Position	Name	Type of remuneration	Period of membership (within the financial year)	Gross/actual remuneration for 2017-18 financial year $
Chair	Member 1	Sessional	12 months	20,940
Executive Officer	Member 2	NA	12 months	0
Category A (vet)	Member 3	Per meeting	12 months	1200
Category A (vet)	Member 4	Per meeting	12 months	1000
Category B (researcher)	Member 5	Per meeting	12 months	1200
Category B (researcher)	Member 6	NA	12 months	0
Category C (animal welfare)	Member 7	Per meeting	12 months	1000
Category C (animal welfare)	Member 8	Per meeting	12 months	1200
Category D (community member)	Member 9	Per meeting	12 months	1200
Category D (community member)	Member 10	Per meeting	12 months	1000
Category E (animal facility representative)	Member 11	Per meeting	12 months	0
			Total	**$28,740**

Data from ‘a look at where we are now’ section

Please see the following inclusions and exclusions for the data found in ‘a look at where we are now’ section on page 3.

Measure	Inclusions and exclusions	Measure	Inclusions and exclusions
Emergency presentations	Total of all patients who presented to an Emergency Department. Includes Royal Perth Hospital, Armadale Hospital and St John of God Midland Public Hospital.	Outpatient appointments	Total count of outpatient appointments where the patient was seen. Includes Royal Perth Hospital, Bentley Hospital, Armadale Health Service, Kalamunda Hospital, St John of God Midland Public Hospital and St John of God Mt Lawley contracted services.
Patients admitted	Total of all patients admitted to hospital. Excludes boarders, unqualified newborns, contracted services and organ procurements. Includes Royal Perth Hospital, Bentley Hospital, Armadale Health Service, Kalamunda Hospital, St John of God Midland Public Hospital and St John of God Mt Lawley contracted services.	Occasions of service for State Aboriginal Mental Health Service	Includes service event items, service event start and end dates and client identifiers recorded in PSOLIS by public community mental health services. Service event items are the actual service activity/intervention delivered, such as counselling, assessment or travel.
Operations performed	Total of all operations performed in any theatre. Includes status suggesting that an operation occurred (i.e. operation was not cancelled). Includes Royal Perth Hospital, Bentley Hospital, Armadale Health Service, Kalamunda Hospital and St John of God Midland Public Hospital.	Occasions of service for community mental health	Includes service event items, service event start and end dates and client identifiers recorded in PSOLIS by public community mental health services. Service event items are the actual service activity/intervention delivered, such as counselling, assessment or travel.
Duration of admission	Average length of stay (days) for multi-day patients (i.e. not day cases). Calculation = (discharge date – admission date) – days on leave. Excludes boarders, unqualified newborns, contracted services and organ procurements. Includes Royal Perth Hospital, Bentley Hospital, Armadale Health Service, Kalamunda Hospital, St John of God Midland Public Hospital and St John of God Mt Lawley contracted services.	Babies born	Total of all liveborn births delivered in the hospital. Includes Bentley Hospital, Armadale Hospital and St John of God Midland Public Hospital.
		Major trauma patients treated by RPH Trauma Service	Includes patients treated with an Injury Severity Score >12. Includes Royal Perth Hospital Trauma Service.

Site locations and contact details:

Royal Perth Bentley Group (RPBG)

Royal Perth Hospital

Address:
197 Wellington Street
Perth WA 6000

Postal address:
GPO box X2213
Perth WA 6847

Telephone: (08) 9224 2244
Fax: (08) 9224 3511
Email: EMHS.GeneralEnquiries@health.wa.gov.au
Website: www.rph.health.wa.gov.au

Bentley Hospital

Address:
18 – 56 Mills Street
Bentley WA 6102

Postal address:
PO box 158
Bentley WA 6982

Telephone: (08) 9416 3666
Fax: (08) 9416 3711
Email: EMHS.GeneralEnquiries@health.wa.gov.au
Website: www.bhs.health.wa.gov.au

Armadale Kalamunda Group (AKG)

Armadale Health Service

Address:
3056 Albany Highway
Mount Nasura WA 6112

Postal address:
PO box 460
Armadale WA 6992

Telephone: (08) 9391 2000
Fax: (08) 9391 2149
Email: EMHS.GeneralEnquiries@health.wa.gov.au
Website: www.ahs.health.wa.gov.au

Kalamunda Hospital

Address:
Elizabeth Street
Kalamunda WA 6076

Postal address:
PO box 243
Kalamunda WA 6926

Telephone: 08) 9257 8100
Fax: (08) 9293 2488
Email: EMHS.GeneralEnquiries@health.wa.gov.au

St John of God Health Care (SJGHC) (contracted services)

St John of God Midland Public Hospital

Address:
1 Clayton Street
Midland WA 6056

Postal address:
GPO box 1254
Midland WA 6936

Telephone: (08) 9462 4000
Fax: 08) 9462 4050
Email: Info.midland@sjog.org.au
Website: www.midlandhospitals.org.au

St John of God Mt Lawley

Address:

Thirlmere Road, Mt Lawley 6050

Postal address:
Thirlmere Road, Mt Lawley 6050

Telephone: (08) 9370 9222
Fax: (08) 9272 1229
Email: info.mtlawley@sjog.org.au
Website: sjog.org.au/mtlawley

East Metropolitan Health Service (area office)

Address:
10 Murray Street
Perth WA 6000

Postal address:
GPO box X2213
Perth WA 6847

Telephone: (08) 9224 2244
Fax: (08) 9224 3511
Email: EMHS.GeneralEnquiries@health.wa.gov.au
Website: www.eastmetropolitan.health.wa.gov.au

Feedback

Thank you for viewing EMHS' Annual Report 2017-18. We invite you to contact us to provide feedback on the report, or if you would like additional information about EMHS.

M180406003