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

ANNUAL REPORT 2018-19

Healthy people, amazing care – Koorda moort, moorditj kwabadak

START

Statement of compliance

For year ended 30 June 2019

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 2019.

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

Suzie May
Acting Board Chair
East Metropolitan Health Service
18 September 2019

Peter Forbes
Board Member
East Metropolitan Health Service
18 September 2019

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

Statement from East Metropolitan Health Service Chief Executive and Board Chair

On behalf of the East Metropolitan Health Service (EMHS) Board and Executive, we are proud to present the 2018-19 EMHS Annual Report.

Key to delivering on our vision of **healthy people, amazing care** is the dedication and commitment of our 8393 staff who work tirelessly to provide outstanding healthcare to our community.

This focus on community is evident throughout the pages of this report, where you will gain an insight into what we have achieved over the past 12 months, how our health service is performing, and where we are concentrating our attention in the years ahead.

Everything we do at EMHS is done with our community in mind. With more than 700,000 people living within our catchment area, we are mindful that health care does not just begin and end in hospitals, but is a collaborative effort between thousands of people working throughout our hospitals and community programs, the not-for-profit sector, primary health care and all levels of Government.

Within our community, we have more than 22 separate programs designed to support our consumers to be the healthiest they can be. This includes a strong focus on health promotion and preventative health through initiatives to inform and educate community members on factors such as alcohol, obesity and smoking. A significant number of these programs have been designed specifically for Aboriginal consumers, where culturally appropriate care is delivered on topics including chronic condition management, health and wellbeing.

We would also like to acknowledge the enormous amount of work that has gone into the development of our *Clinical Services Plan: Towards 2024* (see page 17), which was released in early 2019. This document articulates how we plan for, and deliver, health care services to our community and helps us to focus our collective efforts on our clinical service priorities of managing demand and capacity; and acknowledging patient experience.

This year we have also placed great emphasis on harnessing digital technology to improve the care we provide to our consumers. Over the coming years, we look forward to leading the way in the contemporary delivery of health care using digital technologies.

Another key area of focus for us this year has been the protection of our staff from violence and aggression in the workplace. This continues to remain a challenge, however we are working collaboratively with our staff, other Health Service Providers (HSPs) and key stakeholders to do everything we can to address this issue.

It takes a real community to deliver high-quality health care efficiently and effectively to our consumers. We are so grateful to our own community of EMHS staff who work around the clock every day of the year to provide our consumers with the best possible care.

Liz MacLeod
Chief Executive, EMHS

Ian Smith PSM
Board Chair, EMHS

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Our vision

Healthy people,
amazing care
Koorda moort,
moorditj kwabadak

(Noongar translation)

Our values

Our values reflect the qualities that we demonstrate to each other and our community every day.

- Kindness
- Excellence
- Respect
- Integrity
- Collaboration
- Accountability

Our 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.

Our vision, values and service delivery principles provide a basis for which excellent health care, innovation and creativity are delivered to our community. These are aligned with the overall Western Australia (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.**

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 in 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.

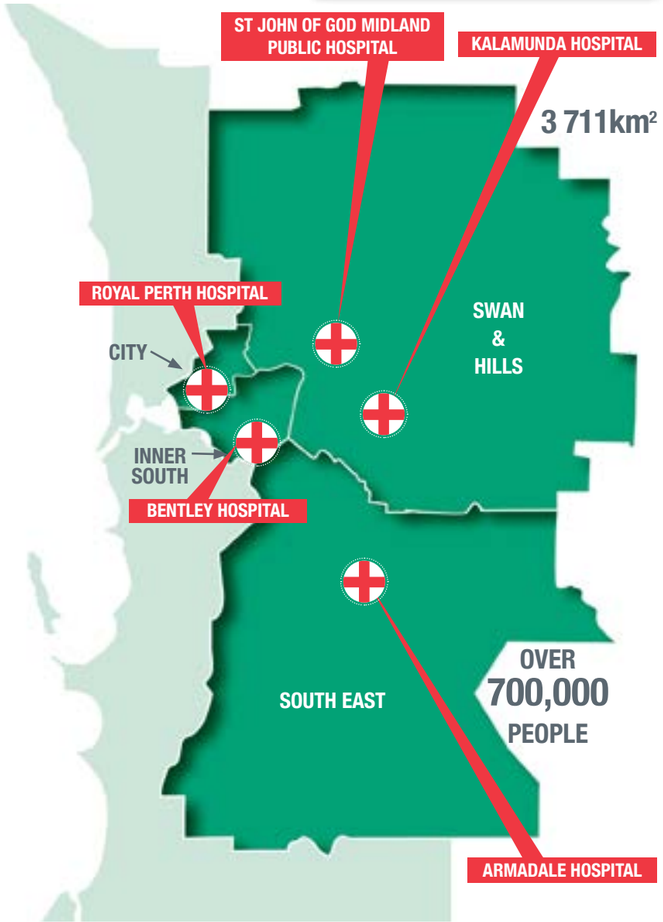
Our catchment area

EMHS provides a comprehensive range of high-quality acute, sub-acute, mental health, ambulatory and community health services to people and communities that are diverse in culture, age, socio-economic status, population and health care needs.

EMHS includes one tertiary hospital, two general hospitals and two specialist hospitals which provide an extensive range of services to the WA community, with a particular focus on people who live and work in the eastern and south eastern metropolitan areas. See page 46 for more information about our hospitals.

EMHS also serves residents living in regional WA if they require more complex care, or if they are visiting Perth.

The country regions that EMHS primarily links with are the Pilbara and Kimberley regions and the Eastern and Western Wheatbelt health districts.



Our year at a glance

5.14 days
average length of hospital stay

226 306
occasions of service for community mental health services

209 637
emergency presentations

228
patients brought in by helicopter

579
patients brought in by Royal Flying Doctor Service and air ambulance

51 116
patients arrived at an Emergency Department (ED) by ambulance

4750
babies born

26
multiple births

151 990
patients admitted

560 849
outpatient appointments

52 093
operations performed

Please see data inclusions/exclusions on page 237

Financial overview

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

2018-19 target ($000)
1,524,426

2018-19 actual ($000)
1,532,377

Variation $000
7,949[1]

Net cost of services
sourced from Statement of Comprehensive Income

2018-19 target ($000)
775,671

2018-19 actual ($000)
765,223

Variation $000
10,449[2]

Total equity
sourced from Statement of Financial Position

2018-19 target ($000)
1,289,899

2018-19 actual ($000)
1,274,830

Variation $000
15,069[3]

Net increase/(decrease) in cash held
sourced from Statement of Cash Flows

2018-19 target ($000)
-271

2018-19 actual ($000)
31,569

Variation $000
31,840[4]

Approved salary expense level
sourced from Statement of Comprehensive Income

2018-19 target ($000)
823,627

2018-19 actual ($000)
841,079

Variation $000
17,452[5]

See page 116 for full financial statements

[1]Total cost of services variance of $7.949 million is attributable to an increase in employee benefits expenses associated with the annual valuation of employee benefits provisions.
[2]Net cost of service variance of $10.449 million is primarily attributable to the additional National Health Reform Agreement (NHRA) funding as a result of increased patient activity. The full effect of this increase in revenue was partially offset by an increase in employee benefits expense recognised as a result of the actuarial valuation of the employee benefits provisions balances.
[3]Total equity variance of $15.069 million is due to a decrease in the asset revaluation reserve as a result of a corresponding decrease in the valuation of EMHS building assets, and an increase in employee benefits expense recognised as a result of the actuarial valuation of the employee benefits provisions balances.
[4]Net increase in cash held of $31.840 million is the result of an increase in cash receipts due to additional revenue from Commonwealth and other grants and contributions.
[5]Total approved salary expense level variance of $17.452 million is mainly due to additional patient activity requiring additional staff, an increase in price per unit of activity that occurred during the year and an increase in employee benefits expense recognised as a result of the actuarial valuation of the employee benefits provisions balances.

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 26).

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 89).

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

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

Key effectiveness indicators	2018-19 Target	2018-19 Actual
Unplanned hospital readmissions for patients within 28 days for selected surgical procedures (per 1000)		
Knee replacement	≤26.2	**24.6**
Hip replacement	≤17.2	**25.8**
Tonsillectomy and adenoidectomy	≤61.0	**109.4**
Hysterectomy	≤41.3	**25.4**
Prostatectomy	≤38.8	**49.8**
Cataract surgery	≤1.1	**3.2**
Appendicectomy	≤32.8	**29.8**
Percentage of elective wait list patients waiting over boundary for reportable procedures		
Category 1	0%	**24.1%**
Category 2	0%	**20.0%**
Category 3	0%	**4.7%**

Summary of key performance indicators

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

	2018-19 Target	2018-19 Actual
Key effectiveness indicators		
Healthcare-associated Staphylococcus aureus bloodstream infections (HA-SABSI) per 10 000 occupied bed-days		
	≤1 per 10 000	**0.74 per 10 000**
Survival rates for sentinel conditions		
Stroke		
0 to 49 years	≥94.4%	**98.7%**
50 to 59 years	≥93.3%	**98.4%**
60 to 69 years	≥92.9%	**95.4%**
70 to 79 years	≥90.0%	**96.0%**
80+ years	≥82.2%	**90.1%**
Acute Myocardial Infarction (AMI)		
0 to 49 years	≥99.1%	**100%**
50 to 59 years	≥98.9%	**99.1%**
60 to 69 years	≥98.0%	**98.7%**
70 to 79 years	≥96.3%	**98.5%**
80+ years	≥91.9%	**90.9%**
Fractured Neck of Femur (FNoF)		
70 to 79 years	≥98.7%	**99.2%**
80+ years	≥95.3%	**98.5%**
Percentage of admitted patients who discharged against medical advice		
Aboriginal patients	≤0.77%	**6.50%**
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%	**1.15%**
Readmissions to acute specialised mental health inpatient services within 28 days of discharge		
	≤12%	**13.3%**
Percentage of post-discharge community care within seven days following discharge from acute specialised mental health inpatient services		
	≥75%	**78.4%**

Summary of key performance indicators

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

	2018-19 Target	2018-19 Actual
Key efficiency indicators		
Average admitted cost per weighted activity unit	$6948	**$6323**
Average Emergency Department cost per weighted activity unit	$7072	**$6835**
Average non-admitted cost per weighted activity unit	$7136	**$7293**
Average cost per bed-day in specialised mental health inpatient services	$1456	**$1581**
Average cost per treatment day of non-admitted care provided by mental health services	$434	**$409**

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

	2018-19 Target	2018-19 Actual
Key efficiency indicators		
Average cost per person of delivering population health programs by population health units	$13	**$15**

EMHS Health Technology Management Unit

Bentley Hospital

EMHS Clinical Services Plan Towards 2024

The inaugural EMHS Clinical Services Plan (CSP) was released in January 2019, following more than a year of extensive planning, consultation and engagement with clinicians, consumers and community service providers.

The CSP articulates how we plan for and deliver services to our community, aligning with the policy directions contained in a number of key national and statewide documents.

The plan helps to guide EMHS in delivering health care services that are responsive to the needs of our community, while recognising our valued yet finite resources.

The EMHS CSP sets out the program of work which will be implemented during the life of the plan to deliver against our clinical services priorities. These priority areas of focus are:

- right care at the right time
- right care at the right location
- value based health care
- strengthening the patient pathway
- person-centred health care
- health promotion.

Since the establishment of EMHS as a statutory authority in July 2016, we have built on the strong foundations of our extensive network of hospitals and community programs and services. The CSP represents another step towards achieving the EMHS vision of healthy people, amazing care, and outlines the journey ahead by focusing our collective efforts on our clinical service priorities.

Visit emhs.health.wa.gov.au/About-Us/Strategic-Planning to view a summary of the CSP.

Photo courtesy of St John of God Midland Public Hospital

East Metropolitan Health Service

Governance & overview

Enabling legislation

The *Health Services Act 2016 WA (HSA 2016)* introduced changes to the governance of the WA 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 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 WA 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 Honourable Roger Cook MLA Deputy Premier; Minister for Health; Mental Health.

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 May 2019) are outlined below.

The Minister for Health has overall responsibility for the WA 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 HSP, 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 Board

L-R: Peter Forbes, Debra Zanella, Mandy Gadsdon, Denise Glennon, Richard Guit, Ian Smith PSM (Chair), Ross Keesing, Suzie May, Laura Colvin, Kingsley Faulkner AM.

Board activities

The EMHS Board is comprised of ten highly capable and committed professionals who collectively determine the strategic direction of EMHS. The Board holds overall accountability for the service delivery and performance of the health service.

Board members hosted bi-annual staff forums at all EMHS sites throughout the year to provide an opportunity for staff to interact with the Board and ask any questions. Leader rounding at both Royal Perth Bentley Group (RPBG) and Armadale Kalamunda Group (AKG) also provided members with the opportunity to interact with staff and patients. Areas visited throughout the year included Kalamunda Hospital (KH); inpatient mental health areas at Armadale Hospital (AH) and Bentley Hospital (BH); security and ED at both Royal Perth Hospital (RPH) and AH; and a range of other corporate and clinical areas throughout the health service.

Throughout 2018-19, the Board were active and engaged with staff and key stakeholders on a number of initiatives including the Sustainable Health Review; Voluntary Assisted Dying legislation; integrity and ethics; quality improvement and health leadership.

Board members also attended a number of workshops covering strategic asset planning; clinical service planning; data and digital innovation; strategic risk; mental health; and engagement.

For more information about the EMHS Board, including professional biographies visit emhs.health.wa.gov.au/About-Us/Health-Service-Board.

Our Board committees

This year our board held:

- 11 Board meetings
- 11 Finance Committee meetings
- 11 Safety & Quality Committee meetings
- 6 Audit & Risk Committee meetings
- 6 Planning & Service Delivery Performance meetings
- 4 People and Partnerships Committee meetings
- 1 SMART EMHS Working Group

Leader rounding at Armadale Hospital

As part of an ongoing focus on staff and patient engagement, the EMHS Board and Area Executive Group continued leader rounding across all EMHS sites, providing an opportunity for the leadership teams to speak directly to staff and patients in all areas of the health service, and use insights gained from the rounding to inform decision making processes.

Our 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
Grant Waterer

- Medico-Legal

Acting Executive Director Corporate Services & Contract Management
Philip Aylward

- 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

Area Director of Workforce
Steve Gregory

- Human Resources
- Industrial Relations
- Work Health and Safety
- Learning and Development

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

Executive Director Clinical Service Strategy and Population Health
Joel Gurr

- 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
Lesley Bennett

- Royal Perth Hospital
- Bentley Health Service

To view the EMHS Executive Group professional biographies please visit emhs.health.wa.gov.au/About-Us/Executive.

EMHS wishes to acknowledge Dr Aresh Anwar who worked as Executive Director (ED) Royal Perth Bentley Group until 25 November 2018; Mr Bradley Sebbes who worked as ED Corporate Services & Contract Management until 25 February 2019; Ms Lisa Seaburne-May who worked as A/ED Clinical Services Planning & Population Health until 20 November 2018; and Dr Mark Platell who worked as Area Director of Clinical Services until August 2018.

EMHS Area Executive Group (l-r): Joel Gurr, Philip Aylward, Anne-Marie Presho, Graeme Jones, Liz MacLeod, Dr Lesley Bennett, Diane Barr, Dr Grant Waterer, Maha Rajagopal, John Buchanan, Sandra Miller, Steve Gregory

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 2018-19 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 5: Aged and continuing care health services.
Service 6: Public and community health services.

Please see pages 28-29 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 13) and described in detail in the KPI section (see page 89).

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 28-29), 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.

There were no changes to the OBM Framework in 2018-19.

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.

Outcome one 1

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

Key **effectiveness** indicators for outcome one

1. Unplanned hospital readmissions for patients within 28 days for selected surgical procedures
2. Percentage of elective wait list patients waiting over boundary for reportable procedures
3. Healthcare-associated Staphylococcus aureus bloodstream infections (HA-SABSI) per 10 000 occupied bed-days
4. Survival rates for sentinel conditions
5. Percentage of admitted patients who discharged against medical advice: a) Aboriginal patients; and b) Non-Aboriginal patients
6. Percentage of live-born term infants with an Apgar score of less than seven at five minutes post delivery
7. Readmissions to acute specialised mental health inpatient services within 28 days of discharge
8. Percentage of post-discharge community care within seven days following discharge from acute specialised mental health inpatient 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 services
13. Average cost per treatment day of non-admitted care provided by mental health services

Services delivered by EMHS to achieve outcome **1**

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

See page 89 for KPI results

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.

2 Outcome two

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

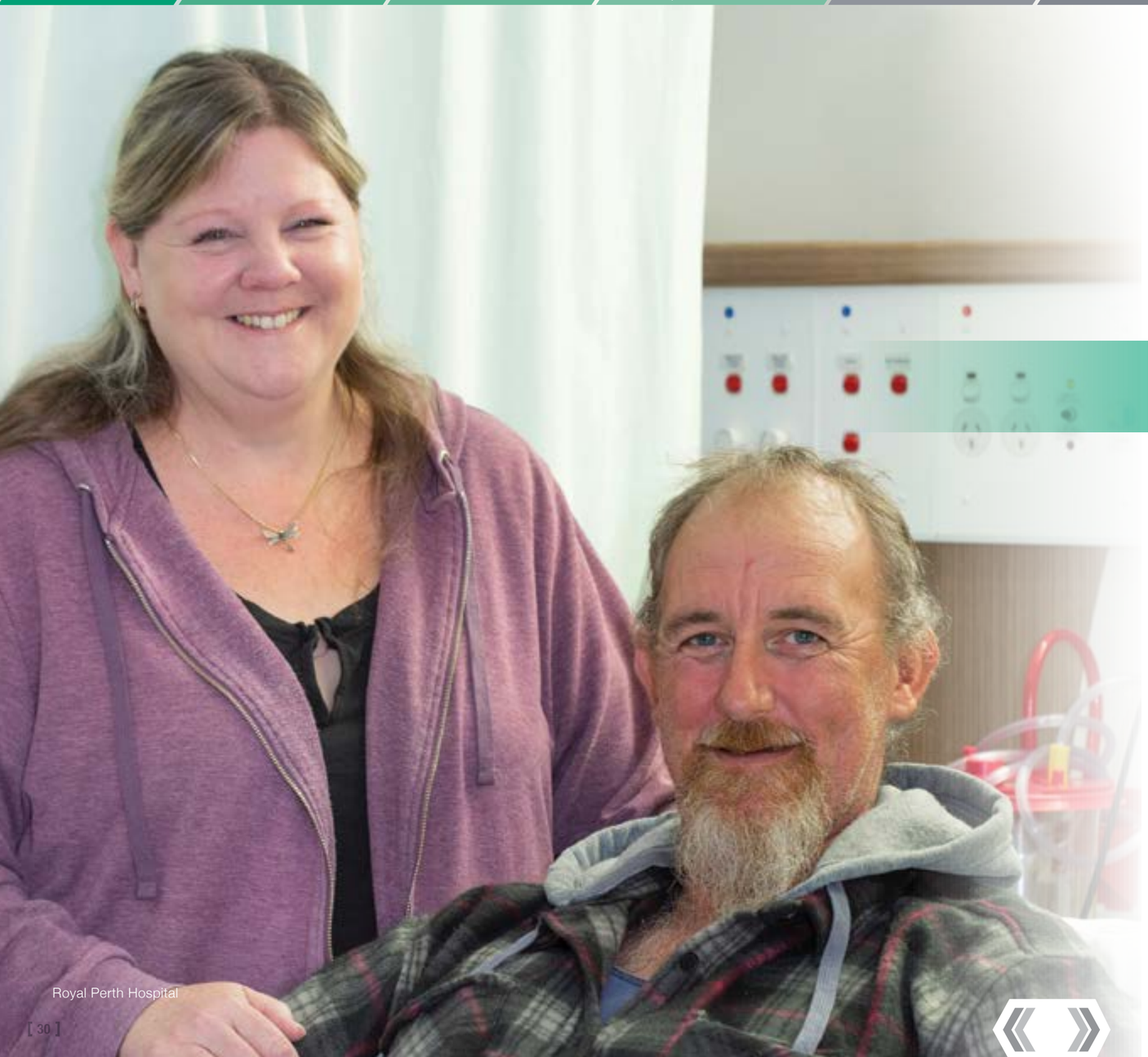
Key **efficiency** indicators for outcome two

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

Services delivered by EMHS to achieve outcome **2**

5. Aged and continuing care health services
6. Public and community health services

See page 89 for KPI results



Royal Perth Hospital

East Metropolitan Health Service

Service delivery & performance

Our community

With a catchment area covering an area of more than 3711 square kilometres, EMHS delivers a broad range of health care services to meet the diverse needs of our community.

More than 700,000 people reside in the EMHS catchment area, representing a significant increase in population since 2011. By June 2028, the EMHS catchment area population is expected to increase to more than 913,000 people. By 2031, the number of older adults aged 65 years and over residing in the EMHS catchment area is projected to almost double.

With changing lifestyles and an ageing population, chronic diseases have become increasingly common and now cause most of the burden of ill health. Recognising the increasing rates of chronic diseases within our community, EMHS is continuing to expand community and population health programs – a strategy that is reinforced through the recommendations of the Sustainable Health Review, released in early 2019. The leading causes of death for the EMHS catchment population are heart disease and various cancers. The major causes of illness for those in the EMHS catchment area include diabetes, heart disease and a range of cancers. These diseases occur more often in socioeconomically disadvantaged people, the Aboriginal community and other vulnerable populations.

These chronic diseases share five common modifiable risk factors: smoking, poor nutrition, physical inactivity, obesity and being overweight, and harmful alcohol use. Small changes in these risk factors can result in significant health gains. Using population health approaches, the EMHS Health Promotion team will focus on these risk factors through initiatives such as the Cities of Armadale, Canning and Gosnells Alcohol Action Plan, the Healthy Options program and supporting local Governments to create healthy environments.

EMHS continues to support and invest in the delivery of services and programs designed to close the gap in the health and wellbeing of Aboriginal people. A dedicated smoke-free program called ‘Yarning it up, don’t smoke it up’ aims to reduce tobacco related harm in the Aboriginal population across the Perth metropolitan area while a significant number of programs deliver culturally appropriate health and wellbeing advice in fields such as diabetes, heart health, sexual health, podiatry and nutrition.

As part of a continued commitment to supporting cultural diversity across EMHS, health service staff work closely with Aboriginal Health Community Advisory Groups (AHCAG) and an Aboriginal Health Advisory Council (AHAC). These groups represent the interests of the significant number of Aboriginal people residing in the EMHS catchment area and collectively provide advice on services, programs and policy development impacting Aboriginal consumers.

Supporting cultural diversity

During 2018-19, the AHCAG and the AHAC:

- Had input into the design and implementation of cultural events across EMHS including Reconciliation Week and NAIDOC Week.
- Represented Aboriginal community members on a number of committees and working groups relating to workforce, addressing racism, cultural respect framework, artwork, the patient journey, primary health care and more.
- Actively contributed to the development of EMHS policies, programs and services.

EMHS operates a broad range of community mental health programs throughout the catchment area, providing specialist, multidisciplinary mental health treatment and care coordination for individuals with mental health issues. Programs such as the Mobile Clinical Outreach Team (MCOT) provide specialist care to clients of the 'Street to Home' program, with more than 2124 occasions of service during 2018-19. MCOT is the only mental health team working in WA which exclusively cares for homeless people and has developed a high level of expertise in working with these clients.

Dedicated adult and older adult outpatient mental health services are also provided for mental health clients within the community at locations in the Perth CBD, Bentley, Midland and Armadale. In addition, EMHS provides a Specialist Aboriginal Mental Health Service (SAMHS), called Wungen Kartup, which works in partnership with other services to provide culturally appropriate mental health care to Aboriginal people across the Perth metropolitan area.

Heirisson Island Cultural Walk

Supporting culture and community

Our community programs are designed to promote and facilitate the health of our community and cover a range of topics including pregnancy, nutrition, physical activity, alcohol, smoking and health promotion. These programs are designed to improve overall health; manage conditions to optimise healthy outcomes; and prevent chronic diseases such as cancers, diabetes, heart disease and some mental health disorders. Our programs focus on creating healthy environments, developing healthy public policy, and developing personal skills; while some offer support with chronic disease self-management.

Aboriginal programs:
The majority of our Aboriginal programs are Aboriginal-led, and have been developed by the Aboriginal community for the Aboriginal community. These programs are based on partnership models between the Aboriginal community, Government and non-Government organisations providing holistic, consumer-centred services.

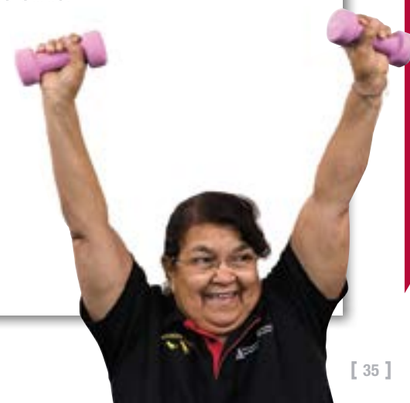
EMHS Aboriginal programs include:

- Moorditj Djena (strong feet, outreach podiatry diabetes services)
- Walyup Kworpading Koort (healthy heart)
- Moorditj Maarman (males yarning group)
- Nidjalla Waangin Mia (healthy lifestyle program)
- Tai Chi classes
- I'm Moordidjabinj (becoming strong)
- Journey of Living With Diabetes (JLWD)
- Midland Healthy Lifestyle Group
- Living Improvements For Everyone (LIFE)
- Aboriginal Acute Care Coordination (supporting patients through pre and post hospital admission)
- Moort Boodjari Mia (family pregnancy place)
- Boodjari Yorgas (pregnant women)
- Aboriginal Youth Health
- Yarning it Up, don't smoke it up.

For more information on these programs, visit emhs.health.wa.gov.au/Hospitals-and-Services/Aboriginal-Health.

Community health and mental health:
Other programs are delivered to support the health and mental health of our community. A number of these programs are run in partnership with local Government, to improve the health of the community both now and into the future. These include:

- Cities of Armadale, Canning and Gosnells Alcohol Action Plan.
- Creating healthy food environments (supporting better food choices, particularly in sporting clubs and local government venues).
- Reducing exposure to second-hand smoke (particularly targeting areas outside shopping complexes and local Government venues).
- Supporting local Governments to improve the health of their community by increasing their understanding of local health issues and effective strategies to deal with the issues identified.
- Bentley Wellness Clinic.
- Midland Wellness Clinic.
- City East Wellness Clinic.
- Wealthy, Well and Wise Group.



Moort Boodjari Mia

Moort Boodjari Mia, delivered by St John of God Midland Public Hospital (SJGMPH), is an innovative service providing culturally appropriate maternity care for Aboriginal women.

The journey allows for a holistic, woman-centred continuum of care where the woman is supported by her immediate family, community and a dedicated team of health professionals.

The journey allows for continuity of maternal care that empowers Aboriginal women to improve their maternity outcomes through engagement with appropriate health care providers. With the provision of this culturally appropriate care, Aboriginal women are able to access maternity care safely, knowing there is respect and understanding, which in the past have proven to be barriers to the access of maternal care.

The program's design, which incorporates Aboriginal values, Aboriginal ways of working and a unique blend of Aboriginal and non-Aboriginal health professionals, is largely responsible for the exceptional outcomes achieved.

Throughout the entire program Aboriginal health perspectives are valued and included, thereby providing maternity care that is relevant, meaningful and effective. Together with a Midwife, an Aboriginal Health Officer and an Aboriginal Liaison Grandmother, each woman is offered spiritual, cultural, social, and psychological care, as well as clinical health care.

Many Aboriginal women are presently at risk of poor maternity outcomes due to socio-economic stressors, the high incidence of perinatal infections, poor nutritional status and higher rates of diabetes throughout the Aboriginal community. Our specific client journeys enable us to work together with other agencies and health care providers to ensure the best evidence based practice is provided to Aboriginal women.

Moort Boodjari Mia is a unique service that is underpinned by an inventive model of care that is proving to be instrumental in improving maternity care to Aboriginal women.

Photo courtesy of St John of God Midland Public Hospital

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

Keeping patients connected to their community

In March 2019, EMHS launched the Hospital Hotline program – a collaboration with Noongar Radio which helps to keep Aboriginal patients connected to their community while in hospital.

Hospital Hotline (contact 0448 821186) is a patient request program on Noongar Radio that helps Aboriginal people staying in EMHS hospitals to keep connected to family, friends and the community. Every Tuesday morning, a segment is broadcast on Noongar Radio where patients and community members can call in with messages of support or song requests.

EMHS Chief Executive Liz MacLeod commented "it is so important for us to ensure that our patients have everything they need to recover, even if that is just a few words from their friends and family".

"This is why we are delighted that we can help our patients from across WA stay connected with friends and family with the Noongar Radio's Hospital Hotline."

Kirkman House, EMHS

Nature provides positive patient outlook

Nestled in the Perth Hills, Kalamunda Hospital provides a unique and scenic landscape for patients, their visitors and staff alike to enjoy.

Nature can offer wonderful stimuli for patients, and a project to enhance the hospital's outdoor space and create a dedicated garden for palliative care patients is now underway.

With the patient in mind, the design incorporates accessibility for wheelchairs and hospital beds; providing a relaxing space for patients to enjoy or experience as a calming outlook from their rooms.

Jo Harris, Coordinator of Nursing, explains that families, carers and friends can also benefit from the garden.

"The ethos of our healthcare team is to care for the families of patients with a life-limiting illness too. Outdoor spaces can be a place of respite for a patient's support network by providing a non-clinical, tranquil area that feels homely" Jo said.

The natural bushland surrounding the hospital site provided much of the inspiration for the landscaping, whilst the inclusion of a gazebo, barbecue and private seating areas offers opportunities for patients to socialise with family and friends.

All sites celebrated Patient Experience Week during early 2019, with SJGMPH holding a dedicated Patient Experience Expo which provided an opportunity for staff to engage with consumers about patient-focused care and increase health literacy within the community. At RPBG and AKG, patient experience training sessions were held for hundreds of staff members in areas including the neuroscience of communication and enriching the patient experience.

EMHS joins forces to tackle alcohol issues

The EMHS Health Promotion team have played a key role in development of a targeted, comprehensive plan to tackle alcohol related harm in Perth's eastern metropolitan region.

Developed in partnership with State Government bodies and community organisations, the Alcohol Action Plan (AAP) focuses on preventing and reducing harms associated with the sale, supply and consumption of alcohol.

"It is the first time we have seen local Government organisations join forces to put a plan in place to tackle such a big issue," said EMHS Health Promotion Manager Megan Milligan.

Active partnerships

Ms Milligan – who took on the role of Chairperson of the Armadale, Canning and Gosnells Local Drug Action Group (ACG LDAG), said by working together, a greater impact for the community would be seen.

ACG LDAG organisations include the Alcohol and Drug Foundation, Cannington Armadale Family Support Network, City of Armadale, City of Canning, City of Gosnells, Crime Stoppers WA, Department of Education – School Drug Education and Road Aware Program, headspace (Armadale), Hope Community Services WA, Mental Health Commission, Neami National (Metropolitan Suicide Prevention Coordinators), Palmerston Association, Public Health Advocacy Institute of WA, WA Police and WA Primary Health Alliance, in conjunction with EMHS.

During the next three years, the ACG LDAG will guide the implementation of strategies outlined within the AAP.

The three year plan provides strategies that are targeted at schools, the wider community, sporting clubs and licensed venues to address underage drinking, alcohol-related anti-social behaviour and promote alcohol-related support services.

The plan is guided by evidence and uses data, insights from advisory groups and community organisations to provide local solutions for local issues.

For information on how EMHS is tackling alcohol related issues visit emhs.health.wa.gov.au/Hospitals-and-Services/Health-Promotion/Alcohol.

Providing healthier options to our community

As part of an ongoing focus on maintaining and improving the health of staff and the broader community, EMHS retailers are working towards compliance to the Healthy Options WA Policy through the provision of a greater range of healthy and nutritious options available for sale.

The transition to healthy options has been a collaboration between EMHS Community and Population Health, retailer and catering staff, and volunteers.

Retail outlets across EMHS hospital sites have made significant progress in providing healthy options for staff, patients and visitors through increasing the range of healthy options available, and reducing junk food and drinks on offer.

Listening to our community

Our ongoing commitment to improving consumer engagement through meaningful feedback mechanisms, and partnering with consumers to develop our health services, has been reflected in the activities undertaken across EMHS during 2018-19.

Following the launch of 'Walk a Day in My Shoes' (WADIMS) in late 2017, and in response to patient feedback, a number of strategies have been introduced. Leader rounding has seen members of the EMHS Board and Executive regularly visiting the sites and talking to staff and patients about their experience and garnering feedback on areas for improvement. Formal customer service training for both clinical and corporate staff has been well received and supplemented by the development of prompt messaging techniques such as telephone etiquette. The WADIMS video has been widely viewed by staff and community members and is used to reinforce the vision and values of the organisation and expectations of our staff in the delivery of patient-centred, compassionate care.

Consumer-centred

Consumers are encouraged to provide feedback on their experiences with EMHS via multiple channels, with increased opportunities and pathways introduced in the past year. These include direct contact with hospital staff and consumer engagement units; hardcopy or online feedback forms, suggestion boxes, email, completion of a survey upon discharge or following an outpatient appointment, and sharing stories via Patient Opinion. EMHS has strived to improve its timeliness to address patient complaints. Targeted strategies employed at RPBG have achieved the June 2019 target of 100% of complaints responded to within WA Health Complaint Management Policy timeframes.

We are working harder than ever with consumers, consumer groups, non-Government organisations, not for profit organisations and other health services to ensure that our approach to delivering services to our consumers is both responsible and proactive.

As a result of Aboriginal consumer feedback, the Aboriginal health teams across EMHS have developed multiple publications to accommodate Aboriginal consumers in their health journey. The publications include educational resources used by clinicians to explain health concerns and wall stickers to direct consumers to areas within the hospital; and Aboriginal artwork displayed around the hospitals and on EMHS documents to make the service more visually welcoming for Aboriginal consumers.

Continuous improvement of the patient experience occurs through staff collaboration, using consumer feedback to provide both formal and informal education and to improve every stage of the consumer journey. Consumer feedback also promotes the recognition of staff going above and beyond, and is used to identify nominees for employee recognition programs.

All EMHS feedback mechanisms have recording and reporting capabilities allowing improvements to be identified, actioned and monitored.

In 2018-19, EMHS received 3252 contacts from patients through formal feedback processes, which included 1004 complaints and 1827 compliments.

EMHS complaints data for 2018-19 demonstrates the major themes concerning consumers as quality of clinical care; access; and rights, respect and dignity. These trends are consistent with the health system more broadly.

Patient Opinion

Patient Opinion continues to be a popular avenue to provide convenient online feedback, whilst receiving timely and responsive information in return. The EMHS Executive remains committed to responding to the stories submitted, with more than 143 stories received throughout 2018-19. This includes good news stories that are shared with staff as well as providing an opportunity to address concerns raised. Examples of using stories to improve the consumer experience include the refit to the "relatives' room" in the RPH ICU to ensure loved ones have a comfortable place to wait for news.

EMHS compliment data for 2018-19 provides an opportunity to celebrate staff efforts.
Of the 1827 compliments received:

- **178** compliments included the word 'helpful'
- **585** compliments included the words 'care', 'caring', or 'attention'
- **176** compliments included the words 'compassionate', 'thoughtful', or 'kind'
- **92** compliments included the words 'polite', 'pleasant', or 'courteous'
- **115** compliments included the word 'amazing'

Valuing the voice of our community

We value the input of our community in the planning and delivery of health care. Across EMHS there are 13 community advisory groups with approximately 140 community members.

In 2018-19 our consumer groups provided valuable advice and feedback on a range of topics which help us to provide better care to our community. This has included:

- Providing consumer-oriented feedback on:
  - all consumer publications
  - food, catering, food delivery systems, and food management processes
  - EMHS dementia project
  - disability services
  - patient demographic data
  - complaints and consumer feedback data
  - the Patient Evaluation of Health Services (PEHS) survey run by DoH
  - safety and quality data relating to falls, pressure injures and medication errors.
- Development of:
  - a consumer representative toolkit for AKG
  - 2018-20 CAC strategy for RPH
  - a consumer-led patient experience survey process, for CAC members to complete a face-to-face survey with inpatients regarding their experiences.
- Leading the self-assessment of the organisation using tools provided by the Australian Commission on Safety and Quality in Health Care (ACSQHC). This body of work is underpinning the development of a person-centred organisation action plan for AKG.

In addition to regular community advisory group meetings, EMHS also places a high priority on community representation on hospital operational committees/ internal groups and attendance at relevant workshops and external events. In 2018-19, this included (but was not limited to):

- Clinical Safety and Quality Committee
- Corporate Governance Committee
- All National Standards committees
- Emergency Management Committee
- RPH and Bentley Health Service (BHS) Medical Advisory Committees
- Disability Access Inclusion Plan Committee
- Mental Health Management Committee
- Choosing Wisely Champions
- EMHS Care of the Older Adult service model workshop
- EMHS clinical services planning session
- EMHS aged care services planning session
- DoH outpatient appointment “app” planning session.

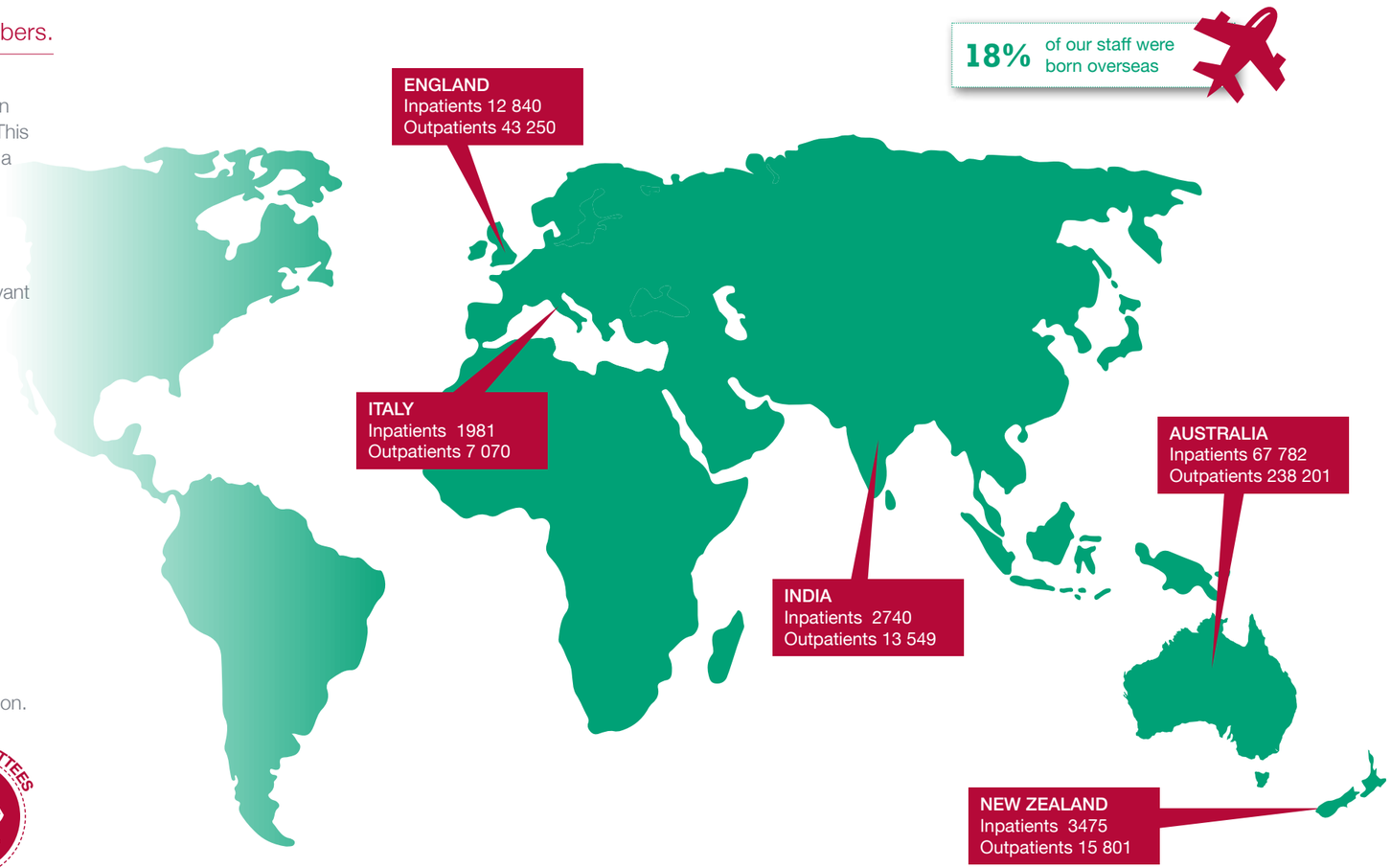
3 Community Advisory Committees (CAC)

2 Mental Health Consumer Advisory Groups (CAG)
1 Aboriginal mental health group

4 Aboriginal Health Community Advisory Groups (AHCAG)
1 Aboriginal Health Advisory Council (AHAC)

2 Ethics Committees

Our patients: top five countries of birth

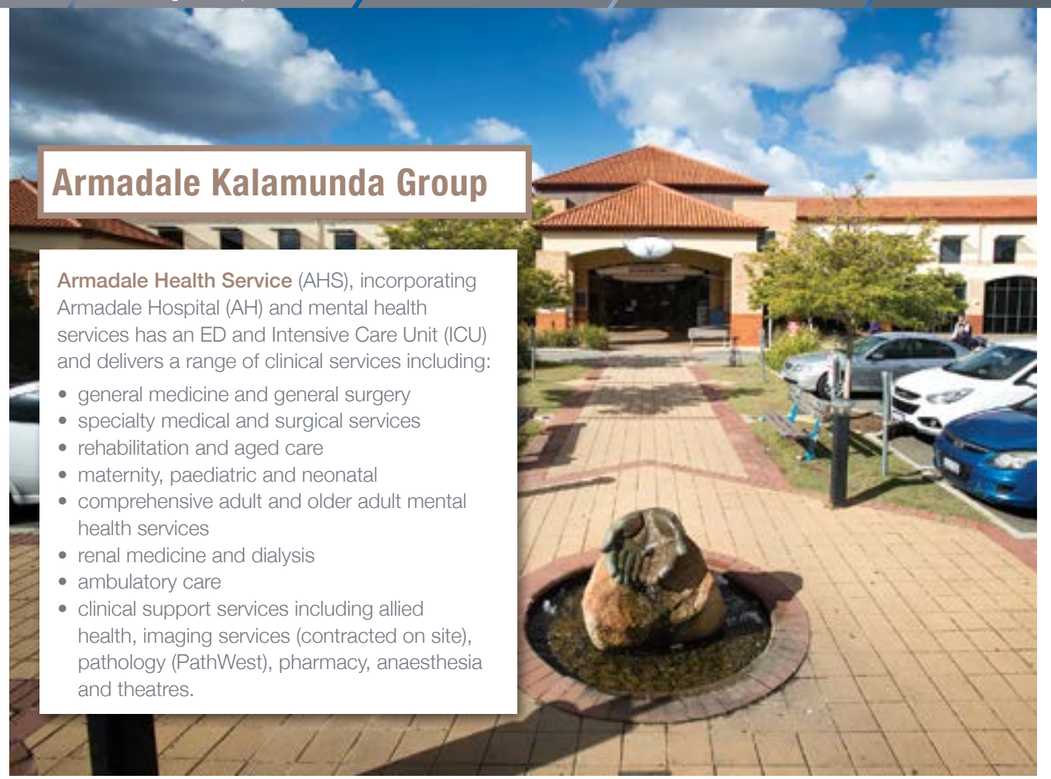


Our hospitals

EMHS provides a comprehensive range of high-quality acute, sub-acute, mental health, ambulatory and community health services to people and communities that are diverse in culture, age, socio-economic status, population and health care needs.

For information on EMHS hospitals visit emhs.health.wa.gov.au/Hospitals-and-Services/Hospitals.

Armadale Kalamunda Group



Armadale Health Service (AHS), incorporating Armadale Hospital (AH) and mental health services has an ED and Intensive Care Unit (ICU) and delivers a range of clinical services including:

- general medicine and general surgery
- specialty medical and surgical services
- rehabilitation and aged care
- maternity, paediatric and neonatal
- comprehensive adult and older adult mental health services
- renal medicine and dialysis
- ambulatory care
- clinical support services including allied health, imaging services (contracted on site), pathology (PathWest), pharmacy, anaesthesia and theatres.

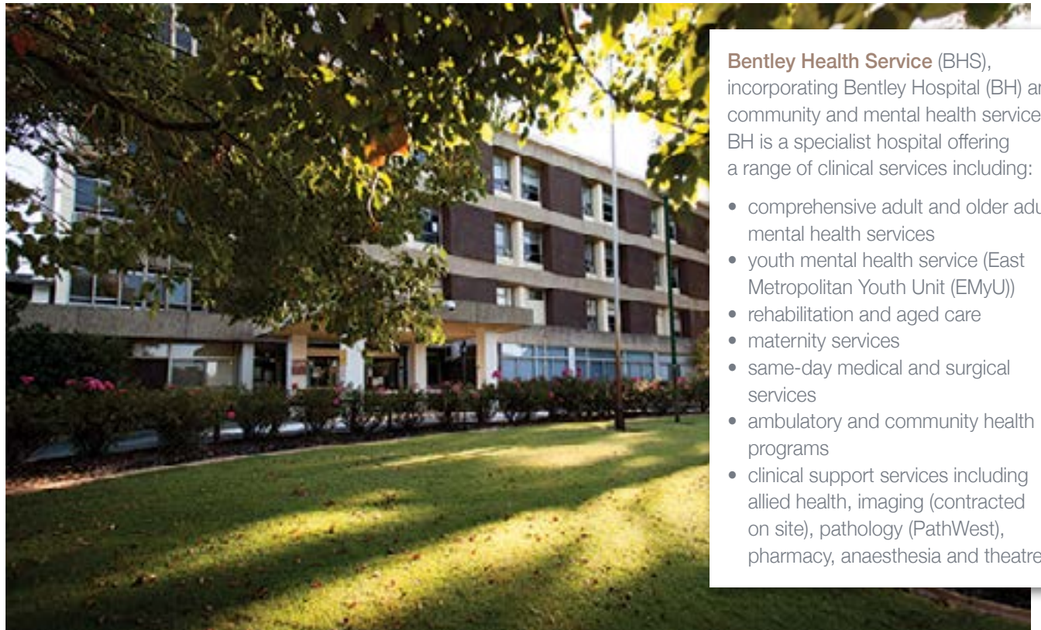
Kalamunda Hospital (KH) is a specialist hospital providing:

- specialist palliative care services
- same day endoscopy services for low-risk, low-complexity patients
- clinical support services including some allied health, imaging on-site, anaesthesia for day procedures, pathology (PathWest outreach) and pharmacy.

Royal Perth Bentley Group

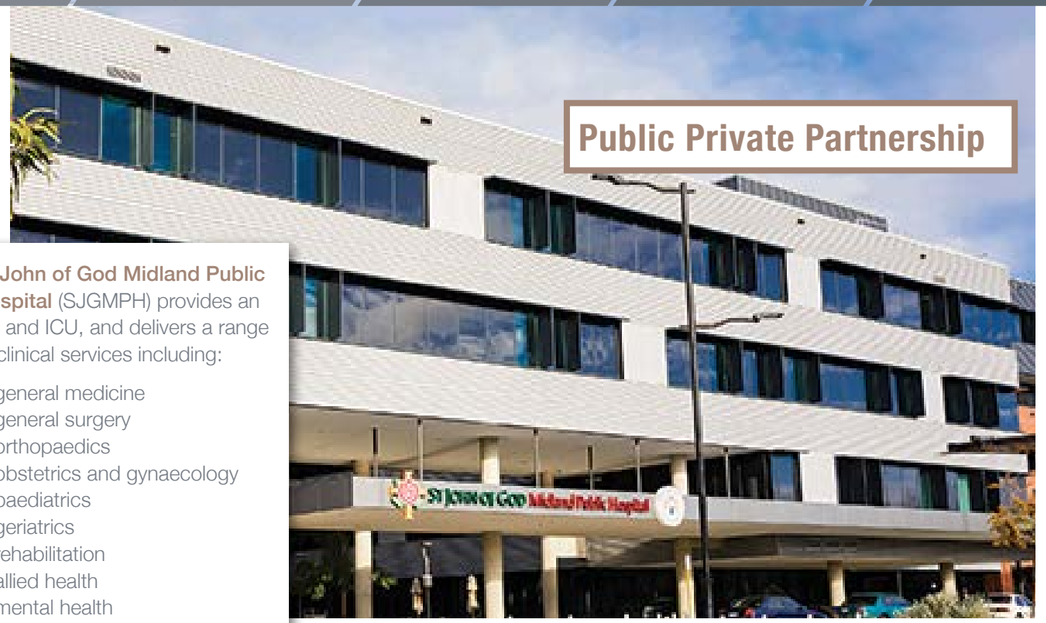
Royal Perth Hospital (RPH) is a tertiary hospital providing an ED and ICU and an extensive range of clinical services including:

- adult major trauma
- complex and elective surgery
- highly specialised surgical services
- tertiary mental health services
- specialist medical services
- clinical support services including allied health, imaging, pathology (PathWest), pharmacy, anaesthesia and theatres.



Bentley Health Service (BHS), incorporating Bentley Hospital (BH) and community and mental health services. BH is a specialist hospital offering a range of clinical services including:

- comprehensive adult and older adult mental health services
- youth mental health service (East Metropolitan Youth Unit (EMyU))
- rehabilitation and aged care
- maternity services
- same-day medical and surgical services
- ambulatory and community health programs
- clinical support services including allied health, imaging (contracted on site), pathology (PathWest), pharmacy, anaesthesia and theatres.



Public Private Partnership

St John of God Midland Public Hospital (SJGMPH) provides an ED and ICU, and delivers a range of clinical services including:

- general medicine
- general surgery
- orthopaedics
- obstetrics and gynaecology
- paediatrics
- geriatrics
- rehabilitation
- allied health
- mental health
- outpatient services.

EMHS has a public private partnership with St John of God Health Care.

St John of God Mount Lawley (SJGML) provides assessment and restorative services for public patients under contract with EMHS.

One patient's journey in our hospitals
(excerpt from Patient Opinion)

Recently, my parent had a midbrain stroke. I provided positive feedback then.

Yesterday, I heard the reports on the ABC on Emergency Department (ED) presentations and long waits of over 4 hours and hospitals not meeting benchmarks.

Our experience was so different.

I suspect, if you are very sick you will be seen, as was our case at the Armadale Hospital and Royal Perth Hospital (RPH).

The doctors at Armadale were amazing, as was the male nurse (sorry I don't know your name). Many thanks to you. They kept us informed all the way through and even sent a senior registrar during the hospital transfer.

The Emergency Department (ED) nurses at RPH were special, offering us coffee, providing privacy screens etc. Then the Neurological Medical Team- doctors Franconi, Emily and Jay and the nurses- Diana, Celine, Lee, Yeon to name a few.

What struck me was they always ensured privacy in a four-bedroom ward, which helped my parent to maintain their dignity. Simply, good care by ward nurses, Carla (Clinical Nurse Specialist), med team, Pina (Snr Physio) and Radiology.

An improvement would be for middle management nursing to be more proactive. I felt an early falls management plan would have benefited. My parent is now at Bentley Rehab (again the doctor and the team listened and involved us). Claire, Tom, Iris and Amy were the staff I saw, and with their help, my parent is on their way to being discharged.

A snapshot of our hospitals this year

EMERGENCY PRESENTATIONS WITH FRACTURES

8094

INCLUDING

- Hands 1413
- Feet 975
- Wrists 447
- Ribs 396
- Jaws 204
- Elbows 176
- Noses 172

OUR PATIENTS WITH NO FIXED ADDRESS

- Inpatients 707
- Outpatients 218

AGES OF OUR OLDEST PATIENTS

- Inpatient 108 years
- Outpatient 105 years

ABORIGINAL PATIENTS

- Inpatients 15 194
- Outpatients 23 445

16 606 FLU RELATED ED PRESENTATIONS

EMERGENCY PRESENTATIONS

Average per day 581

Most presentations in a single day 731

REPORTS SENT TO CUSTOMERS BY THE DATA & DIGITAL INNOVATION TEAM

More than 600 000

OUR HEALTH TECHNOLOGY MANAGEMENT UNIT:

provided 629 temporary loan wheelchairs to patients

fitted 1356 orthotics to patients

Choosing Wisely program

EMHS joined the national Choosing Wisely program in 2016 and continues to focus on ensuring that the tests, treatments and procedures prescribed within the organisation deliver the highest value to patients at the lowest risk.

Choosing Wisely aims to eliminate unnecessary tests, treatments and procedures through promoting important conversations between patients and their healthcare providers, ensuring our patients get the level of care that is right for them. This is supported by improving clinical pathways through implementation of 158 evidence-based recommendations developed by Australia's peak colleges, societies and associations. All hospital sites within EMHS participate in the Choosing Wisely program, which is coordinated under an overarching steering group.

Doing the right thing

Since commencement, the key to success has been direct engagement from clinical staff in the program, implementing recommendations, auditing practices, changing their own practice and promoting the cultural change amongst their colleagues.

Highlights of the EMHS Choosing Wisely program during 2018-19 include:

- Strengthened engagement with clinical staff and consumer groups to promote Choosing Wisely and further embed cultural change. As one example, through standardisation of pathology ordering pathways and adherence to robust evidence-based recommendations, the RPH ED reduced the number of unnecessary tests performed by approximately 4200 per month. This resulted in significant cost savings of approximately $580,000 for the 2018-19 financial year, which can be re-directed towards more high value activities.
- The establishment of a Choosing Wisely Champions Roadshow, including consumer representation to share learnings from Choosing Wisely projects
- Broadened the Choosing Wisely clinical Champions network with support, guidance and resources for staff members wishing to undertake a Choosing Wisely service improvement initiative.
- Development of a range of consumer resources designed to enhance health literacy and encourage important conversations with health care professionals.
- Customised project support for new and existing initiatives across EMHS, whilst facilitating area wide linkages, improving data access, and reducing 'road blocks' to provide high value patient focused care.
- New project governance processes making it easier for clinicians to submit projects and increase visibility of project tracking.
- Engagement on the national and local level with other Choosing Wisely champion health services, including showcasing EMHS work at the 2019 Choosing Wisely Conference.

Choosing Wisely projects

The ICU Blood Gas Project

This project aimed to reduce the number of unnecessary blood gas tests performed on some of our most unwell patients in the RPH ICU. Based on contemporary evidence, the guidelines for blood gas testing were changed to clearly articulate 'when to test' and 'when not to test'.

Staff education was provided to all clinical staff and was also included in the orientation process for junior medical officers. Information was shared with all ICU clinical staff about the updated blood gas testing guidelines and the costs involved in the inappropriate testing.

As a result of this project, the volume of blood gas tests performed in the RPH ICU halved, with approximately 133 less blood gas tests undertaken each month. In practical terms this means staff time and resources are able to be diverted towards more high value activities and there is less risk to patients from exposure to unnecessary testing.

Goals of Patient Care (GOPC) Project

Another project was undertaken to empower patient choices made in hospital and better communicate this on discharge. Through collaboration with St John Ambulance and Hall and Prior Nursing home, a service improvement initiative was implemented to ensure information captured on the GOPC form (completed in the hospital) is communicated in the community setting. This information can be used to encourage discussions around Advance Care Planning and potentially prevent unnecessary hospital presentations.

Post intensive care clinic a first for WA patients

A new clinic offering support to ICU patients after discharge from hospital was introduced at Armadale Hospital in late 2018.

The aim of this innovative clinic is to help patients transition from the ICU back to their everyday life and community.

The clinic was developed by a multidisciplinary team to provide comprehensive multidisciplinary care, allowing patients to be seen by an ICU doctor, nurse and physiotherapist in the same visit.

ICU Head of Department Dr David Blythe explains the concept for the clinic came from clinicians in the ICU asking, "how can we do something more to help our patients?"

"The logical step was to provide specialised follow-up care to ensure their rehabilitation is going as planned and to address any concerns they may have after discharge," Dr Blythe said.

"Critical care follow-up clinics are well established internationally, with evidence showing that post ICU clinics are highly valued by patients."

As part of the post ICU clinic at Armadale, patients return to the hospital six weeks after their discharge. They can expect a functional assessment, a review of medication for ongoing care, and the opportunity to get a better understanding of their time in ICU. Any concerns with ongoing physical or mental health issues are managed through liaison with their General Pracititioner (GP) or other health professionals including community services.

Using data and digital technologies to enhance care

EMHS is seeking to transform the delivery of healthcare services in support of our vision of healthy people, amazing care.

A number of areas of focus have been defined to transform EMHS into a digitally enabled organisation, including use of artificial intelligence and automation; cybersecurity; enhancing the consumer experience; digital workspaces; and data and analytics.

Some key programs of work undertaken by the EMHS Data and Digital Innovation (DDI) team during 2018-19 include:

- Development of an automated alert system to enable users to subscribe to receive updates on patients, issues or events. DDI are currently piloting this system on nominated patients with chronic disease, whereby their treating physician will be automatically alerted whenever the patient presents to the ED.
- Supporting work underway in the development of a Medihotel and Command Centre set to provide remote monitoring capabilities for patients throughout the State.
- Deployed Microsoft Teams as a tool for clinical staff to collaborate and use as a shared online workspace.

EMHS invests significant resources into the recording, monitoring and utilisation of a broad range of data sourced from a myriad of core health applications on a daily basis.

During the past year, EMHS business intelligence applications had more than 16 million hits, with more than 2500 users regularly accessing data and analytics products. This data has been used for key statewide projects including Mental Health Patient Flow and Theatres, in addition to EMHS initiatives such as bed management and patient flow, mandatory training and leave management.

As part of the Mental Health Patient Flow project, the DDI team created a dashboard which collates near-live data of mental health bed demand and availability across the health system. More than 300 users regularly access this dashboard which enables greater visibility of mental health bed status across the system. A collaboration across all HSPs also resulted in the development of a theatre dashboard, which monitors theatre activity including pending surgeries across all metropolitan hospitals.

High performing systems and teams

EMHS data capabilities have also been deployed across corporate areas of the health service, with specific dashboards developed to monitor staff compliance against mandatory training, leave, and performance management.

EMHS Data & Digital Innovation

Robotic first for orthopaedic patients in Perth's eastern region

St John of God Midland Public Hospital has become the first public hospital in the Perth eastern region to use robotic technology.

A Mako Stryker orthopaedic robot is being used by orthopaedic surgeons to provide computer-guided assistance for total knee and partial knee surgery for appropriately selected public and private patients.

The use of robotic technology in knee replacement surgery can provide patients with increased access to partial knee replacement surgeries with a shorter hospital stay and a quicker return to normal activities.

Robotic-assisted surgical technique allows highly accurate pre-operative planning, merging the accuracy of computer navigation and the pre-operative planning and custom component positioning of patient-specific knee systems.

The technology forms part of SJGMPH's focus on providing first-class facilities, clinical excellence and exceptional patient outcomes.

SJGMPH is only the third hospital in Perth to offer the technology for orthopaedic surgery.

Hon Roger Cook MLA Deputy Premier; Minister for Health; Mental Health testing the new Mako Stryker orthopaedic robot.

Photo courtesy of St John of God Midland Public Hospital

Royal Perth Hospital

Providing dementia friendly health services

EMHS has been recognised as the first metropolitan health service in Australia to be actively working towards becoming a Dementia Friendly Organisation through Dementia Australia's Dementia Friendly Communities program.

It is nationally recognised that more needs to be done to support people living with dementia, their families and carers.

RPBG Clinical Specialist for Delirium and Dementia, Ellie Newman, has been working alongside the EMHS Safety, Quality and Consumer Engagement and clinical teams to develop an action plan and dementia strategy that will strengthen our commitment to delivering a better way to care for patients living with dementia and delirium.

As part of this work, a growing number of EMHS staff have completed Dementia Change Champions training conducted by Alzheimer's WA, and a delirium working party has been established in the RPH ICU.

EMHS will continue to implement dementia friendly initiatives, including building an education program that will support raising awareness of dementia across the health service; working with the Facilities Management teams to provide spaces where people living with dementia and delirium can recover more positively; and ongoing contributions to quality improvement initiatives and research opportunities.

In the hospital setting, up to one in four patients are living with dementia and/or delirium, and increasing numbers of our staff care for people living with cognitive impairment in their personal lives. It is nationally recognised that more needs to be done to support people living with dementia, their families and carers, and as such, our commitment to improving our understanding and the way we deliver care in support of each other, our patients and our vision of becoming a dementia friendly health service is being strengthened by this work.

Research

As a progressive health service, EMHS is committed to research and innovation that translates into evidence-based practice, delivers excellent health outcomes for all and improves patient experience and safety.

EMHS is proud of its outstanding history of clinical research and innovation; this past year has seen EMHS continue in this tradition by conducting and supporting a wide range of research projects, from basic and laboratory science, to clinical trials to projects testing innovative new treatment pathways designed to improve the quality, safety and cost-effectiveness of our services. The year saw a 27% increase in overall research activity, with projects initiated by EMHS staff and industry-sponsored clinical trials both up 50%.

Our clinical, nursing, allied health and scientific staff have again been highly competitive in attracting research grants, such as the RPH Research Foundation's 'Springboard' grants that support talented early-career researchers. EMHS researchers were also awarded several highly sought after Department of Health 'Research Translation Program' grants used to fund projects whose results are likely to have an immediate effect on patient outcomes, as well as improve the cost-effectiveness and efficiency of healthcare delivery. EMHS researchers have also been part of teams that have won national grants, including two major National Health and Medical Research Council grants.

A key focus area over the past year has been a series of steps aimed at substantially improving the capacity of EMHS to effectively support research. Research administration, ethics and governance staff have been co-located within a new EMHS Research Hub, headed by a Research Manager. The Hub is tasked with taking a fresh approach to supporting staff to identify research questions, develop projects, build and utilise partnerships, access research training and effectively communicate research findings to ensure the ultimate goals of improving patient care is achieved.

These ambitious goals have been articulated in a three-year EMHS Research Strategy due to be launched early in the 2019-20 financial year, following consultation with EMHS staff and key partners. The strategy aims to:

- Embed research into core business, remove barriers and increase capacity across our hospital network, community and public programs
- Better translate research knowledge into evidence-based practices and technologies that improve patient outcomes and deliver outstanding care.

A priority in the coming year is to improve communication with researchers and provide comprehensive and clear advice about all aspects of conducting research in EMHS via a new online home for the Research Hub: emhs.health.wa.gov.au/research.

Single Troponin Accelerated Triage (STAT)-Chest Pain Study

A young Royal Perth Hospital doctor is testing an innovative clinical pathway for the assessment and treatment of patients presenting to the Royal Perth Hospital ED with chest pain.

Acute chest pain is one of the most common reasons for presentation to EDs, however most patients are at low risk of serious complications, with only a small proportion ultimately diagnosed with an Acute Coronary Syndrome (ACS) or other major problem. The consequences of misdiagnosis are significant and so considerable time and resources are expended to ensure the accurate triage of such patients.

Recent research suggests that patients with very low levels of 'high sensitivity troponin' (hs-cTn) - a blood marker of cardiac injury - on arrival to ED are at extremely low risk and could be safely and quickly discharged.

This study will determine if a new triage and treatment pathway involving early high sensitivity cardiac troponin I (hs-cTnI) measurement, benefits patients and improves service efficiency and cost effectiveness, compared to the current standard pathway.

The study also seeks to strengthen collaborative ties between the Cardiology and ED.

Intellectual curiosity

Dr Cara Winnall has been conducting the study as part of a DOH Registrar Research Fellowship that has allowed her to dedicate time to research while continuing her advanced clinical training.

"The STAT-Chest Pain study puts RPH at the forefront of research into the assessment of low-risk patients presenting with to the ED with chest pain. The results of this study could be a 'game-changer' and impact clinical practice in ED across Australia by accelerating patient care without compromising on safety", Dr Winnall said.

Haemodialysis Access and their Vibration and Sound Evaluation (HAVSE)

For patients unable to access transplantation of peritoneal dialysis, the primary form of renal replacement therapy is haemodialysis.

Haemodialysis is often performed via repeated needling of a surgically created arterio-venous fistula (AVF), but over time, many initially high-flow AVFs narrow or even fail.

Monitoring AVF patency (effective blood flow) is essential to predicting AVF failure and initiating preventative measures to ensure dialysis can be continued. Current methods of monitoring fistula patency, such as via stethoscope, are often unsophisticated and subjective.

This study will test a new device for objective monitoring of fistula patency; a small accelerometer sensor encased in heat-shrink plastic with a microcontroller module to send signals to a computer via USB. This device has the potential to provide a more accurate and lower cost assessment of fistula patency and better prediction of fistula failure and, therefore, improved scheduling of preventative treatment.

HAVSE is based on a concept created by RPH surgeon Dr Patrik Tosenovsky, who heard about the use of accelerometers in the mining industry and noted their potential application to solving a real problem for patients and the staff treating them. Taking an idea such as this from concept to reality is a huge challenge. For this project, Dr Tosenovsky and his team are partnering with RPH Nephrologists and external collaborators in engineering and software development to see the idea translate to improved outcomes for dialysis patients.

Nephrologist, Clinical Professor Mark Thomas, said “it is exciting to see if modern technology can help long-standing clinical problems. I hope we can develop a simple fistula tester that makes life easier for dialysis patients and nurses”.

2018-19 research snapshot

Research in EMHS was supported by grants and funding from universities and not-for-profit collaborative research groups to the total of **$940,000.**

Industry clinical trials commencing in 2018-19 have been funded to the tune of **$6.1 million.**

New research studies

Investigator-initiated studies conducted by EMHS staff

New clinical trials of drugs and medical devices

Studies conducted in collaboration with WA universities

Risk management

EMHS has an active culture of risk management, which is embedded within clinical and corporate systems and is monitored through an integrated enterprise risk management system.

EMHS has an active culture of risk management, which is embedded within clinical and corporate systems and is monitored through an integrated enterprise risk management system. The EMHS Risk Management Policy and framework describes the governance of risk within EMHS. The assessment of risk impact is supported by the EMHS Risk Appetite Statement and the WA Health Integrated Clinical and Corporate Risk Analysis Tables.

Sound risk awareness ensures risks are identified from all functional areas and tiers of the organisation. In addition to improving systems for the identification of risk, during 2018-19 a number of targeted risk workshops have been held with frontline staff and executives on emerging risk areas. This has supplemented existing risk identification processes, while also providing a valuable perspective to the level of risk in new and emerging areas.

Doing the right thing

The embedding of the Enterprise Risk Management System has continued to strengthen the monitoring and oversight of risk within EMHS. In addition to regular management review and board oversight of risks in accordance with the risk management policy, a number of bespoke risk reports have been tailored for use by subject specific committees and working groups. This ensures that risks remain contemporary and are considered in all aspects of business decision making.

The EMHS Board and Executive have further refined planning in relation to EMHS strategic risks, focusing on emerging risks, opportunities and threats. This dedicated process of review for strategic risks provides the framework for management to consider the broader strategic risks in the management of business operations and for resulting actions to be reported back to the Board.

Over the next year EMHS plans to undertake an independent maturity assessment of its risk function. Risk training is also a priority, with a risk capacity assessment to be undertaken and a risk management for managers training module to be developed.

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 clinical incidents

During 2018-19, 151 990 patients were admitted to EMHS hospitals. In addition, 209 637 patients were seen in our EDs and another 560 849 patients were seen in an outpatient clinic or setting.

As a testament to 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 2018-19 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 2018-19, there were 122 clinical incidents reported with a Severity Assessment Code rating of '1' (SAC1). 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 is a decrease compared with 155 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.

Of the 122 serious incidents, the patient outcome[1] was noted as:

Total in brackets indicates 2017-18 comparison

[1]The outcome does not necessarily arise as a direct cause of the incident. Factors other than healthcare-related may have contributed to the patient's outcome.

Copeland's Risk Adjusted Barometer (CRAB)

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.

To assist in the monitoring of the quality of care and patient outcomes, EMHS launched the Copeland's Risk Adjusted Barometer (CRAB) platform in 2019, which is a web based quality improvement system that measures patient outcomes, adjusted for the clinical complexity of every patient treated. EMHS is the first health service in Australia to implement this innovative program as part of our continued investment in tools to support our clinicians to monitor clinical outcomes and identify learnings and opportunities for improvement in a proactive way.

Case Study

Learning from a SAC1 Incident

Situation:
A 66 year old patient was admitted to hospital through the ED and was noted to develop a fever on day three of their admission. The source of the fever was unknown. Blood tests revealed that the patient had developed a blood-stream infection.

Clinical incident:
An investigation of the patient's infection discovered that the likely source of the infection was the intravenous cannula; the device that was inserted into a vein in the patient's arm, which had been used to give medications and fluids to the patient.

Contributory factors:
The panel determined that the level of adherence to aseptic technique (including hand washing) during the insertion of the intravenous cannula increased the likelihood of bacteria being introduced during the intravenous cannula insertion.

The panel also found that the level of documentation associated with the insertion and management of the intravenous cannula affected the ability of staff to remove the intravenous cannula at the earliest sign of infection.

Together these two contributing factors may have increased the likelihood of the blood stream infection occurring.

Recommendations:
The incident led to a review of the level of staff compliance with training and procedures to ensure that staff were applying the correct infection control techniques when inserting intravenous cannulas.

The hospital is implementing ways to ensure that intravenous cannulas are only being put into patients when they are absolutely necessary for clinical care and that they are removed as soon as they are no longer needed.

In addition, the hospital is considering ways to empower patients to ask their treating team whether their intravenous cannula is necessary.

Lessons learned:
All areas that care for patients must apply best practice techniques when putting in intravenous cannulas or similar devices and levels of training and practice should be monitored regularly. Patients should be empowered to ask questions of their treating team about their care and treatment.

For more information visit emhs.health.wa.gov.au/Patient-Care/Safety-and-Quality/Learning.

Our staff

The 8393 staff working within EMHS are our greatest asset, and are integral to achieving our vision of healthy people, amazing care.

The safety, wellbeing and development of staff throughout the organisation is of the utmost importance. EMHS has a dedicated team of education staff who provide training and support for evidence-based practice, organisational learning and development, clinical audit and service improvement. EMHS staff are provided with access to a range of development opportunities including leadership programs and the innovative NEXUS program, which provides human performance training in non-technical skills such as teamwork, situational awareness and error management.

The commitment and dedication of high-performing staff is also recognised through internal staff recognition programs, including the AKG Extra Mile Awards and the RPBG Above and Beyond Awards, Outstanding Service Awards, and Nursing and Midwifery Awards.

Attracting, retaining and recruiting Aboriginal staff members also forms a key focus of the EMHS Aboriginal Health Strategy team. A dedicated Aboriginal Workforce Engagement Group includes representation from 44 staff members from across all areas of the health service. This group provides a network and communication forum through which information and feedback is shared.

In early 2019, an Aboriginal Workforce Engagement Event was held to celebrate the diverse knowledge, skills and culture of our Aboriginal staff members. EMHS continues to look at opportunities to build our future Aboriginal workforce, and provides a range of different career pathways including internships, traineeships, cadetships and graduate programs.

During 2018-19, EMHS maintained its focus on staff support, with a range of initiatives including a greater focus on family and domestic violence leave and workplace support; the launch of the Centre for Wellbeing and Sustainable Practice at RPH along with dedicated wellbeing programs at AKG and RPBG, and targeted programs such as the Doctor's Wellbeing Program.

This continued focus on staff support and wellbeing was recognised in a 2018 hospital-wide accreditation conducted by the Postgraduate Medical Council of Western Australia, who surveyed 31 departments and services across RPH. The hospital was commended for the positive transformation in organisational culture over the preceding three years and noted the positive impact of the Doctor's Wellbeing Program. During 2019, RPH also received the highest number of intern applications in WA, with 102 applications received for 87 positions. The hospital has been oversubscribed for first preference placements since 2018, and continues to perform well against peers with regards to staff morale and wellbeing.

A system-wide staff engagement survey was conducted in 2019, with results anticipated early in the 2019-20 financial year. The Your Voice in Health survey provides a platform for staff to share their opinions about their workplace. Feedback from this survey will be used to inform strategies to make improvements to the workplace, and as a result, improve services for patients, employees and the community.

Staff profile

As of 30 June 2019, EMHS employed a total of **8393** staff (individual staff head count), or **6297** full time equivalent (FTE).

Total in brackets indicates 2017-18 comparison

Please see important note on page 236 about EMHS staff

Junior Doctors Wellbeing Program

The cover of the May 2019 edition of the Australian Medical Association's (AMA) Medicus magazine said it all – "Junior doctor wellbeing has come a long way in the last few years, but Royal Perth Hospital seems to be a cut above".

The cover alluded to the success enjoyed by RPH in the annual public release of its "Hospital Health Check" report for 2019.

As AMA (WA) Doctors in Training Co-Chair, Dr Rebecca Wood, highlighted in her Medicus article, RPH yet again scored an 'A' in 'morale and culture', as it did in the 2018 survey.

"RPH has once again outshone its public hospital counterparts in the North and South Metropolitan Area Health Services with a glowing result for 'Morale & Culture' (A) and a solid showing for 'Wellbeing' (C)," Dr Wood wrote.

For RPBG Executive Director, Dr Lesley Bennett, the score was evidence of the high priority herself, her predesessor, Dr Aresh Anwar, and the overarching EMHS Board and Executive place on Junior Doctor Wellbeing.

"The bottom line is that junior doctors are absolutely essential for the day-to-day functioning of the hospital and that recognition is why we prioritise investment in training and nurturing every doctor within RPBG," Dr Bennett said.

"Everything we do to help them – from high-quality teaching to carefully programmed mentoring or simply having someone available for them to talk to and keep check of their personal wellbeing – it's all designed to provide a supportive environment and deliver job satisfaction."

"We know if our doctors feel safe and supported at work, it provides the right environment to provide the best care we can for our patients – to deliver what matters most to them and with the best clinical outcomes."

Valuing our staff

The Doctors Wellbeing Program – launched in January 2017 - is one such resource, specifically designed to support staff with voluntary attendance steadily increasing since its inception.

The much praised program fits within the Centre for Wellbeing and Sustainable Practice which was launched early in 2019, and brings together the pastoral care service for patients, its associated chaplaincy training unit and the wellbeing program for doctors.

EMHS celebrates our award-winning staff

During 2018-19, a significant number of staff and programs were recognised in a variety of high profile award programs for significant achievements within their field.

- **Dr Sudhakar Rao,** recipient of the General Surgeon's Australia Excellence in Teaching WA Award.
- **Professor Daniel Fatovich,** who was awarded the prestigious 2018 Edward Brentnall Award by the Australasian College for Emergency Medicine for co-authoring a paper on Alcohol Related Harm in ED.
- The **RPBG Peripheral Parenteral Nutrition team** and the **SJGMPH Advanced Scope Physiotherapy team,** who each won awards in the 2018 Rotary Allied Health Team Excellence Awards.
- The **SJGMPH Emergency Department team** who were awarded the 2018 Australasian College for Emergency Medicine Wellbeing Award.
- **Professor Wendy Cheng,** winner of the 2018 Gastroenterological Society of Australia Outstanding Clinician Award.
- The **Mental Health Co-Response team**, winners in both the 2018 WA Health Excellence Awards and WA Police Excellence Awards.
- **RPH** for receiving the 2018 Defence Reserve Support Council's Employer Support Awards.

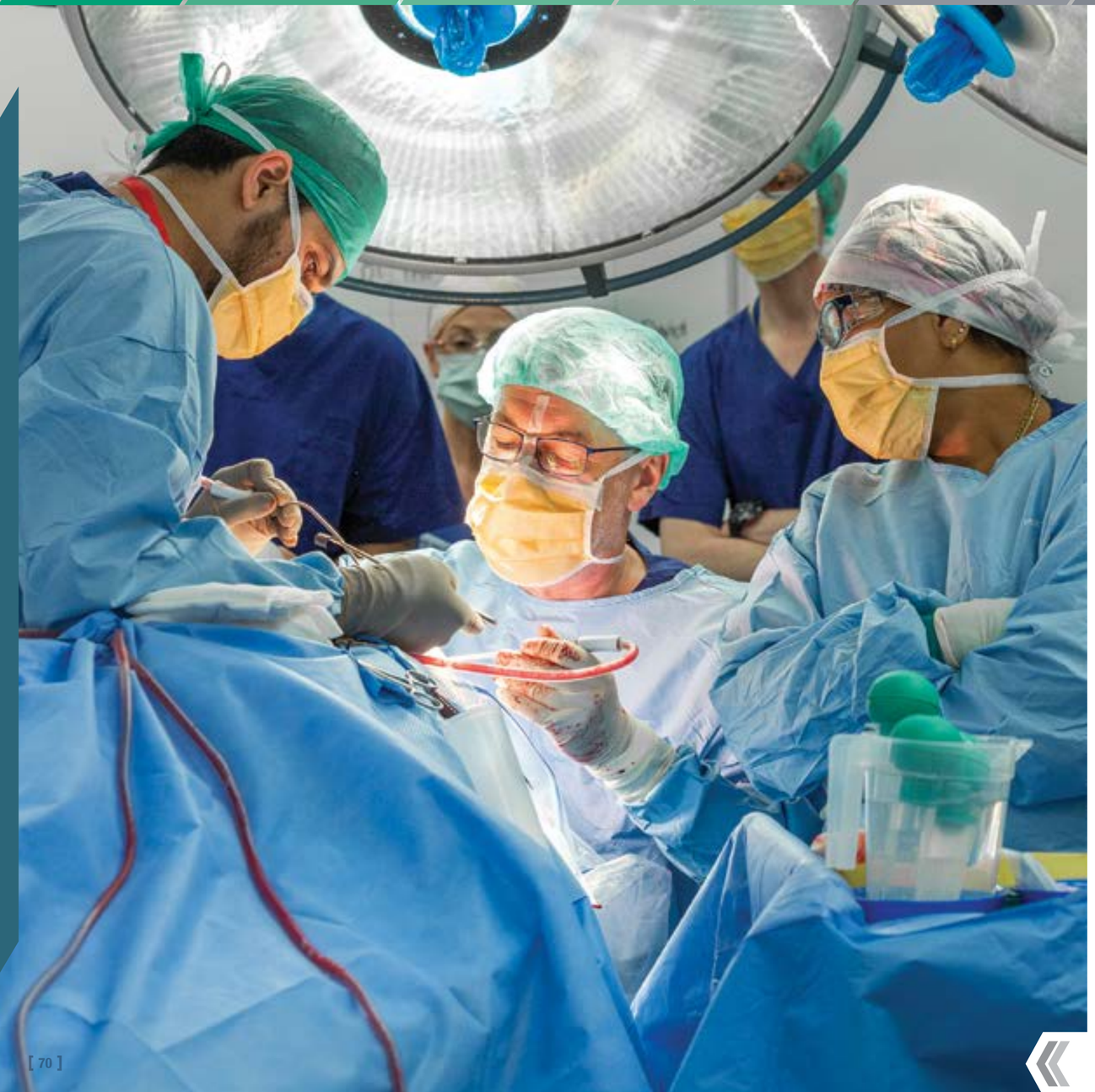
Dr Nick Waldron, winner of the Jill Porteous Memorial Award for Quality and Safety in the WA Health Excellence Awards.

Photo courtesy of Department of Health

- The **RPBG Safety After Hours for Everyone 'SAFE' Initiative** and the **Junior Doctors Wellbeing Program,** who were each recognised as highly commended in their categories at the 2018 Australian Council on Healthcare Standards (ACHS) Quality Improvement Awards (see page 67).
- **Dr Lucy Kilshaw,** recognised as the 2018 WA and National Clinical Educator of the Year by the Confederation for Postgraduate Medical Education Councils.
- The **Yarning It Up, Don't Smoke It Up team,** who were recognised for their role in the WA Aboriginal Tobacco Control Strategic Leadership Team, which was awarded the 2018 Australian Council on Smoking and Health's Bob Elphick Award.
- **RPH Respiratory Medicine department,** who received a research excellence award from the Thoracic Society of Australia and New Zealand for 'Best Training Video' for their Strong Wulyan (Strong Lungs) program. The video was a collaborative project with the EMHS Aboriginal Community Health team and provides a simple demonstration of what is involved in diagnostic respiratory testing to improve understanding of what to expect for our Aboriginal patients. For more information visit emhs.health.wa.gov.au/Hospitals-and-Services/Aboriginal-Health/Service-Collaboration.
- **Nick May,** who received a Health Round Table Innovation Fellowship for his Take 5 education series.
- The **Centre for Wellbeing and Sustainable Practice,** who were announced as the winner of the 2019 Best of Care Award – Outstanding Team, at the Spiritual Care Australia Conference.

Ellie Newman and the RPBG Forget Me Nots, who were awarded the inaugural 2019 Health Round Table Innovation Award for accelerating innovation through collaboration (see page 56).

EMHS also congratulates the many staff members who were recognised as finalists in a number of prestigious award programs throughout the year.



Putting on a new thinking cap

Recognising our ongoing focus on intellectual curiosity, a team of talented engineers and scientists from EMHS progressed to the final round of the *2018 WA Innovator of the Year Awards.*

The team of Dr Alan Kop and Dr David Morrison from the Health Technology Management Unit, Dr Marian Sturm from Cell and Tissue Therapy WA and Mr Stephen Honeybul from RPH's Department of Neurosurgery, competed with four other finalists in the *Emerging Innovation Category* of these prestigious awards.

The recognition came after the team collaborated on an exciting new research program. The program involves a clinical trial to explore how tissue engineering can be combined with the power of stem cells and advanced manufacturing techniques to re-grow bone.

Intellectual curiosity

Following a serious accident, a person may develop life threatening brain swelling. To save the person's life and prevent further brain injury, a large piece of the skull is removed to allow the injured brain to freely expand. Historically this piece of skull is then replaced by the patient's now dead bone or an artificial material, both of which are known to cause common complications such as infection.

In this trial, the team are undertaking a clinical trial to re-grow a patient's skull bone by combining stem cells with specially formulated 3D-printed ceramic scaffolds. The ceramic scaffold would replace the piece of skull bone that has been removed. As the patient's bone slowly regenerates, the ceramic scaffold dissolves, and leaves the patient with their own skull bone.

This innovation is ground-breaking, as it aims to show that the team could one day reconstruct a person's skull after they have had cancer surgery or serious accident by re-growing their own bone.

Being recognised as a finalist in this important award was an honour for the team. EMHS is incredibly proud to be supporting this excellent example of collaboration and innovation.

For more information visit emhs.health.wa.gov.au/News/2019/05/Putting-a-new-thinking-cap-on.

A snapshot of our staff

Age ranges of our staff:

11	staff are under 20 years of age
1331	staff are between 20-29 years of age
2084	staff are between 30-39 years of age
1925	staff are between 40-49 years of age
1817	staff are between 50-59 years of age
1119	staff are between 60-69 years of age
106	staff are over 70 years of age
44	average age of staff (years)

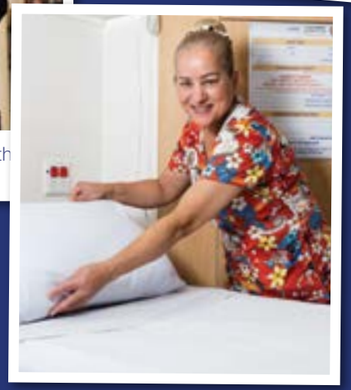
Years of service:

We are proud of our 8393 staff, who within WA Health have served:

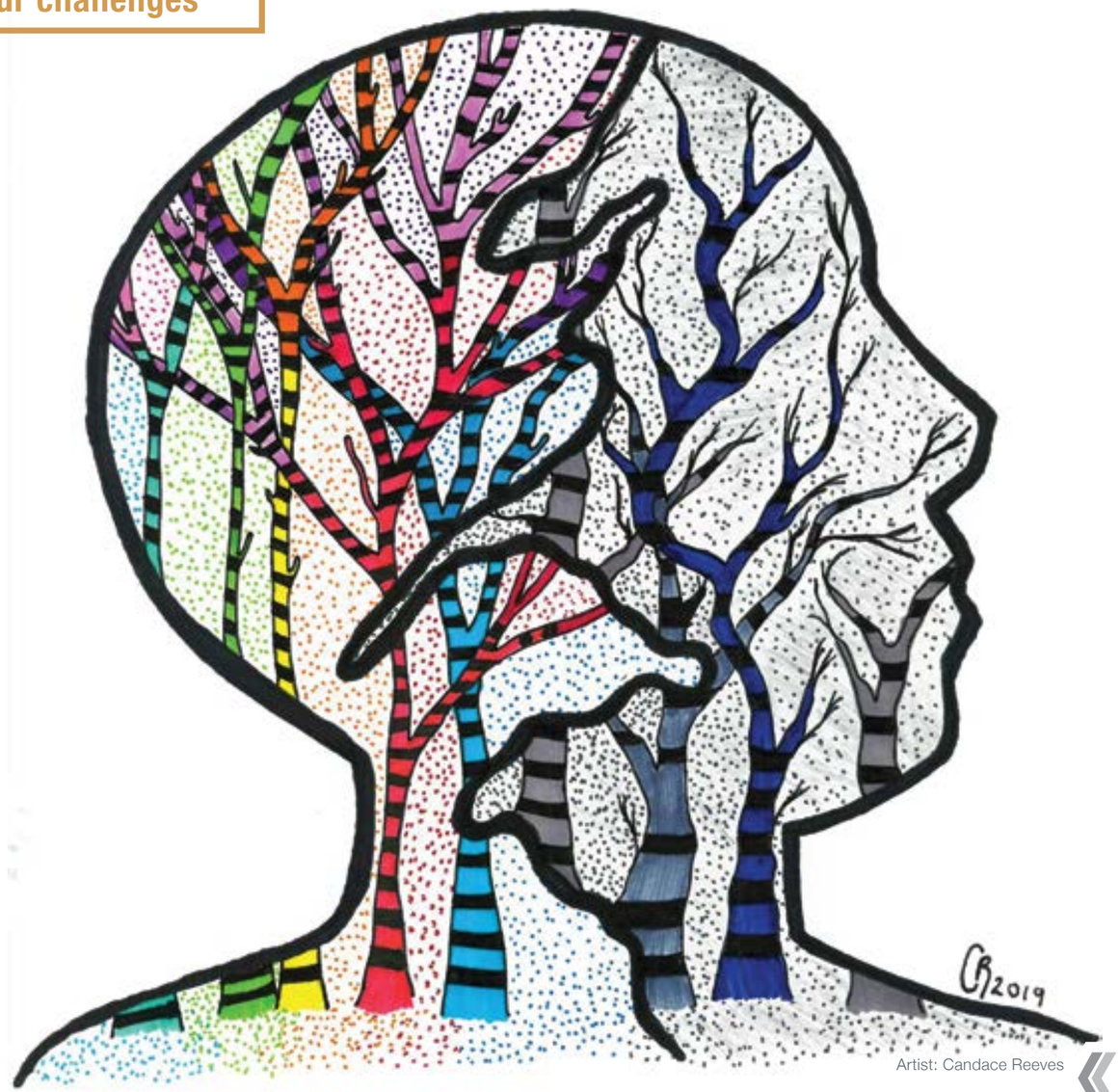
- <10 YEARS: **6433** STAFF
- 10-19 YEARS: **1347** STAFF
- 20-29 YEARS: **398** STAFF
- 30-39 YEARS: **182** STAFF
- 40-49 YEARS: **31** STAFF
- > 50 YEARS: **2** STAFF

MORE THAN **475** VOLUNTEERS

We are supported by wonderful volunteers who donate th time to contribute to our patients' healthcare journey



Our challenges



Artist: Candace Reeves

Staff safety

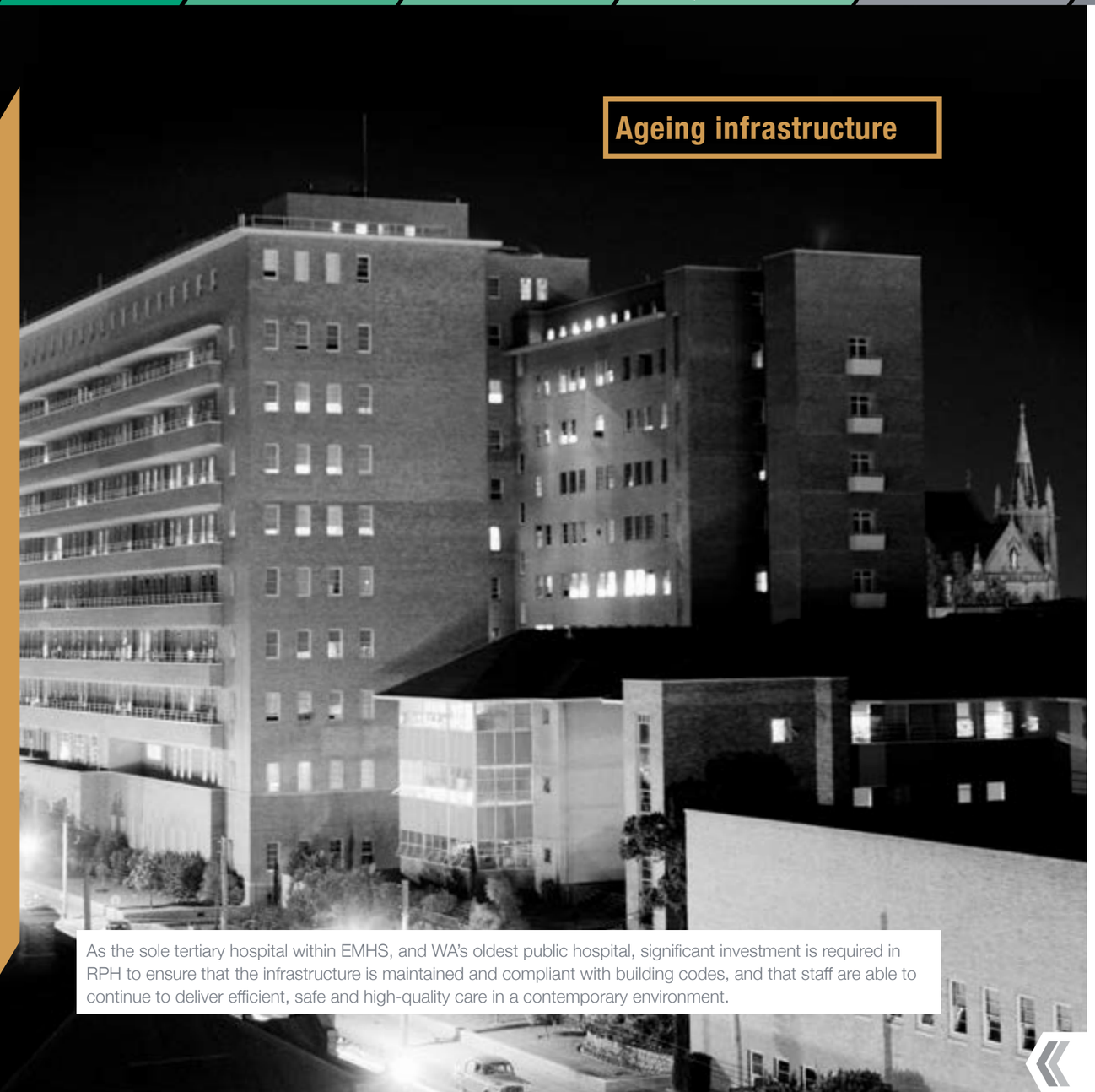
Protecting our staff from violence and aggression in the workplace continues to remain a high priority across all EMHS sites, with 7543 aggressive incidents reported by EMHS staff during 2018-19. This represents an increase when compared with previous years, with 6994 aggressive incidents reported in 2017-18.

Aggressive incidents refer to situations where staff members felt threatened, duress alarms were activated, violent altercations occurred, verbal or physical abuse was experienced or self-harm attempts or threats were made.

Strategies employed via the EMHS Stop the Violence Committee to address these increasing incidents of violence and aggression included stronger engagement with WA Police to specifically address issues around handover of patients between Police and hospitals; a public information campaign to educate patients and visitors that aggression is not tolerated within our hospitals; increased staff education and training; a stronger focus on encouraging staff reporting of incidents; and improved security measures such as CCTV, duress alarms and procurement of slash-proof vests.

While we have done a lot of work in this space, there is still a lot of work yet to be done, both within EMHS and more broadly across the health sector. EMHS is working in partnership with other HSPs and key stakeholders on a system-wide strategy to better protect our staff against incidences of violence and aggression in the workplace.

Ageing infrastructure



As the sole tertiary hospital within EMHS, and WA's oldest public hospital, significant investment is required in RPH to ensure that the infrastructure is maintained and compliant with building codes, and that staff are able to continue to deliver efficient, safe and high-quality care in a contemporary environment.

The significant maintenance and ongoing investment required to support our ageing infrastructure continues to remain a challenge for EMHS.

Royal Perth Hospital

A priority for the coming year will be the development of a detailed business case to scope options to redevelop the inner city campus into a consolidated, modern health, teaching and research campus. $22.7 million has been allocated for a significant upgrade of the RPH Intensive Care Unit (ICU), which will assist in improving the patient experience through larger patient areas, more single patient rooms, a dedicated area for distressed relatives, and new storage and drug preparation areas.

Doing the right thing

Development of a dedicated Mental Health Emergency Centre (MHEC) and planning towards a new authorised Mental Health Unit at RPH continued throughout 2018-19, with the MHEC scheduled to open in late 2019. Planning for a MHEC at SJGMPH is also underway.

Planning is also underway for construction of a new helipad at RPH to replace the existing helipad. The new helipad is anticipated to be operational towards the end of 2021, and will have capacity to receive larger rescue helicopters and be compliant with new Civil Aviation Safety Authority regulations.

Bentley Hospital

At BH, there are a number of critical infrastructure and maintenance works required which include replacement/repair of roofs, upgrading electrical items and replacement of plant equipment which is nearing end-of-life. $7.3 million was allocated in the 2019-20 State Budget to address high-priority works however further investment is still required at BH for the refurbishment of clinical areas including maternity, mental health and rehabilitation.

Armadale Kalamunda Group

Within AKG, a number of works were completed during 2018-19 including development of a new purpose-built neonatal nursery; a new staff lounge and central equipment store; a staff room and medication room in the Medical Admissions Unit; upgrades to the lifts at AH, and a replacement of the Private Automatic Branch Exchange (PABX) telephone system at both AH and KH. As part of the 2019-20 EMHS Minor Works Program, additional office and storage space will be built for Pharmacy staff at AH. At KH, a refurbishment to the main reception area; new air-conditioning installation; electrical system improvements; a new hot water system and upgrades to the hospital roof have been completed.

$7 million has also been allocated to addressing outstanding fire risk mediation works identified by external Fire Safety Audits across RPH, AHS and BH. The works required include upgrading fire detection, sprinkler systems, hydrants, exit, fire doors, emergency lighting and occupant warning systems. A large amount of work has already been undertaken at hospital sites across EMHS to reduce fire risks, and the additional funding is to continue that work and ensure all potential fire risks are remediated.

A project to install a medical-grade wi-fi network across EMHS commenced in 2018, with the first round of deployment anticipated in 2020 to critical service areas. Once fully installed, the wi-fi network will enable flexibility in accessing both clinical and corporate systems for staff and our community.

Work continues on a Strategic Asset Management Plan across EMHS which identifies building assets, plant, biomedical equipment and departments that require consideration for a planned replacement/upgrade during the next ten years.

Demand

EMHS continues to concentrate on ensuring that our services are delivered in the most appropriate setting, within clinically appropriate timeframes and within purchased activity levels. Our focus is always to prioritise those most in need and ensure equity of access and culturally appropriate care is provided for all our patients.

During 2018-19, EMHS services continued to receive increased levels of demand, with:

209 637 people treated in our EDs

151 990 inpatients admitted to our hospitals

4750 babies born in our hospitals

52 093 operations performed in our hospitals

226 306 occasions of service in community mental health services.

Emergency access

EMHS closely monitors performance against the WA Emergency Access Target (WEAT) which requires that 90% of all patients presenting to a hospital ED are seen and admitted, transferred or discharged within four hours.

Across EMHS, sites with an ED (RPH, SJGMPH and AH) monitor and manage their WEAT performance on a daily, weekly and monthly basis, and a range of strategies are in place to improve performance and ensure timely, equitable access for all emergency patients. While some improvements have been made in WEAT performance during the past few years, the ongoing demand for access to emergency services has proven to be challenging to all EDs across EMHS.

EMHS recognises that WEAT solutions expand beyond emergency and increased attention has been placed on hospital wide systems and community pathways. Sustainability is reliant on collaborative agreements to create capacity through safely and effectively moving patients through their health care journey. In late 2018, as part of a broader program of work encompassing a range of improvement strategies, EMHS commissioned an independent review into patient flow and experience through RPH and AH from admission to discharge.

Recommendations from this review are being worked through and implemented by both sites.

AH for instance, has achieved notable improvements in WEAT performance by implementing eight evidenced based solutions identified in the review. A key strategy has seen the hospital leadership team working collaboratively at a daily 'safety huddle'. The focus is on safety and quality with an emphasis on patient experience. Solutions are identified in partnership with Executive and Clinical Leadership teams. Similarly, RPH continues to work on strategies to improve WEAT performance and reduce ambulance ramping, with a particular focus on improving the flow of patients through the hospital and strengthening the use of ambulatory care models designed to stream appropriate patients from ED into non-admitted pathways.

In 2018-19 EMHS continued to achieve the target for triage category one, two and five. We recognise there has been a decrease in performance to target for triage category three and four. This will continue to be an area of focus for strategies to improve WEAT performance in 2019-20.

1 **TRIAGE:** Immediately life-threatening
TREATMENT: Immediate (within 2 minutes) — 100%

2 **TRIAGE:** Imminently life-threatening
TREATMENT: Within 10 minutes — 80%

3 **TRIAGE:** Potentially life-threatening, important time-critical treatment required or severe pain
TREATMENT: Within 30 minutes — 75%

4 **TRIAGE:** Potentially life-serious, situational urgency or significant complexity
TREATMENT: Within 60 minutes — 70%

5 **TRIAGE:** Less urgent
TREATMENT: Within 120 minutes — 70%

Triage category 1

2017-18	2018-19
TARGET 100%	TARGET 100%
ACTUAL 100%	ACTUAL 100%

Triage category 2

2017-18	2018-19
TARGET 80%	TARGET 80%
ACTUAL 84%	ACTUAL 81.3%

Triage category 3

2017-18	2018-19
TARGET 75%	TARGET 75%
ACTUAL 47.1%	ACTUAL 37.6%

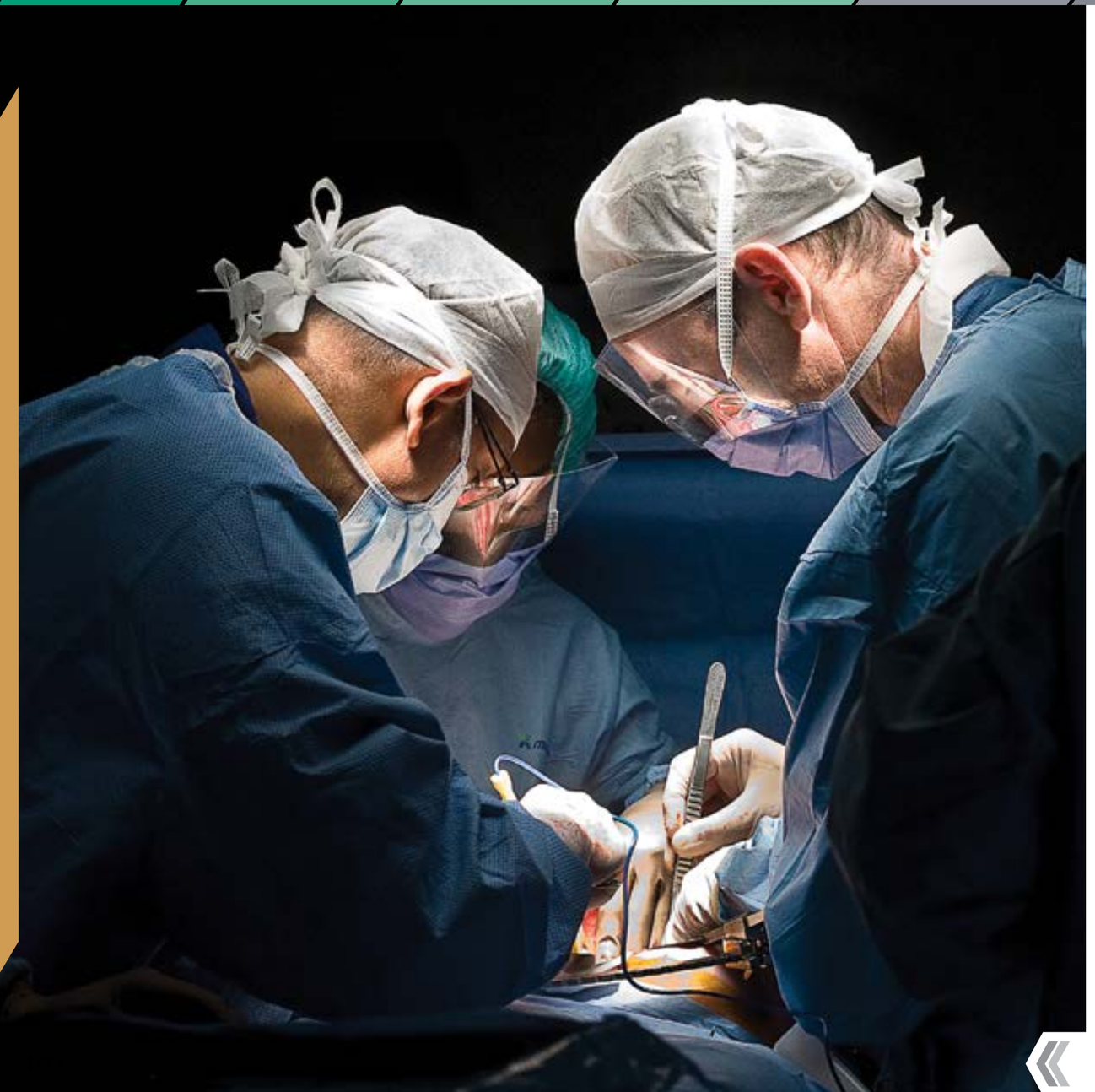
Triage category 4

2017-18	2018-19
TARGET 70%	TARGET 70%
ACTUAL 64.9%	ACTUAL 58.5%

Triage category 5

2017-18	2018-19
TARGET 70%	TARGET 70%
ACTUAL 93.1%	ACTUAL 89.9%

Data period: 2017-18 and 2018-19 financial years.
Data source: Emergency Department Data Collection.



Elective surgery

EMHS continues to target reducing elective surgery waitlists and monitors performance against the WA Elective Services Target (WEST), which aims to ensure timely and equitable access to public elective surgery services.

The WEST indicator refers to the percentage of cases on elective surgery waitlists where the patients wait longer than the clinically recommended time for their procedure (i.e. over boundary) according to their urgency category. The WEST targets are:

- Category 1 patients are clinically identified as requiring surgery within 30 days from time of request
- Category 2 patients are clinically identified as requiring surgery within 90 days from time of request
- Category 3 patients are clinically identified as requiring surgery within 365 days from time of request.

In November 2018, EMHS launched its WEST Action Plan recognising the increasing demand on the elective surgery wait list (ESWL) across all categories. As at the end of the 2018-19 financial year, the EMHS over-boundary waitlist was the lowest it had been in 12 months, with 357 over boundary cases recorded as at 30 June 2019, with particular improvement demonstrated for Category 2 cases.

Strategies employed to reduce the ESWL included scheduling additional 'twilight' 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 sooner.

Within the specialty of plastic surgery, considerable improvement has been made to reduce over boundary cases through the scheduling of additional theatre lists and the allocation of some RPH surgeons to perform plastic surgery at AH. To facilitate surgery for patients who have been waiting greater than 500 days, EMHS has commenced transferring appropriate patients from RPH to BH for their procedures.

A significant program of work has been undertaken to distribute the gastroenterology waitlist equitably across EMHS. Cases have been redistributed from RPBG to AKG, with increased endoscopy theatre lists implemented at both AH and KH to manage the additional demand. The urology waitlist continues to remain a challenge, in part due to a shortage of appropriately skilled urology consultants, however additional theatre lists have been scheduled to help address this issue.

EMHS is working to strengthen the outpatient referral criteria across all surgical specialties with tightened inclusion and exclusion criteria to ensure patients are appropriately categorised for review according to the urgency and complexity of their condition. More broadly, EMHS is also investigating a longer term strategy of postcode redistribution for outpatient referrals to assist in maintaining a sustainable ESWL across EMHS. Strategic priorities are focused on ensuring elective services are appropriate and provided in a timely way at a service as close to home as possible.

Mental health patient flow

All persons requiring mental health services deserve timely and efficient access to the best possible care.

In WA, the demand for mental health beds is high, with long waits for inpatient admission often experienced and this is known to contribute to the deterioration of the wellbeing of patients.

In EMHS bed occupancy rates for mental health inpatient units consistently exceed 95%, and for every bed vacated there is an admission waitlist.

Patient flow describes the processes involved in the movement of patients along a pathway of care. For mental health patients, this can include their care in the community as well as to and from emergency departments and inpatient units.

The new model for mental health patient flow provides WA health services with strengthened local accountability.

When patient flow works well, and there are no supply/demand issues, patients move through the stages of care with minimal delay. When there is a problem with patient flow, for example, when a patient is waiting in the ED for an inpatient bed to be available for them, these problems can cause significant delays and inconvenience for the patient.

During 2018-19, EMHS led the Mental Health Patient Flow Steering Committee to implement the new statewide mental health model to better manage patient flow. The new model applies to the coordination of the referral, admission, transfer and discharge of all public mental health patients, 16 years or older, from any location to inpatient care, including private providers of public mental health inpatient services in WA.

The new model for mental health patient flow provides WA health services with strengthened local accountability while also being able to provide a response at statewide level, where clinical need is assessed to determine prioritisation for mental health admission.

Improving mental health patient flow to deliver more efficient, safe and timely access to the best possible care required a significant amount of work and collaboration across all the health service providers, including EMHS.

The program of work completed included:

- standardising the bed management processes across mental health services
- embedding routine review of available beds and capacity making strategies to better adapt during times of peak demand
- clarifying the function, roles and responsibilities in the system for mental health beds through development and implementation of policy and reporting systems
- developing escalation pathways within health services and to a statewide response level if required
- establishing a Statewide Mental Health Medical Director as the senior decision maker when patient flow pathways cannot be resolved at the local level
- implementing health service and statewide performance indicators
- creating a dashboard which collates near-live data from existing WA Health software applications to enable greater visibility and an enhanced ability to monitor mental health bed demand and availability across the system.

EMHS is committed to maintaining a system-wide perspective for bed capacity and demand, and assisting to negotiate transfers and create capacity by working in partnership with other health services.

Integrity, fraud and corruption

As part of a significant program of work across WA Health into integrity, fraud and corruption, in 2018-19 EMHS launched a project focused on reinforcing our service delivery principle of doing the right thing.

This project focused on three main areas of detection, prevention and reporting, which included a range of actions such as audits, strengthening of policy and processes, and enhanced communication, education and training.

A series of audits were conducted into:

- EMHS procurement, contract management and contract variation practices.
- Fraud and corruption controls.
- Procurement and contracts under $50,000.
- Pharmacy procurement and contract management practices.
- Conflict of interest, travel, secondary employment and staff leave.

Doing the right thing

Following these audits, two new resources were developed for staff – the EMHS Fraud and Corruption Control Plan, and the EMHS Procurement and Contract Management Manual.

EMHS also put in place a number of measures to help prevent misconduct and poor behaviour, including enhanced education and training for staff about procurement processes and responsibilities; improved induction processes; promotion of pathways to support suspicions of misconduct; and establishment of a Fraud Hotline for staff and members of the community to report suspected fraud within EMHS.

Efforts to build a culture within the health service where all staff can feel comfortable voicing their concerns and reporting suspicions of misconduct is ongoing. Work conducted to date includes a survey of staff to understand how we can better recognise and respond to potential misconduct; a communications campaign about misconduct processes and how to report suspicions of misconduct; communication with staff and contractors about our gifts policy; and a stronger focus on integrating the EMHS values with particular attention on integrity and accountability.

East Metropolitan Health Service

Key Performance Indicators

Certification of KPIs

East Metropolitan Health Service

For the year ended 30 June 2019

We hereby certify the key performance indicators are based on proper records, are relevant and appropriate for assisting users to assess the East Metropolitan Health Service's performance, and fairly represent the performance of the East Metropolitan Health Service for the financial year ended 30 June 2019.

Suzie May
Acting Board Chair
East Metropolitan Health Service
18 September 2019

Peter Forbes
Chair, EMHS Board Finance Committee
East Metropolitan Health Service
18 September 2019

Photo courtesy of St John of God Midland Public Hospital

Audit opinion

Please see the full audit opinion in the financial statements section on page 112.

Outcomes

Key performance indicators (KPIs) assist EMHS to assess and monitor achievement of the following Department of Health outcomes:

1 Outcome one

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

2 Outcome two

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

See page 28 for additional information on outcomes.

KPI data legend

Please note the following for KPI data:

UNDESIRED RESULT

DESIRED RESULT

* 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.

Outcome 1

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

Rationale

Higher hospital readmission rates may be the result of patients being discharged prematurely and/or ineffective discharge planning and communication. Many unplanned hospital readmissions are associated with the original reason for hospitalisation. These readmissions necessitate patients spending additional periods of time in hospital as well as utilising additional hospital resources.

Readmission rate is considered a global performance measure, as it potentially points to deficiencies in the functioning of the overall healthcare system. Along with the provision of appropriate interventions, good discharge planning can help to decrease the likelihood of unplanned hospital readmissions by providing patients with the care instructions they need after a hospital stay and helping patients recognise symptoms that may require medical attention.

The surgeries selected to be measured by this indicator are based on the seven surgery types in the current National Health Agreement Unplanned Readmission performance indicator (NHA PI 23).

Target

The table below outlines the 2018 target for each surgical procedure. Improved or maintained performance is demonstrated by a result below or equal to the target.

Surgical procedure	2018 target (per 1000)
knee replacement	≤26.2
hip replacement	≤17.2
tonsillectomy & adenoidectomy	≤61.0
hysterectomy	≤41.3
prostatectomy	≤38.8
cataract surgery	≤1.1
appendicectomy	≤32.8

Results

East Metropolitan Health Services (EMHS) strives to provide safe, high-quality care to its patients at all times. In 2018, EMHS has performed well against the target for three of the seven selected surgical procedures. Where performance has not met the target, case review has been undertaken by clinicians to ascertain service improvement opportunities.

Performance for knee replacement and appendicectomy continues to achieve target. In addition, improvement in performance has been demonstrated in 2018 for hysterectomy readmissions, when compared with 2017. Although a significant achievement, this indicator is representative of very small numbers of cases, being three readmissions from a total of 118 surgeries.

EMHS continues to monitor and address performance for tonsillectomy and adenoidectomy and instances of readmission is subject to peer review as part of a morbidity and mortality review process. Case review has demonstrated that patients are often readmitted as a precaution and for observation and follow up of minor symptoms following surgery.

Performance for cataract surgery was slightly over target for the second year in a row. A process of review by clinicians has demonstrated that patients are often readmitted for symptoms or conditions that are not necessarily related to their initial surgery. A conservative approach to readmission is undertaken with patients admitted for observation for short periods of time.

While the performance for prostatectomy in 2018 has not achieved target, case review has not identified any significant trends or concerns. Rates will continue to be monitored closely for improvement opportunities.

Similarly, review of episodes of readmission following hip replacement has not identified any significant trends, noting performance represents 11 cases across three hospitals from a total of 426 surgeries.

Knee replacement

Prostatectomy

Hip replacement

Cataract surgery

Tonsillectomy and adenoidectomy

Appendicectomy

Hysterectomy

EMHS contributing sites: Armadale Hospital, Bentley Hospital, Kalamunda Hospital, Royal Perth Hospital and St John of God Midland Public Hospital.

Data period: 2016, 2017 and 2018 calendar years.

*Please note: 2016 data only includes the period from 1 July 2016 to 31 December 2016.

Data source: Hospital Morbidity Data Collection (HMDC), WA Data Linkage System.

Outcome 1

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

Rationale

Elective surgery refers to planned surgery that can be booked in advance following specialist assessment that results in placement on an elective surgery waiting list (ESWL).

Elective surgery wait lists should be actively managed by hospitals to ensure fair and equitable access to the limited elective services available within the public health system.

Elective services delivered in the WA health system are those deemed to be clinically necessary procedures, and potential negative impacts of excessive waiting times for these services include the likelihood of a worsening of the patient's condition and/or quality of life or even death. Therefore, waiting lists must be actively managed by hospitals to ensure all patients are treated in clinically appropriate timeframes. Patients are 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 statewide performance target for the provision of elective services. For reportable procedures, the target requires that no patients (0%) on the elective waiting lists wait longer than the clinically recommended time for their procedure, according to their urgency category.

Target

The 2018-19 target for patients waiting over boundary for all urgency categories is 0%. This target has not changed from 2017-18.

A result equal to target is desired.

Results

There has been a slight improvement from last year in the performance for the proportion of elective waitlist patients waiting over boundary for reportable procedures.

Initiatives employed to manage the elective surgery waitlist has included additional theatre activity in specific specialities and the redistribution of surgical activity across EMHS sites where appropriate to facilitate surgery earlier and reduce wait times. This has resulted in a considerable reduction in overboundary cases, especially in gastroenterology, through allocating the ESWL more equitably, with a significant number of cases transferred and performed at Armadale Kalamunda Group (AKG). Urology remains a challenge due to workforce shortages.

Both Royal Perth Bentley Group (RPBG) and AKG have initiated programs in their theatres with a focus on improving productivity and efficiency.

EMHS will continue its efforts in 2019-20 to embed recent gains and further improve performance. Additional lists added in 2018-19 are planned to continue in 2019-20 to reduce the number of overboundary cases.

Category 1

2016-17	2017-18	2018-19
TARGET 0% ACTUAL 24.6%	TARGET 0% ACTUAL 25.4%	TARGET 0% ACTUAL 24.1%

Category 2

2016-17	2017-18	2018-19
TARGET 0% ACTUAL 21.6%	TARGET 0% ACTUAL 22.4%	TARGET 0% ACTUAL 20.0%

Category 3

2016-17	2017-18	2018-19
TARGET 0% ACTUAL 3.7%	TARGET 0% ACTUAL 5.2%	TARGET 0% ACTUAL 4.7%

EMHS contributing sites: Armadale Hospital, Bentley Hospital, Kalamunda Hospital, Royal Perth Hospital, St John of God Midland Public Hospital.

Data period: 2016-17, 2017-18 and 2018-19 financial years (average of weekly census data).

Data source: Elective Services Wait List Data Collection (ESWLDC).

Outcome 1

Healthcare-associated Staphylococcus aureus bloodstream infections (HA-SABSI) per 10 000 occupied bed-days

Rationale

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

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

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

Target

The 2018 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

During 2018, EMHS performed favourably compared with the target for HA-SABSI per 10 000 occupied bed-days.

In addition, performance improved in 2018 when compared with 2017, with a drop in the rate of infection per 10 000 occupied bed-days.

EMHS has robust processes for the review of all potential cases of HA-SABSI by infection control specialists and staff. The identification of contributing factors related to healthcare has led to the development of recommendations for improvement. Education and training remains essential and a strong focus on practical training regarding aseptic technique continues, together with the application of guidelines for the management of invasive devices. In addition, EMHS continues to regularly audit staff compliance with hand hygiene (handwashing) practices and overall compliance rates remain above target. Infections have been shown to be linked to transmission via the hands of healthcare workers, hence good hand hygiene practice is paramount to reducing infection rates.

EMHS contributing sites: Armadale Hospital, Bentley Hospital, Kalamunda Hospital, Royal Perth Hospital.
Data period: 2017 and 2018 calendar years.
Data source: Healthcare Infection Surveillance Western Australia (HISWA) Data Collection.

Outcome 1

Survival rates for sentinel conditions

Rationale

This indicator measures 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).

These three conditions have been chosen as they are particularly significant for the health care of the community and are leading causes of death and hospitalisation in Australia. Patient survival after being admitted for one of these three sentinel conditions can be affected by many factors including the diagnosis, the treatment given or procedure performed, age, comorbidities at the time of the admission and complications which may have developed while in hospital. However, survival is more likely when there is early intervention and appropriate care on presentation to an emergency department and on admission to 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.

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 2018, EMHS exceeded targets for survival rates for stroke in all age groups. Effective clinical engagement and coordination of care between the neurology, emergency and acute medical teams continues to result in excellent survival rates for patients experiencing this condition.

0-49 years

50-59 years

60-69 years

Stroke continued...

70-79 years

80 plus years

Results

Acute Myocardial Infarction (AMI)

For 2018, EMHS exceeded targets for survival rates for AMI in four of the five age groups. Effective inter hospital transfer arrangements for the transfer of acute coronary syndrome patients from Armadale Health Service (AHS) and St John of God Midland Public Hospital (SJGMPH) to Royal Perth Hospital (RPH) for treatment continues to ensure timely access for patients to invasive coronary diagnostic and interventional procedures, leading to improved outcomes.

Despite the best interventions, patients in the 80 plus age group often present with chronic conditions and multiple comorbidities which place them at increased risk of mortality or morbidity associated with an acute cardiac event. Although slightly below target, the rate for 2018 represents the survival of 249 patients from a total of 274 patients across four EMHS hospitals.

0-49 years

50-59 years

AMI continued...

60-69 years

70-79 years

80 plus years

Results

Fractured neck of femur

During 2018, EMHS exceeded the target for survival rate for fractured neck of femur in both age groups. This was in improvement on performance from 2017 and continues to reflect the standardisation of care provision associated with fractured neck of femur pathways.

70-79 years

80 plus years

EMHS contributing sites: Armadale Hospital, Bentley Hospital, Kalamunda Hospital, Royal Perth Hospital, St John of God Midland Public Hospital.
Data period: 2016, 2017 and 2018 calendar years.
*Please note: 2016 data only includes the period from 1 July 2016 to 31 December 2016.
Data source: Hospital Morbidity Data Collection.

Outcome **1**

Percentage of admitted patients who discharged against medical advice: a) Aboriginal patients; and b) Non-Aboriginal patients

Rationale

Discharge against medical advice (DAMA) refers to patients leaving hospital against the advice of their treating medical team or without advising hospital staff (i.e. absconding or missing and not found). Patients who DAMA have a higher risk of readmission and mortality and have been found to cost the health system 50% more than patients who are discharged by their physician.

Between July 2013 and June 2015 Aboriginal patients in WA were almost 12.7 times more likely than non-Aboriginal patients to discharge against medical advice, compared with seven times nationally. This statistic indicates a need for improved responses by the health system to the needs of Aboriginal patients.

This indicator provides a measure of the safety and quality of inpatient care. Reporting the results by Aboriginality assists in measuring the effectiveness of initiatives within the WA health system to deliver culturally secure services to Aboriginal people and addressing underlying factors in achieving an equitable treatment outcome for Aboriginal patients compared with non-Aboriginal patients.

Target

The 2018 target for admitted patients who discharged against medical advice is ≤0.77% for both a) Aboriginal and b) non-Aboriginal patients.

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

Results

There has been a slight improvement in the performance of the percentage of admitted Aboriginal patients who discharged against medical advice, while the percentage of non-Aboriginal patients who discharged against medical advice is relatively stable. In both indicators EMHS is not achieving the desired results.

In late 2018, EMHS released its updated DAMA policy and associated guideline to promote a consistent interpretation of the DAMA definition, and outline organisational strategies to be employed by staff to manage patients who express the intention to DAMA. An electronic DAMA dashboard has also been created, which allows hospital staff to identify the primary specialities/wards that patients DAMA from. This allows for targeted strategies to be developed and implemented for those specific cohorts.

Strategies aimed at reducing DAMA rates are being implemented at a hospital level with input from the Aboriginal Health Strategy team, including staff education, enhanced communication and improving the availability of culturally appropriate information and signage.

Aboriginal patients

Non-Aboriginal patients

EMHS contributing sites: Armadale Hospital, Bentley Hospital, Kalamunda Hospital, Royal Perth Hospital, St John of God Midland Public Hospital.
Data period: 2017 and 2018 calendar years.
Data source: Hospital Morbidity Data Collection (HMDC).

"Damper Club" highlights the fun and therapeutic benefits of kneading

The staff at Bentley Hospital live by the EMHS vision of healthy people, amazing care, which is exactly what they delivered when they initiated a "Damper Club".

"We had a number of Aboriginal ladies from the North West of the State in the hospital at the same time who had all experienced a stroke and were understandably missing home," BH Occupational Therapist Jaya Saraswati said.

"They mentioned that they traditionally made damper either daily or weekly when back at home. We thought it would be a good idea to try and make them feel as at home as possible and make damper on the ward."

"Patients receiving therapy within a meaningful activity, or what we call occupation, is what occupational therapy is all about."

"Kneading – as is involved when making damper – happens to be a great activity for hand and arm therapy for sensory motor retraining. The added bonus is that it is a meaningful activity which is also very person-centred as it reminds them of their typical daily routine."

As it happened, each of the ladies had their own special recipe, so the scene was set for a MasterChef inspired cooking challenge!

Jaya said the ladies had a great morning of laughing and exchanging "secret" recipe ideas while listening to Aboriginal music and importantly, increasing their fine motor-skills and hand and arm strength.

"It was nice to be able to provide a culturally appropriate activity and bring some sense of home to the ladies" she said.

"As an Occupational Therapist, it is lovely to be able to watch the ladies enjoy their therapy in a fun way while also aligning to the National Clinical Guidelines for Stroke Management."

"Therapy does not have to be boring and generic and that is something Occupational Therapy are keen to promote at BH."

Outcome **1**

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

Rationale

This indicator of the condition of newborn infants immediately after birth provides an outcome measure of intrapartum care and newborn resuscitation.

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 (if required by the protocol) 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 and aligns to the National Core Maternity Indicators (2018) Health, Standard 06/09/2018.

Target

The 2018 target is 1.8%.

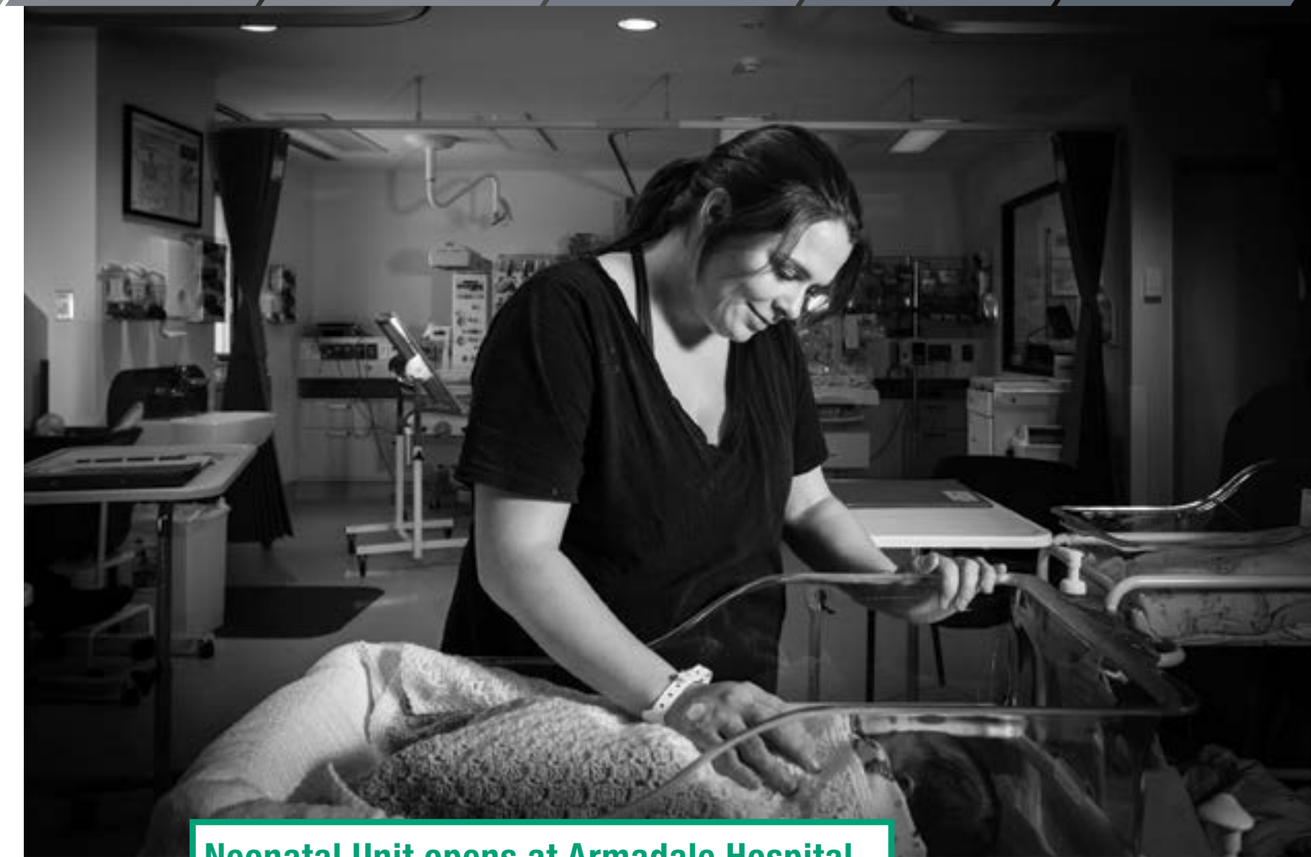
Improved or maintained performance is demonstrated by a result below or equal to target.

Results

For 2018, EMHS achieved a positive rate that remains below the target rate. This is indicative of the quality of care and skilled workforce providing maternity and neonatal services in EMHS hospitals.

An EMHS Maternity Group has been formed as an improvement initiative with senior management and clinicians to embed best practice across EMHS maternity services and closely monitor performance against core key performance indicators and outcomes measures, including this one.

EMHS contributing sites: Armadale Hospital, Bentley Hospital, St John of God Midland Public Hospital.
Data period: 2016, 2017 and 2018 calendar years.
*Please note: 2016 data only includes the period from 1 July 2016 to 31 December 2016.
Data source: Midwives Notification System.



Neonatal Unit opens at Armadale Hospital

Armadale Hospital improved its ability to provide safe care for acutely ill newborns with the opening of a new neonatal unit in 2018.

The eight cot unit provides for apnoea monitoring, low level oxygen therapy and nasal/oral-gastric feeding for low dependency babies, as well as a dedicated parents' area to enhance privacy.

The new unit means more local mothers can have their babies closer to home and fewer babies will need to be transferred to other hospitals.

AKG Executive Director, Di Barr, said "caring for neonates who are in their first few weeks of life requires specialist equipment, skilled staff and a dedicated area."

"AH is proud and excited to be able to provide all of these in our amazing neonatal unit."

Outcome 1

Readmissions to acute specialised mental health inpatient services within 28 days of discharge

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.

International literature identifies the concept of one month as an appropriate defined time period for the measurement of readmissions following separation from an acute inpatient mental health service. Based on this a timeframe of 28 days for this indicator has been set and endorsed by the Australian Health Minister's Advisory Council (AHMAC) Mental Health Information Strategy Standing Committee (as at 24 March 2011).

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 aim to improve mental health and quality of life of Western Australians.

Target

The 2018 target for this KPI is ≤12%.

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

Results

EMHS has improved performance in 2018 and is trending close to the target of 12% of patients having an unplanned readmission.

Readmission data is used by sites to review clinical practice and identify opportunities for improvement within the healthcare setting. Homelessness and drug and alcohol issues are contributing factors to readmission and some youth readmissions may form part of the Consumers Crisis Care Plan. It is recognised that the full involvement of consumers and carers in the development of the treatment support and discharge plan, and recovery based planning, minimises the risk of readmission. Community teams work with inpatient units to support successful discharge, and partnerships with accommodation and support services are in place.

EMHS contributing sites: Armadale Health Service, Bentley Health Service, Royal Perth Hospital, St John of God Midland Public Hospital, St John of God Mount Lawley.
Please note: comparative data for 2017 included patients admitted to the Ursula Frayne Unit at St John of God Mt Lawley. EMHS was commissioned by the Mental Health Commission to provide inpatient support to the unit until 30 June 2018 only and therefore 2018 data is inclusive of the Ursula Frayne Unit for the period of 1 January – 30 June 2018. From 1 July 2018, the inpatient support was purchased by the Mental Health Commission from another provider.
Data period: 2017 and 2018 calendar years.
Data source: Hospital Morbidity Data Collection and Mental Health Information Data Collection (MInD).

Outcome 1

Percentage of post-discharge community care within seven days following discharge from acute specialised mental health inpatient services

Rationale

In 2014-15 there were 4 million Australians (17.5%) who reported having a mental or behavioural condition. Therefore, it is crucial to ensure effective and appropriate care is provided not only in a hospital setting but also in the community.

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

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

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

Target

The 2018 target for this KPI is ≥75%.

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

Results

EMHS continues to achieve its target for timely contacts with community based mental health services.

In recognising this as a vulnerable period for the person following discharge from the hospital, each site has a process with allocated responsibility for completing follow up via face to face contacts or other direct contact within seven days of discharge. Where they are not able to make contact with a patient, they will endeavour to make contact with a family member or carer.

EMHS also notes Psychiatric Services Online Information System (PSOLIS) data entry issues, which has resulted in seven day follow-up being attended but not captured in the reported data for a period. To manage this, targeted PSOLIS education is provided to clinicians on an ongoing basis.

EMHS contributing sites: Armadale Health Service, Bentley Health Service, Royal Perth Hospital, St John of God Midland Public Hospital, St John of God Mount Lawley.
Please note: comparative data for 2016 and 2017 included patients admitted to the Ursula Frayne Unit at St John of God Mt Lawley. EMHS was commissioned by the Mental Health Commission to provide inpatient support to the unit until 30 June 2018 only and therefore 2018 data is inclusive of the Ursula Frayne Unit for the period of 1 January – 30 June 2018 only. From 1 July 2018, the inpatient support was purchased by the Mental Health Commission from another provider.
Data period: 2016, 2017 and 2018 calendar years *Please note: 2016 data only includes the period from 1 July 2016 to 31 December 2016.
Data source: Mental Health Information Data Collection (MInD), Hospital Morbidity Data Collection (Inpatient Separations).

Outcome 1

Average admitted cost per weighted activity unit

Service 1: Public hospital admitted services

Rationale

This indicator is a measure of the cost per weighted activity unit (WAU) compared with the State (aggregated) target, as approved by the Department of Treasury and published in the 2018-19 Budget Paper No. 2, Volume 1.

The measure ensures a consistent methodology is applied to calculating and reporting the cost of delivering inpatient activity against the State's funding allocation. As admitted services received nearly half of the overall 2018-19 budget allocation, it is imperative that efficiency of this service delivery is accurately monitored and reported.

Target

The 2018-19 target for average admitted cost per WAU is $6948.

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

Results

The target for 2018-19 was developed at a WA Health level for all Health Service Providers (HSPs). Performance against the 2018-19 target demonstrates EMHS performed better than the target with the result demonstrating an average admitted cost per WAU of $6323, or $625 below the 2018-19 target of $6948.

When compared to actual performance in 2017-18, the 2018-19 average admitted cost per WAU increased from $6230 to $6323, or by $93. This is due mainly to normal cost increases associated with the change in the Consumer Price Index (CPI) from one year to the next.

EMHS contributing sites: Armadale Hospital, Bentley Hospital, Kalamunda Hospital, Royal Perth Hospital, St John of God Midland Public Hospital.
Data period: 2017-18 and 2018-19 financial years.
Data source: OBM Allocation application, Oracle 11i financial system, Hospital Morbidity Data Collection extracts, TOPAS, webPAS and SJGMPH data extracts.

Outcome 1

Average Emergency Department cost per weighted activity unit

Service 2: Public hospital emergency services

Rationale

This indicator is a measure of the cost per WAU compared with the State (aggregated) target as approved by the Department of Treasury, which is published in the 2018-19 Budget Paper No. 2, Volume 1.

The measure ensures that a consistent methodology is applied to calculating and reporting the cost of delivering Emergency Department (ED) activity against the State's funding allocation. With the increasing demand on EDs and health services, it is imperative that ED service provision is monitored to ensure the efficient delivery of safe and high-quality care.

Target

The 2018-19 target for average ED cost per WAU is $7072.

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

Results

The target for 2018-19 was developed at a WA Health level for all HSPs. Performance against the 2018-19 target demonstrates that EMHS performed better than the target, with efficiencies in the provision of emergency services resulting in an average ED cost per WAU of $6835, or $237 below the target of $7072.

The performance in 2018-19 is also a $7 per unit cost improvement when compared to the results in 2017-18, further demonstrating efficiency gains in the year and the delivery of more services for the total dollars expended.

EMHS contributing sites: Armadale Hospital, Royal Perth Hospital, St John of God Midland Public Hospital.
Data period: 2017-18 and 2018-19 financial years.
Data source: OBM Allocation application, Oracle 11i financial system, Emergency Department Data Collection extract.

Outcome 1

Average non-admitted cost per weighted activity unit

Service 3: Public hospital non-admitted services

Rationale

This indicator is a measure of the cost per WAU compared with the State (aggregated) target, as approved by the Department of Treasury, which is published in the 2018-19 Budget Paper No. 2, Volume 1.

The measure ensures that a consistent methodology is applied to calculating and reporting the cost of delivering non-admitted activity against the State's funding allocation. Non-admitted services play a pivotal role within the spectrum of care provided to the WA public, therefore it is imperative that non-admitted service provision is monitored to ensure the efficient delivery of safe and high-quality care.

Target

The 2018-19 target for average non-admitted cost per WAU is $7136.

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

Results

The target for 2018-19 was developed at a WA Health level for all HSPs. The EMHS average non-admitted cost per WAU is $7293, which is $157 above the target of $7136. The variance above target is attributable to the additional effort and focus by EMHS in 2018-19 to reduce outpatient waitlists.

When comparing performance between 2017-18 and 2018-19, there is a $55 increase in actual costs between the two years. This increase is reflective of the additional effort in 2018-19 to reduce outpatient waitlists, as both activity levels and dollar expenditure increased.

EMHS contributing sites: Armadale Health Service, Bentley Health Service, Kalamunda Hospital, Royal Perth Hospital, St John of God Midland Public Hospital.
Data period: 2017-18 and 2018-19 financial years.
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).

Outcome 1

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

Service 4: Mental health services

Rationale

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

Target

The 2018-19 target for average cost per bed-day in specialised mental health inpatient services is $1456.

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

Results

The EMHS average cost per bed-day in specialised mental health inpatient services is $1581, which is $125 above the target of $1456. This is due to the continuing need to ensure mental health inpatient services have the necessary levels of highly specialised resources to appropriately manage increasing demands in a highly complex environment.

The 2018-19 result of $1581 is also unfavourable when compared against the 2017-18 result of $1482. The year on year increase is likely to represent a full year of operations and services related to the East Metropolitan Youth Unit (EMyU) at Bentley Hospital (a small cohort of patients requiring longer-term care and services) and normal cost increases related to changes in the CPI.

EMHS contributing sites: Armadale Health Service, Bentley Health Service, Royal Perth Hospital, St John of God Midland Public Hospital.
Please note: Comparative data for 2016-17 and 2017-18 included patients admitted to the Ursula Frayne Unit at St John of God Mt Lawley. EMHS was commissioned by the Mental Health Commission to provide inpatient support to the unit until 30 June 2018 only and therefore 2018-19 data does not include the Ursula Frayne Unit. From 1 July 2018, the inpatient support was purchased by the Mental Health Commission from another provider.
Data period: 2016-17, 2017-18 and 2018-19 financial years.
Data source: OBM Allocation Application, Oracle 11i Financial System, BedState.

Outcome 1 Average cost per treatment day of non-admitted care provided by mental health services

Service 4: Mental health services

Rationale

Public community mental health services consist of a range of community-based services such as emergency assessment and treatment, case management, day programs, rehabilitation, psychosocial, residential services and continuing care. The aim of these services is to provide the best health outcomes for the individual through the provision of accessible and appropriate community mental health care. Efficient functioning of public community mental health services is critical to ensure that finite funds are used effectively to deliver maximum community benefit.

Public community-based mental health services are generally targeted towards people in the acute phase of a mental illness who are receiving post-acute care. This indicator provides a measure of the cost effectiveness of treatment for public psychiatric patients under public community mental healthcare (non-admitted/ambulatory patients).

Target

The 2018-19 target for average cost per treatment day of non-admitted care provided by mental health services is $434.

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 mental health services is $409 which is $25 below the target of $434. The results against the 2018-19 target indicate that EMHS has continued to provide non-admitted services commensurate with a highly complex environment and patient demographic.

When comparing the 2018-19 performance against the 2017-18 performance, there is an observable increase of treatment days recorded in 2018-19 relative to 2017-18. EMHS was able to keep overall costs lower, leading to an overall improvement in efficiency.

EMHS contributing sites: Armadale Health Service, Bentley Health Service, Royal Perth Hospital, St John of God Midland Public Hospital.
Data period: 2017-18 and 2018-19 financial years.
Data source: OBM Allocation Application , Oracle 11i Financial System, Mental Health Information Data Collection (MInD).

Outcome 2 Average cost per person of delivering population health programs by population health units

Service 6: Public and community health services

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 2018-19 target for average cost per person of delivering population health programs by population health units is $13.

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

Results

The EMHS average cost per person of delivering population health programs by population health units is $15, which is marginally above the target of $13.

For accuracy, the EMHS population figure used to calculate the 2018-19 result is based on data recently made available from the 2016 census. This however, was lower than the population figure used to calculate results in 2016-17 and 2017-18, which was based on the 2011 census.

While the EMHS population figure for 2018-19 decreased, the total cost of delivering population health programs also decreased from 2017-18, meaning that the actual average cost per person of delivering population health programs by population health units remained static across both years, at $15.

Please note: comparative data from 2016-17 and 2017-18 was calculated based on the WA Health Epidemiology Branch from 2012-16 estimates. Data for 2018-19 is based on 2013-17 calendar year population.

Data period: 2016-17, 2017-18 and 2018-19 financial years.
Data source: OBM Allocation Application, Oracle 11i Financial System, 2013-17 calendar year population extracted from EpiCalc version 1.0 (beta), WA Department of Health Epidemiology Branch, 2018 calendar year population projected by the Epidemiology Branch from 2013-17 estimates using the FORECAST function of Microsoft Excel 2010.

East Metropolitan Health Service

Financials

Certification of financial statements

East Metropolitan Health Service

For the reporting period ended 30 June 2019

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 present fairly the financial transactions for the reporting period ended 30 June 2019 and financial position as at 30 June 2019.

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.

Suzie May
Acting Board Chair
East Metropolitan Health Service
18 September 2019

Peter Forbes
Chair, EMHS Board Finance Committee
East Metropolitan Health Service
18 September 2019

Graeme Jones
Chief Finance Officer
East Metropolitan Health Service
18 September 2019

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 2019, 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 2019 and the financial position at the end of that period. They are in accordance with Australian Accounting Standards, the *Financial Management Act 2006* and the Treasurer's Instructions.

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

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

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

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

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

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for my opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the agency's internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Board.
- Conclude on the appropriateness of the Board's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the agency's ability to continue as a going concern. If I conclude that a material uncertainty exists, I am required to draw attention in my auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify my opinion. My conclusions are based on the audit evidence obtained up to the date of my auditor's report.
- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

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

Report on Controls

Opinion
I have undertaken a reasonable assurance engagement on the design and implementation of controls exercised by the 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.

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 2019.

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

Auditor General's Responsibilities
As required by the *Auditor General Act 2006*, my responsibility as an assurance practitioner is to express an opinion on the suitability of the design of the controls to achieve the overall control objectives and the implementation of the controls as designed.

I conducted my engagement in accordance with Standard on Assurance Engagements ASAE 3150 *Assurance Engagements on Controls* issued by the Australian Auditing and Assurance Standards Board. That standard requires that I comply with relevant ethical requirements and plan and perform my procedures to obtain reasonable assurance about whether, in all material respects, the controls are suitably designed to achieve the overall control objectives and the controls, necessary to achieve the overall control objectives, were implemented as designed.

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

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

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

Report on the Key Performance Indicators

Opinion
I have undertaken a reasonable assurance engagement on the key performance indicators of the East Metropolitan Health Service for the year ended 30 June 2019. 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 2019.

Matter of Significance
Emergency Department Waiting Times
The Under Treasurer has continued his approval to remove the following indicator as a key performance indicator (KPI):

- Percentage of emergency department patients seen within the recommended times

The Under Treasurer's approval requires WA Health to reassess whether this indicator can be re-instated as a KPI once a new emergency department data collection system has been implemented. There is currently no set timeframe for the implementation of a new system.

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

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

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

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

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

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

Matters Relating to the Electronic Publication of the Audited Financial Statements and Key Performance Indicators
This auditor's report relates to the financial statements and key performance indicators of the East Metropolitan Health Service for the year ended 30 June 2019 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
18 September 2019

East Metropolitan Health Service
Statement of comprehensive income
For the year ended 30 June 2019

	Note	2019 $000	2018 $000
Cost of services			
Expenses			
Employee benefits expense	3.1(a)	841,079	791,277
Fees for visiting medical practitioners	3.4	29,710	25,200
Contracts for services	3.2	288,127	274,334
Patient support costs	3.3	215,116	214,528
Finance costs	3.4	40	65
Depreciation and amortisation expense	5.3	44,084	44,258
Asset revaluation decrement	3.4	2,010	3,130
Loss on disposal of non-current assets	3.4	805	85
Repairs, maintenance and consumable equipment	3.4	24,395	26,257
Other supplies and services	3.4	7,712	6,707
Other expenses	3.4	79,299	81,572
Total cost of services		**1,532,377**	**1,467,413**
Income			
Revenue			
Patient charges	4.4	67,689	64,787
Other fees for services	4.5	48,184	52,481
Commonwealth grants and contributions	4.2	499,647	451,887
Other grants and contributions	4.3	132,697	123,985
Donation revenue	4.6	196	2,075
Commercial activities	4.7	154	98
Other revenue	4.8	18,587	8,146
Total income other than income from State Government		**767,154**	**703,459**
Net cost of services		**765,223**	**763,954**
Income from State Government			
Service appropriations	4.1	718,928	714,341
Assets assumed	4.1	95	97
Services received free of charge	4.1	53,476	56,196
Total income from State Government		**772,499**	**770,634**
Surplus for the period		**7,276**	**6,680**
Other comprehensive income			
Items not reclassified subsequently to profit or loss			
Changes in asset revaluation reserve	8	(10,443)	14,183
Total other comprehensive income		**(10,443)**	**14,183**
Total comprehensive income/(loss) for the period		**(3,167)**	**20,863**

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 2019

	Note	2019 $000	2018 $000
Assets			
Current assets			
Cash and cash equivalents	7.3	135,893	108,797
Restricted cash and cash equivalents	7.3	28,706	27,584
Receivables	6.1	30,119	31,893
Inventories	6.3	4,519	5,091
Other current assets	6.4	1,207	876
Total current assets		200,444	174,241
Non-current assets			
Restricted cash and cash equivalents	7.3	9,710	6,359
Amounts receivable for services	6.2	481,822	435,334
Property, plant and equipment	5.1	875,506	915,969
Intangible assets	5.2	1,221	2,027
Other non-current assets	6.4	37	150
Total non-current assets		1,368,296	1,359,839
Total assets		**1,568,740**	**1,534,080**
Liabilities			
Current liabilities			
Payables	6.5	82,321	74,486
Borrowings	7.1, 7.2	839	819
Employee benefits provisions	3.1(b)	169,305	155,913
Other current liabilities	6.6	461	190
Total current liabilities		252,926	231,408
Non-current liabilities			
Employee benefits provisions	3.1(b)	40,984	35,329
Borrowings	7.1, 7.2	-	839
Total non-current liabilities		40,984	36,168
Total liabilities		**293,910**	**267,576**
Net assets		**1,274,830**	**1,266,504**
Equity			
Contributed equity	8	1,132,398	1,120,444
Reserves	8	78,633	89,076
Accumulated surplus		63,799	56,984
Total equity		**1,274,830**	**1,266,504**

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 2019

	Note	2019 $000	2018 $000
Contributed equity	8		
Balance at start of period		1,120,444	1,111,364
Transactions with owners in their capacity as owners:			
Capital appropriations		11,698	13,613
Other contributions by owners		256	37
Distributions to owners		-	(4,570)
Balance at end of period		**1,132,398**	**1,120,444**
Reserves	8		
Asset revaluation reserve			
Balance at start of period		89,076	74,893
Other comprehensive income for the period		(10,443)	14,183
Balance at end of period		**78,633**	**89,076**
Accumulated surplus			
Balance at start of period		56,984	50,304
Changes in accounting policy	10	(461)	-
Restated balance at start of period		56,523	50,304
Surplus for the period		7,276	6,680
Balance at end of period		**63,799**	**56,984**
Total equity			
Balance at start of period		1,266,504	1,236,561
Changes in accounting policy		(461)	-
Restated balance at start of period		1,266,043	1,236,561
Total comprehensive income/(loss) for the period		(3,167)	20,863
Transactions with owners in their capacity as owners		11,954	9,080
Balance at end of period		**1,274,830**	**1,266,504**

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 2019

	Note	2019 $000 Inflows/(Outflows)	2018 $000 Inflows/(Outflows)
Cash flows from State Government	7.3.3		
Service appropriations		672,398	670,035
Capital appropriations		10,901	12,890
Net cash provided by State Government		**683,299**	**682,925**
Utilised as follows:			
Cash flows from operating activities			
Payments			
Employee benefits		(818,493)	(776,312)
Supplies and services		(585,209)	(559,172)
Finance costs		(1)	(3)
Receipts			
Receipts from customers		66,091	60,703
Commonwealth grants and contributions		499,647	451,887
Other grants and contributions		132,697	123,985
Donations received		142	187
Other receipts		67,106	59,774
Net cash used in operating activities	7.3.2	**(638,020)**	**(638,951)**
Cash flows from investing activities			
Payments			
Purchase of non-current assets		(13,784)	(14,518)
Receipts			
Proceeds from sale of non-current assets		96	95
Net cash used in investing activities		**(13,688)**	**(14,423)**
Cash flows from financing activities			
Payments			
Repayment of finance lease liabilities		(22)	(30)
Net cash used in financing activities	7.3.4	**(22)**	**(30)**
Net increase in cash and cash equivalents		31,569	29,521
Cash and cash equivalents at the beginning of the period		142,740	113,219
Total cash and cash equivalents at the end of the period		**174,309**	**142,740**

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 2019

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 18 September 2019.

Statement of compliance

These general purpose financial statements are 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 2019

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. The Health Service is predominantly funded by Parliamentary appropriations.

East Metropolitan Health Service
Notes to the financial statements
As at 30 June 2019

2.1 Health Service objectives (continued)

The Health Service provides the following services:

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 include 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 include 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 include 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 include 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 2019

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 include 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 2019

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
	2019 $000	2019 $000	2019 $000	2019 $000	2019 $000	2019 $000	2019 $000
Cost of services							
Expenses							
Employee benefits expense	486,131	103,011	106,545	127,277	6,795	11,320	841,079
Fees for visiting medical practitioners	22,859	1,750	4,929	172	-	-	29,710
Contracts for services	178,321	57,567	22,052	29,646	492	49	288,127
Patient support costs	140,831	18,324	39,054	6,511	1,827	8,569	215,116
Finance costs	24	3	10	3	-	-	40
Depreciation and amortisation expense	27,641	5,745	5,682	4,687	245	84	44,084
Asset revaluation decrement	1,348	215	375	72	-	-	2,010
Loss on disposal of non-current assets	409	61	-	303	17	15	805
Repairs, maintenance and consumable equipment	14,859	2,818	3,533	2,772	249	164	24,395
Other supplies and services	4,082	642	904	1,833	58	193	7,712
Other expenses	45,484	9,909	7,912	14,441	708	845	79,299
Total cost of services	**921,989**	**200,045**	**190,996**	**187,717**	**10,391**	**21,239**	**1,532,377**
Income							
Patient charges	59,404	1,942	5,476	867	-	-	67,689
Other fees for services	28,318	2,078	11,776	1,328	56	4,628	48,184
Commonwealth grants and contributions	318,214	59,882	68,097	50,014	3,285	155	499,647
Other grants and contributions	1,613	61	242	129,073	996	712	132,697
Donation revenue	130	12	21	33	-	-	196
Commercial activities	109	17	28	-	-	-	154
Other revenue	12,664	1,878	2,733	1,196	84	32	18,587
Total income other than income from State Government	**420,452**	**65,870**	**88,373**	**182,511**	**4,421**	**5,527**	**767,154**
Net cost of services	**501,537**	**134,175**	**102,623**	**5,206**	**5,970**	**15,712**	**765,223**
Income from State Government							
Service appropriations	471,329	126,093	96,443	4,690	5,610	14,763	718,928
Assets assumed	95	-	-	-	-	-	95
Services received free of charge	33,796	6,444	5,230	7,448	318	240	53,476
Total income from State Government	505,220	132,537	101,673	12,138	5,928	15,003	772,499
Surplus/(deficit) for the period	**3,683**	**(1,638)**	**(950)**	**6,932**	**(42)**	**(709)**	**7,276**

East Metropolitan Health Service
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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	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**
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/(deficit) 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 2019

	2019 $000	2018 $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)	841,079	791,277
Employee benefits provisions	3.1(b)	210,289	191,242
Contracts for services	3.2	288,127	274,334
Patient support costs	3.3	215,116	214,528
Other expenses	3.4	143,970	143,016

3.1(a) Employee benefits expense

Salaries and wages	769,516	725,002
Superannuation - defined contribution plans (a)	71,563	66,275
Total employee benefits expense	841,079	791,277

(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 salaries and wages, fringe benefits plus the fringe benefits tax component, leave entitlements including superannuation contribution components and redundancy expenses of $0.8 million (2018: $2.4 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 to the Government Employees Superannuation Board (GESB) in respect of the GSS is paid back into the Consolidated Account by the GESB.

East Metropolitan Health Service
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	2019 $000	2018 $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 salaries and wages, annual leave, time off in lieu and long service leave for services rendered up to the reporting date and recorded as an expense during the period the services are delivered.

Current		
Annual leave (a)	79,738	65,793
Time off in lieu leave (a)	25,194	32,392
Long service leave (b)	63,959	57,224
Deferred salary scheme (c)	414	504
	169,305	155,913
Non-current		
Long service leave (b)	40,984	35,329
Total employee benefits provisions	210,289	191,242

(a) Annual leave 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.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2019

	2019 $000	2018 $000
3.1(b) Employee benefits provisions (continued)		

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

Within 12 months of the end of the reporting period	73,920	70,405
More than 12 months after the end of the reporting period	31,012	27,780
	104,932	98,185

(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	14,539	13,774
More than 12 months after the end of the reporting period	90,404	78,779
	104,943	92,553

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 market yields at the end of the reporting period on national government bonds with terms to maturity that match, as closely as possible, the estimated future cash outflows.

(c) 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.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2019

	2019 $000	2018 $000
3.1(b) Employee benefits provisions (continued)		

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

Within 12 months of the end of the reporting period	221	144
More than 12 months after the end of the reporting period	193	360
	414	504

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 Health Service'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.

3.2 Contracts for services		
Public patients services (a)	258,245	247,425
Mental health services (a)	28,653	26,853
Home and community care (a)	493	21
Other contracts	736	35
Total contracts for services	288,127	274,334

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

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2019

	2019 $000	2018 $000
3.3 Patient support costs		
Drug supplies	56,528	61,303
Pathology	38,054	37,433
Prosthesis	24,479	24,127
Other medical supplies and services	62,938	60,687
Domestic charges	13,931	13,346
Fuel, light and power	8,588	8,547
Food supplies	6,438	5,991
Patient transport costs	2,793	2,674
Research, development and other grants	1,367	420
Total patient support costs	215,116	214,528

3.4 Other expenses

Fees for visiting medical practitioners

Clinical	23,507	19,392
Radiology	6,203	5,808
Total fees for visiting medical practitioners	29,710	25,200

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.

Finance costs

Interest expense	40	62
Finance lease charges	0	3
Total finance costs	40	65

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

Asset revaluation decrement

Land	2,010	3,130
Total asset revaluation decrement	2,010	3,130

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2019

	2019 $000	2018 $000
3.4 Other expenses (continued)		

Asset revaluation decrement (continued)
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	901	180
Proceeds from disposal of non-current assets:		
Property, plant and equipment	(96)	(95)
Net loss on disposal	805	85

Repairs, maintenance and consumable equipment

Repairs and maintenance	18,446	18,656
Consumable equipment	5,949	7,601
Total repairs, maintenance and consumable equipment	24,395	26,257

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').

Other supplies and services

Sanitisation and waste removal services	1,531	1,350
Administration and management services	1,643	1,125
Interpreter services	1,426	1,180
Security services	940	505
Library subscription	1,317	1,284
Contract management	-	153
Patient experience survey	-	295
Outsourced health promotion	147	131
Outsourced engineering	110	194
Other	598	490
Total other supplies and services	7,712	6,707

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 2019

	2019 $000	2018 $000
3.4 Other expenses (continued)		
Other expenses		
Services provided by Health Support Services: (a)		
ICT services	26,963	28,662
Supply chain services	4,583	4,490
Financial services	2,109	2,778
Human resources services	5,489	5,829
Workers compensation insurance	14,138	13,361
Operating lease expenses	2,125	1,899
Other insurances	6,774	7,456
Consultancy fees	3,200	2,242
Printing and stationery	2,639	2,291
Doubtful debts expense	-	5,684
Expected credit losses expense (b)	3,638	-
Communications	1,921	1,993
Other employee related expenses	1,609	1,570
Write-down of assets (c)	129	6
Motor vehicle expenses	617	510
Computer services	1,025	548
Other	2,340	2,253
Total other expenses	79,299	81,572

(a) Services received free of charge. (See note 4.1 'Income from State Government').
(b) Expected credit losses were not measured in 2017-18.
(c) See note 5.1 'Property, plant and equipment'.

Doubtful debts expense was recognised as the movement in the allowance for doubtful debts. From 2018-19, expected credit losses expense is recognised as the movement in the allowance for expected credit losses. The allowance for expected credit losses of trade receivables is measured at the lifetime expected credit losses at each reporting date. The Health Service has established a provision matrix that is based on its historical credit loss experience. (See note 6.1.1 'Movement of the allowance for impairment of receivables').

East Metropolitan Health Service
Notes to the financial statements
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	2019 $000	2018 $000
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 Health Service and the relevant notes are:

	Note		
Income from State Government	4.1	772,499	770,634
Commonwealth grants and contributions	4.2	499,647	451,887
Other grants and contributions	4.3	132,697	123,985
Patient charges	4.4	67,689	64,787
Other fees for services	4.5	48,184	52,481
Donation revenue	4.6	196	2,075
Commercial activities	4.7	154	98
Other revenue	4.8	18,587	8,146

4.1 Income from State Government

Appropriation received during the year:		
Service appropriation (funding via the Department of Health) (a)	718,928	714,341
	718,928	714,341
Assets transferred from/(to) other State government agencies during the year (b):		
- Transfer of medical equipment from Perth Children's Hospital	60	-
- Transfer of non-medical equipment from Perth Children's Hospital	62	-
- Transfer of medical equipment from North Metropolitan Health Service	-	203
- Transfer of medical equipment to WA Country Health Service	-	(66)
- Transfer of medical equipment to South Metropolitan Health Service	(12)	(40)
- Transfer of computer equipment to Department of Health	(10)	-
- Transfer of artwork to Perth Children's Hospital	(5)	-
Total assets transferred	95	97
Services received free of charge from other State government agencies during the year (c):		
Health Support Services - shared services	39,144	41,759
Pathwest - indirect costs	14,332	14,434
Department of Finance - rental lease management	-	3
Total services received free of charge	53,476	56,196
Total income from State Government	772,499	770,634

East Metropolitan Health Service
Notes to the financial statements
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	2019 $000	2018 $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

Recurrent grants:		
National Health Reform Agreement (funding via the Department of Health) (a)	434,506	393,294
National Health Reform Agreement (funding via the Mental Health Commission) (a)	50,014	49,422
Other - Commonwealth specific grants (recurrent)	15,127	9,171
Total Commonwealth grants and contributions	499,647	451,887

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2019

	2019 $000	2018 $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	125,711	117,293
Mental Health Commission - other	3,362	3,991
Disability Services Commission - community aids and equipment program	1,358	1,696
Road Trauma Program - Injury Prevention	698	759
Research grants	279	-
Other	1,289	246
Total other grants and contributions	132,697	123,985

4.4 Patient charges

Inpatient bed charges	54,374	53,671
Inpatient other charges	5,897	6,057
Outpatient charges	7,418	5,059
Total patient charges	67,689	64,787

4.5 Other fees for services

Recoveries from the Pharmaceutical Benefits Scheme (PBS)	38,422	42,792
Health Technology Management Services	5,184	5,132
Business Intelligence Services	4,003	4,043
Non clinical services to other health organisations	368	476
Other	207	38
Total other fees for services	48,184	52,481

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	2019 $000	2018 $000
4.6 Donation revenue		
Body scanner donated to Royal Perth Hospital	-	1,300
General public donations	196	775
Total donations	196	2,075
4.7 Commercial activities		
Sales:		
Cafeteria sales revenue	3,098	3,390
Car parking fees revenue	78	2,069
Total sales	3,176	5,459
Cost of sales	(3,022)	(5,361)
Gross profit	154	98
4.8 Other revenue		
RiskCover insurance premium rebate	12,328	3,501
Abatements	440	376
Royalty revenues	1,514	766
Rent from commercial properties	750	937
Parking	775	377
Commissions	196	251
Sponsorship	754	584
Training and education	9	336
Clinical trial revenue	1,299	247
Use of hospital facilities	109	92
Other	413	679
Total other revenue	18,587	8,146

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2019

	2019 $000	2018 $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	875,506	915,969
Intangible assets	5.2	1,221	2,027
Depreciation and amortisation expense	5.3	44,084	44,258

East Metropolitan Health Service
Notes to the financial statements
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	2019 $000	2018 $000
5.1 Property, plant and equipment		
Land		
Gross carrying amount	88,928	90,938
Reconciliation:		
Carrying amount at start of period	90,938	98,638
Transfers from/(to) other reporting entities	-	(4,570)
Revaluation increments/(decrements)	(2,010)	(3,130)
Carrying amount at end of period	88,928	90,938
Buildings		
Gross carrying amount	675,145	709,654
Reconciliation:		
Carrying amount at start of period	709,654	697,889
Additions	4,264	2,622
Transfers from works in progress	574	4,208
Revaluation increments/(decrements)	(10,443)	14,183
Transfers between asset classes	-	19,184
Depreciation	(28,904)	(28,432)
Carrying amount at end of period	675,145	709,654

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2019

	2019 $000	2018 $000
5.1 Property, plant and equipment (continued)		
Site infrastructure		
Gross carrying amount	45,787	45,787
Accumulated depreciation	(6,106)	(4,204)
	39,681	41,583
Reconciliation:		
Gross carrying amount at start of period	45,787	64,971
Accumulated depreciation	(4,204)	(2,302)
Carrying amount at start of period	41,583	62,669
Additions	46	-
Transfers between asset classes	(45)	(19,184)
Depreciation	(1,903)	(1,902)
Carrying amount at end of period	39,681	41,583
Leasehold improvements		
Gross carrying amount	2,709	2,709
Accumulated depreciation	(847)	(553)
	1,862	2,156
Reconciliation:		
Gross carrying amount at start of period	2,709	2,709
Accumulated depreciation	(553)	(259)
Carrying amount at start of period	2,156	2,450
Depreciation	(294)	(294)
Carrying amount at end of period	1,862	2,156

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Notes to the financial statements
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	2019 $000	2018 $000
5.1 Property, plant and equipment (continued)		
Computer equipment		
Gross carrying amount	2,341	2,354
Accumulated depreciation	(2,121)	(1,412)
	220	942
Reconciliation:		
Gross carrying amount at start of period	2,354	2,360
Accumulated depreciation	(1,412)	(706)
Carrying amount at start of period	942	1,654
Transfers from/(to) other reporting entities	(9)	-
Transfers between asset classes	1	-
Write-down of assets (a)	-	(6)
Depreciation	(714)	(706)
Carrying amount at end of period	220	942
Furniture and fittings		
Gross carrying amount	3,588	4,813
Accumulated depreciation	(1,387)	(1,159)
	2,201	3,654
Reconciliation:		
Gross carrying amount at start of period	4,813	4,651
Accumulated depreciation	(1,159)	(558)
Carrying amount at start of period	3,654	4,093
Additions	-	419
Other disposals	(21)	-
Transfers between asset classes	(648)	(257)
Write-down of assets (a)	(108)	-
Write-off of assets	(83)	-
Depreciation	(593)	(601)
Carrying amount at end of period	2,201	3,654

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Notes to the financial statements
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	2019 $000	2018 $000
5.1 Property, plant and equipment (continued)		
Motor vehicles		
Gross carrying amount	75	13
Accumulated depreciation	(19)	(10)
	56	3
Reconciliation:		
Gross carrying amount at start of period	13	13
Accumulated depreciation	(10)	(5)
Carrying amount at start of period	3	8
Additions	63	-
Depreciation	(10)	(5)
Carrying amount at end of period	56	3
Medical equipment		
Gross carrying amount	62,675	57,820
Accumulated depreciation	(25,465)	(17,957)
	37,210	39,863
Reconciliation:		
Gross carrying amount at start of period	57,820	51,207
Accumulated depreciation	(17,957)	(8,746)
Carrying amount at start of period	39,863	42,461
Additions	6,518	6,819
Transfers from/(to) other reporting entities	48	97
Other disposals	(731)	(180)
Transfers between asset classes	116	-
Write-off of assets	(37)	-
Depreciation	(8,567)	(9,334)
Carrying amount at end of period	37,210	39,863

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2019

	2019 $000	2018 $000
5.1 Property, plant and equipment (continued)		
Other plant and equipment		
Gross carrying amount	27,919	25,261
Accumulated depreciation	(6,249)	(3,862)
	21,670	21,399
Reconciliation:		
Gross carrying amount at start of period	25,261	24,812
Accumulated depreciation	(3,862)	(1,736)
Carrying amount at start of period	21,399	23,076
Additions	1,533	192
Transfers from/(to) other reporting entities	61	-
Transfers from works in progress	366	-
Other disposals	(21)	-
Transfers between asset classes	576	257
Write-off of assets	(7)	-
Depreciation	(2,237)	(2,126)
Carrying amount at end of period	21,670	21,399
Artworks		
Gross carrying amount	2,052	2,045
Reconciliation:		
Carrying amount at start of period	2,045	2,031
Additions	12	14
Transfers from/(to) other reporting entities	(5)	-
Carrying amount at end of period	2,052	2,045

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2019

	2019 $000	2018 $000
5.1 Property, plant and equipment (continued)		
Works in progress		
Gross carrying amount	6,481	3,732
Reconciliation:		
Carrying amount at start of period	3,732	4,344
Additions	3,710	3,596
Capitalised to asset classes	(940)	(4,208)
Write-down of assets (a)	(21)	-
Carrying amount at end of period	6,481	3,732
Total property, plant and equipment		
Gross carrying amount	917,700	945,126
Accumulated depreciation	(42,194)	(29,157)
	875,506	915,969
Reconciliation:		
Gross carrying amount at start of period	945,126	953,625
Accumulated depreciation	(29,157)	(14,312)
Carrying amount at start of period	915,969	939,313
Additions	16,146	13,662
Transfers from/(to) other reporting entities	95	(4,473)
Other disposals	(773)	(180)
Revaluation increments/(decrements)	(12,453)	11,053
Write-down of assets (a)	(129)	(6)
Write-off of assets	(127)	-
Depreciation	(43,222)	(43,400)
Carrying amount at end of period	875,506	915,969

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2019

5.1 Property, plant and equipment (continued)

(a) Expenses capitalised in the previous financial year, expensed in the current financial year. See note 3.4 'Other expenses'.

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 2019

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 2018 by the Western Australian Land Information Authority (Valuations and Property Analytics). The valuations were performed during the year ended 30 June 2019 and recognised at 30 June 2019. In undertaking the revaluation, fair value was determined by reference to market values for land: $18.2 million (2018: $20.1 million) and buildings: $2.7 million (2018: $2.7 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 2019

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.

As at 30 June 2019 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 2019

	2019 $000	2018 $000
5.2 Intangible assets		
Computer software		
Gross carrying amount	3,817	3,761
Accumulated amortisation	(2,596)	(1,734)
	1,221	2,027
Reconciliation:		
Gross carrying amount at start of the period	3,761	3,761
Accumulated amortisation	(1,734)	(876)
Carrying amount at start of the period	2,027	2,885
Additions	56	-
Depreciation	(862)	(858)
Carrying amount at end of the period	1,221	2,027

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
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For the year ended 30 June 2019

	2019 $000	2018 $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 reliably measure 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	28,904	28,432
Medical equipment	8,567	9,334
Site infrastructure	1,903	1,902
Leasehold improvements	294	294
Computer equipment	714	706
Furniture and fittings	593	601
Motor vehicles	10	5
Other plant and equipment	2,237	2,126
Total depreciation for the period	43,222	43,400
Computer software	862	858
Total amortisation for the period	862	858
Total depreciation and amortisation for the period	44,084	44,258

East Metropolitan Health Service
Notes to the financial statements
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	2019 $000	2018 $000

5.3 Depreciation and amortisation expense (continued)

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 Health Service 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.

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.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2019

		2019 $000	2018 $000
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	30,119	31,893
Amounts receivable for services (Holding Account)	6.2	481,822	435,334
Inventories	6.3	4,519	5,091
Other assets	6.4	1,244	1,026
Liabilities			
Payables	6.5	82,321	74,486
Other liabilities	6.6	461	190

6.1 Receivables

Current		
Patient fee debtors (a)	30,662	35,356
Other receivables	6,862	6,222
Less: Allowance for impairment of receivables	(20,661)	(23,314)
Accrued revenue	10,092	10,645
GST receivable	3,164	2,984
Total current	30,119	31,893

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 $2.1 million in ex-gratia payments for the 2018-19 period (2017-18: $1.5 million).

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.

East Metropolitan Health Service
Notes to the financial statements
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	2019 $000	2018 $000

6.1 Receivables (continued)

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, PathWest Laboratory Medicine WA, 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	23,314	28,553
Remeasurement under *AASB 9*	461	-
Restated balance at start of period	23,775	28,553
Doubtful debts expense (note 3.4 'Other expenses')	-	5,684
Expected credit losses (note 3.4 'Other expenses')	3,638	-
Amounts written off during the period	(6,655)	(9,433)
Debt waivers during the period (a)	(97)	(1,490)
Balance at end of period	20,661	23,314

(a) 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 maximum exposure to credit risk at the end of the reporting period for receivables is the carrying amount of the asset inclusive of any allowance for impairment as shown in the table at note 9.1 c) Credit risk exposure.

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.

East Metropolitan Health Service
Notes to the financial statements
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	2019 $000	2018 $000
6.2 Amounts receivable for services (Holding Account)		
Current	-	-
Non-current	481,822	435,334
Total amounts receivable for services	481,822	435,334

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.

Amounts receivable for services are considered not impaired (i.e. there is no expected credit loss of the holding accounts).

6.3 Inventories		
Current		
Pharmaceutical stores - at cost	3,964	4,579
Engineering stores - at cost	555	512
Total inventories	4,519	5,091

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.

6.4 Other assets		
Current		
Prepayments	1,207	876
Non-current		
Prepayments	37	150
Total other assets	1,244	1,026

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.

East Metropolitan Health Service
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	2019 $000	2018 $000
6.5 Payables		
Current		
Accrued expenses	47,910	44,243
Trade creditors	12,616	11,675
Accrued salaries	15,571	12,773
Other creditors	6,222	5,791
Accrued interest	2	4
Total current	82,321	74,486

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.

6.6 Other liabilities		
Current		
Refundable deposits	168	133
Paid parental leave scheme	55	55
Unearned revenue	234	-
Other current liabilities	4	2
Total current	461	190

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	2019 $000	2018 $000
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	839	1,658
Finance leases	7.2	-	22
Cash and cash equivalents	7.3	174,309	142,740
Commitments	7.4	6,094,364	5,547,305

7.1 Borrowings

Current		
Department of Treasury loans (a)	839	797
Finance lease liabilities (b)	-	22
Total current	839	819
Non-current		
Department of Treasury loans (a)	-	839
Total non-current	-	839
Total borrowings	839	1,658

(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. The finance lease was paid in full during the 2018-19 financial year. See note 7.2 'Finance leases'.

Borrowing costs are expensed in the period in which they are incurred.

East Metropolitan Health Service
Notes to the financial statements
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		2019 $000	2018 $000
7.2 Finance leases			

Finance lease commitments
Minimum lease payment commitments in relation to finance leases are payable as follows:

	Note		
Within 1 year		-	23
Minimum finance lease payments		-	23
Less future finance charges		-	(1)
Present value of finance lease liabilities		-	22
The present value of finance leases payable is as follows:			
Within 1 year		-	22
Present value of finance lease liabilities		-	22
Included in the financial statements as:			
Current	7.1	-	22
		-	22

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.

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	2019 $000	2018 $000
7.3 Cash and cash equivalents		
7.3.1 Reconciliation of cash		
Current		
Cash and cash equivalents	135,893	108,797
Restricted cash and cash equivalents (a)	28,706	27,584
	164,599	136,381
Non-current		
Accrued salaries suspense account (b)	9,710	6,359
Total cash assets	174,309	142,740

(a) 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.

(b) 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.

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
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	Note	2019 $000	2018 $000
7.3.2 Reconciliation of net cost of services to net cash flows used in operating activities			
Net cost of services (statement of comprehensive income)		(765,223)	(763,954)
Non-cash items			
Depreciation and amortisation expense	5.3	44,084	44,258
Doubtful debt expense	3.4	-	5,684
Expected credit loss expense	3.4	3,638	-
Services received free of charge	4.1	53,476	56,196
Net (gain)/loss on disposal of non-current assets	3.4	805	85
Donation of non-current assets	4.6	(53)	(1,888)
Write down of property, plant and equipment	3.4	129	6
Interest paid by the Department of Health	3.4	42	64
Asset revaluation decrement	3.4	2,010	3,130
Write off of receivables	6.1.1	(6,752)	(10,923)
Remeasurement of receivables under *AASB 9*	6.1.1	461	-
Adjustment for other non-cash items		(2,570)	2,741
(Increase)/decrease in assets			
GST receivable	6.1	(180)	(285)
Other current receivables	6.1	4,607	5,919
Inventories	6.3	571	495
Prepayments and other current assets	6.4	(331)	(111)
Other non-current assets	6.4	113	113
Increase/(decrease) in liabilities			
Current payables	6.5	7,835	4,300
Current employee benefits provisions	3.1(b)	13,392	13,594
Other current liabilities	6.6	271	(30)
Non-current employee benefits provisions	3.1(b)	5,655	1,655
Net cash used in operating activities (statement of cash flows)		(638,020)	(638,951)

East Metropolitan Health Service
Notes to the financial statements
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	2019 $000	2018 $000
7.3.3 Cash flows from State Government		
Service appropriations (statement of comprehensive income)	718,928	714,341
Capital contributions credited directly to Contributed equity (note 8)	11,698	13,650
	730,626	727,991
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	(46,488)	(44,240)
Repayment of interest-bearing liabilities to Department of Treasury	(797)	(762)
Interest paid to Department of Treasury	(42)	(64)
Total notional cash flows	(47,327)	(45,066)
Cash flows from State Government (statement of cash flows)	683,299	682,925

7.3.4 Reconciliation of liabilities arising from financing activities

	Loan $000	Finance lease $000	Total (a) $000
2019			
Balance at beginning of period	1,636	22	1,658
Repayment of principal:			
Cash	-	(22)	(22)
Non-cash (b)	(797)	-	(797)
Balance at end of period	839	-	839
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

(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').

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	2019 $000	2018 $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:		
		(a)
Within 1 year	919	1,005
Later than 1 year, and not later than 5 years	3,064	2,333
Later than 5 years	749	1,177
Balance at end of period	4,732	4,515

(a) Prior year figures have been restated for comparative purpose.

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	5,106	9,148
Balance at end of period	5,106	9,148

The totals presented for capital commitments are inclusive of GST.

East Metropolitan Health Service
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	2019 $000	2018 $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:

		(a)
Within 1 year	352,991	310,272
Later than 1 year, and not later than 5 years	1,445,444	1,246,290
Later than 5 years, and not later than 10 years	1,842,196	1,579,618
Later than 10 years	2,423,939	2,383,212
Balance at end of period	6,064,570	5,519,392

(a) Prior year figures except for "Later than 10 years" category have been restated for comparative purpose.

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	16,487	13,659
Later than 1 year, and not later than 5 years	2,905	590
Later than 5 years	564	-
Balance at end of period	19,956	14,249

The totals presented for other commitments are inclusive of GST.

East Metropolitan Health Service
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	2019 $000	2018 $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	1,120,444	1,111,364
Contributions by owners (a)		
Capital appropriation (b)	11,698	13,613
Transfer of assets and liabilities from South Metropolitan Health	256	37
Total contributions by owners	1,132,398	1,125,014
Distributions to owners (a)		
Transfer of land to the Ministerial Body	-	(4,570)
Total distributions to owners	-	(4,570)
Balance at end of the period	1,132,398	1,120,444

(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.

(b) *TI 955 'Contributions by Owners Made to Wholly Owned Public Sector Entities'* designates capital appropriations as contributions by owners in accordance with *AASB Interpretation 1038 'Contributions by Owners Made to Wholly-Owned Public Sector Entities'*.

East Metropolitan Health Service
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	2019 $000	2018 $000
8 Equity (continued)		
Asset revaluation reserve		
Balance at start of the period	89,076	74,893
Net revaluation increments/(decrements):		
Land	-	-
Buildings	(10,443)	14,183
Balance at end of the period	78,633	89,076

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.

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Notes to the financial statements
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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.

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. Debt will be written off against the allowance account when it is improbable or uneconomical to recover the debt. 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.

Liquidity risk
Liquidity risk arises when the Health Service is unable to meet its financial obligations as they fall due. The Health Service is exposed to liquidity risk through its normal course of operations.

The Health Service has appropriate procedures to manage cash flows including drawdowns of appropriations by monitoring forecast cash flows to ensure that sufficient funds are available to meet its commitments.

Market risk
Market risk is the risk that changes in market prices such as foreign exchange rates and interest rates will affect the Health Service's income or the value of its holdings of financial instruments. The Health Service does not trade in foreign currency and is not materially exposed to other price risks. The Health Service's exposure to market risk for changes in interest rates relates primarily to the long-term debt obligations. The Health Service's borrowings are limited to the Department of Treasury loans. The interest rate risk for the loans is managed by the Department of Treasury through portfolio diversification and variation in maturity dates.

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Notes to the financial statements
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	2019 $000	2018 $000
9 Financial risk management (continued)		

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:

Financial assets		
Cash and cash equivalents	135,893	108,797
Restricted cash and cash equivalents	38,416	33,943
Receivables (a)	-	28,909
Financial assets at amortised cost (a)	26,955	-
Amounts receivable for services	481,822	435,334
Total financial assets	683,086	606,983
Financial liabilities		
Financial liabilities measured at amortised cost	83,160	76,144
Total financial liabilities	83,160	76,144

(a) The amount of receivables and financial assets at amortised cost excludes GST recoverable from ATO (statutory receivable).

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9.1 Financial risk management (continued)

c) Credit risk exposure

The following table details the credit risk exposure on the Health Service's receivables using a provision matrix.

		Days past due				
	Total $000	Current $000	< 30 days $000	31-60 days $000	61-90 days $000	>91 days* $000
30 June 2019						
Expected credit loss rate		4%	12%	26%	32%	82%
Estimated total gross carrying amount at default	47,616	15,899	6,083	1,661	1,804	22,169
Expected credit losses	(20,661)	(708)	(701)	(430)	(569)	(18,253)
1 July 2018 (remeasurement)						
Expected credit loss rate		4%	20%	12%	32%	78%
Estimated total gross carrying amount at default	52,223	14,838	3,692	4,520	1,634	27,539
Expected credit losses	(23,775)	(549)	(755)	(565)	(520)	(21,386)

*Includes receivables with maturity dates greater than 2 years.

d) Liquidity risk and interest rate exposure

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

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Notes to the financial statements
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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
2019										
Financial Assets										
Cash and cash equivalents		135,893	-	-	135,893	135,893	135,893	-	-	-
Restricted cash and cash equivalents		38,416	-	-	38,416	38,416	38,416	-	-	-
Receivables - non interest bearing (a)		26,955	-	-	26,955	26,955	26,955	-	-	-
Amounts receivable for services		481,822	-	-	481,822	481,822	-	-	-	481,822
		683,086	-	-	683,086	683,086	201,264	-	-	481,822
Financial Liabilities										
Payables	-	82,321	-	-	82,321	82,321	82,321	-	-	-
Department of Treasury Loans	3.15%	839	-	839	-	865	216	649	-	-
		83,160	-	839	82,321	83,186	82,537	649	-	-
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	-	-	-
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 Hospital	3.62%	22	22	-	-	23	8	15	-	-
		76,144	22	1,636	74,486	76,195	74,703	642	850	-

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

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Notes to the financial statements
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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
2019					
Financial assets					
Receivables	-	-	-	-	-
Financial liabilities					
Department of Treasury Loans	839	8	8	(8)	(8)
Total increase/(decrease)	839	8	8	(8)	(8)
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)

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Notes to the financial statements
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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 the best estimate.

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 6 claims pending litigation not recoverable from RiskCover insurance that may affect the financial position of the Health Service. These claims total $173,373.

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.

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.

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9.3 Fair value measurements

Assets measured at fair value 2019	Level 1 $000	Level 2 $000	Level 3 $000	Total $000
Land (note 5.1 'Property, plant and equipment')				
Vacant land	-	880	-	880
Specialised land	-	17,320	70,728	88,048
Buildings (note 5.1 'Property, plant and equipment')				
Residential and commercial carpark	-	2,720	-	2,720
Specialised buildings	-	-	672,425	672,425
	-	20,920	743,153	764,073

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

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
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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.

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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 replacement costs include:

a) Review and updating of the 'as-constructed' drawing
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 37.5 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.

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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
2019		
Fair value at beginning of period	70,838	706,934
Additions	-	4,838
Revaluation increments/(decrements) recognised in profit or loss	(110)	-
Revaluation increments/(decrements) recognised in other comprehensive income	-	(10,497)
Depreciation	-	(28,850)
Fair value at end of period	70,728	672,425

	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

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.

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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.

10.2 Initial application of Australian Accounting Standards

AASB 9 Financial Instruments

AASB 9 Financial Instruments replaces AASB 139 Financial Instruments: Recognition and Measurements for annual reporting periods beginning on or after 1 January 2018, bringing together all three aspects of the accounting for financial instruments: classification and measurement; impairment; and hedge accounting.

The Health Service applied *AASB 9* prospectively, with an initial application date of 1 July 2018. The adoption of *AASB 9* has resulted in changes in accounting policies and adjustments to the amounts recognised in the financial statements. In accordance with *AASB 9.7.2.15*, the Health Service has not restated the comparative information which continues to be reported under *AASB 139*. Differences arising from adoption have been recognised directly in Accumulated Surplus.

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10.2 Initial application of Australian Accounting Standards (continued)

The effect of adoption *AASB 9* as at 1 July 2018 was, as follows:

	Adjustments	1 July 2018 $000
Assets		
Receivables	(a), (b)	(461)
Equity		
Accumulated surplus	(a), (b)	(461)

The nature of these adjustments are described below:

(a) Classification and measurement:
Under *AASB 9*, financial assets are subsequently measured at amortised cost, fair value through other comprehensive income (fair value through OCI) or fair value through profit or loss (fair value through P/L). The classification is based on two criteria: the Health Services's business model for managing the assets; and whether the assets' contractual cash flows represent 'solely payments of principal and interest' on the principal amount outstanding.

The assessment of the Health Service's business model was made as of the date of initial application, 1 July 2018. The assessment of whether contractual cash flows on financial assets are solely comprised of principal and interest was made based on the facts and circumstances as at the initial recognition of the assets.

The classification and measurement requirements of *AASB 9* did not have a significant impact to the Health Service. The following are the changes in the classification of the Health Service's financial assets:

Receivables as at 30 June 2018 are held to collect contractual cash flows and give rise to cash flows representing solely payments of principal and interest. These are classified and measured as Financial assets at amortised cost beginning 1 July 2018.

The Health Service did not designate any financial assets as at fair value through P/L.

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10.2 Initial application of Australian Accounting Standards (continued)

In summary, upon the adoption of *AASB 9*, the Health Service had the following required (or elected) reclassifications as at 1 July 2018:

		AASB 9 Category		
		Amortised cost	Fair value through OCI	Fair value through P/L
		$000	$000	$000
***AASB 139* Category**	**$000**			
Receivables*	28,909	28,448	-	-

* The change in the carrying amount is a result of additional impairment allowance. See the discussion on impairment below.

(b) Impairment
The adoption of *AASB 9* has fundamentally changed the Health Service's accounting for impairment losses for financial assets by replacing *AASB 139*'s incurred loss approach with a forward-looking expected credit loss (ECL) approach. *AASB 9* requires the Health Service to recognise an allowance for ECLs for all financial assets not held at fair value through P/L.

Upon adoption of *AASB 9*, the Health Service recognised an additional impairment on the Health Service's receivables of $460,704 which resulted in a decrease in the accumulated surplus of $460,704 as at 1 July 2018.

Set out below is the reconciliation of the ending impairment allowances in accordance with *AASB 139* to the opening loss allowances determined in accordance with *AASB 9*:

	Impairment under *AASB 139* as at 30 June 2018 $000	Remeasurement $000	ECL under *AASB 9* as at 1 July 2018 $000
Receivables under *AASB 139*/ Financial assets at amortised cost under *AASB 9*	23,314	461	23,775

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10.3 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 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 contracts with customers. The mandatory effective 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.

The recognition of additional assets and liabilities, mainly from operating leases, will increase the Health Service's total assets and total liabilities by an estimated $4.3 million at 1 July 2019. In addition, interest and depreciation expenses will increase, offset by a decrease in rental expense for the year ending 30 June 2020 and beyond.

AASB 1058 Income of 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.

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10.3 Future impact of Australian Accounting Standards issued not yet operative (continued)

Title	Operative for reporting periods beginning on/after
AASB 1059 Service Concession Arrangements: Grantors	1 Jan 2020

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 mandatory effective date of this Standard is currently 1 January 2020 after being amended by *AASB 2018-5*.

The Health Service has not yet determined the impact of the Standard.

AASB 2016-8 Amendments to Australian Accounting Standards – Australian Implementation Guidance for Not-for-Profit Entities — 1 Jan 2019

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.

AASB 2018-4 Amendments to Australian Accounting Standards – Australian Implementation Guidance for Not-for-Profit Public Sector Licensors — 1 Jan 2019

This Standard amends *AASB 15* to add requirements and authoritative implementation guidance for application by not-for-profit public sector licensors to transactions involving the issue of licences. There is no financial impact as the Health Service does not issue licences.

AASB 2018-5 Amendments to Australian Accounting Standards – Deferral of AASB 1059 — 1 Jan 2019

This Standard amends the mandatory effective date of *AASB 1059* so that *AASB 1059* is required to be applied for annual reporting periods beginning on or after 1 January 2020 instead of 1 January 2019. There is no financial impact.

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10.3 Future impact of Australian Accounting Standards issued not yet operative (continued)

Title	Operative for reporting periods beginning on/after
AASB 2018-8 Amendments to Australian Accounting Standards – Right-of-Use Assets of Not-for-Profit Entities	1 Jan 2019

This Standard provides a temporary option for not-for-profit lessees to elect to measure a class of right-of-use assets arising under concessionary leases at initial recognition at cost rather than at fair value.

The Health Service has not yet measured the impact of the Standard.

10.4 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 ($)	2019	2018
$ 0 - $ 10,000 (a)	-	1
$ 20,001 - $ 30,000	-	1
$ 40,001 - $ 50,000	9	7
$ 70,001 - $ 80,000	1	1
Total:	10	10

(a) Includes members of the Accountable Authority with nil compensation.

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	2019 $000	2018 $000

10.4 Key management personnel (continued)

Compensation of senior officers

Compensation band ($)	2019	2018
$ 50,001 - $ 60,000	-	1
$ 70,001 - $ 80,000	-	1
$ 80,001 - $ 90,000	2	1
$100,001 - $110,000	-	1
$120,001 - $130,000	-	1
$160,001 - $170,000	1	-
$170,001 - $180,000	4	2
$210,001 - $220,000	1	2
$230,001 - $240,000	2	1
$240,001 - $250,000	1	-
$270,001 - $280,000	1	-
$480,001 - $490,000	-	1
$490,001 - $500,000	2	-
$500,001 - $510,000	-	1
$550,001 - $560,000	-	1
Total:	14	13

Short-term employee benefits (a)	3,258	3,144
Post employment benefits	340	356
Other long-term benefits	100	(103)
Total compensation of key management personnel	3,698	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.

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10.5 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 controllec 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 Genera	10.9
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.

10.6 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 2019

	2019 $000	2018 $000

10.7 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.

10.8 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	632	124
Receipts		
Commonwealth contributions (note 4.2)	50,014	49,422
State contributions (note 4.3)	125,711	117,293
Other (note 4.3)	3,362	3,991
	179,719	170,830
Payments	(179,374)	(170,198)
Balance at end of period	345	632

The special purpose accounts are established under section 16(1)(d) of the *Financial Management Act 2006*.

10.9 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 statements, controls, and key performance indicators	232	217

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2019

	2019 $000	2018 $000
10.10 Supplementary financial information		
a) Write-offs		
Debts written off under the authority of the Accountable Authority	6,088	6,971
Public and other property written off under the authority of the Accountable Authority	127	-
Debts written off under the authority of the Minister	567	2,462
	6,782	9,433
b) Debt waivers		
Debts waived under the authority of the Accountable Authority	97	1,490
	97	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.

10.11 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	34	29
Add receipts	71	89
	105	118
Less payments	(90)	(84)
Balance at end of period	15	34

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2019

	2019 $000	2018 $000
10.11 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	294	293
Add receipts	-	1
	294	294
Less payments	-	-
Balance at end of period	294	294

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2019

Note 11 Explanatory statement

All variances between actual results for 2019 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 2019 $000	Actuals 2019 $000	Variance between actual and estimate $000
Expenses				
Employee benefits expense		823,627	841,079	17,452
Fees for visiting medical practitioners		26,517	29,710	3,192
Contracts for services		284,878	288,127	3,249
Patient support costs		217,088	215,116	(1,971)
Finance costs		43	40	(3)
Depreciation and amortisation expense		46,488	44,084	(2,404)
Asset revaluation decrement		-	2,010	2,010
Loss on disposal of non-current assets		-	805	805
Repairs, maintenance and consumable equipment		26,066	24,395	(1,671)
Other supplies and services		4,765	7,712	2,946
Other expenses		94,954	79,299	(15,656)
Total cost of services		**1,524,426**	**1,532,377**	**7,949**
Income				
Revenue				
Patient charges		73,018	67,689	(5,329)
Other fees for services		63,495	48,184	(15,310)
Commonwealth grants and contributions	1	425,329	499,647	74,318
Other grants and contributions	1	178,550	132,697	(45,854)
Donation revenue		546	196	(351)
Commercial activities		-	154	154
Other revenue		7,817	18,587	10,770
Total income other than income from State Government		**748,755**	**767,154**	**18,399**
Net cost of services		**775,671**	**765,223**	**(10,449)**
Income from State Government				
Service appropriations		720,589	718,928	(1,662)
Assets assumed		-	95	95
Services received free of charge		54,811	53,476	(1,335)
Total income from State Government		**775,400**	**772,499**	**(2,902)**
Surplus / (deficit) for the period		**(271)**	**7,276**	**7,547**

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2019

Note 11 Explanatory statement (continued)

Statement of comprehensive income (continued)	Estimates 2019 $000	Actuals 2019 $000	Variance between actual and estimate $000
Other comprehensive income			
Items not reclassified subsequently to profit or loss	-	-	-
Changes in asset revaluation reserve	-	(10,443)	(10,443)
Total other comprehensive income	**-**	**(10,443)**	**(10,443)**
Total comprehensive income/(loss) for the period	**(271)**	**(3,167)**	**(2,896)**

Significant variances between estimates and actuals - statement of comprehensive income

1. Revenue from Commonwealth and other grants and contributions are higher than initial estimates by $28.5m (4.7%). Due to increased patient activity, the Health Service received additional Commonwealth National Health Reform Agreement (NHRA) funding of $20.9M. In addition, the initial estimates did not include grants and contributions received for additional research and clinical trials ($1.5M), the Community Aids and Equipment ($1.3M) and Aged Care Assessment ($3.3M) programs, increased mental health funding ($0.5M) and other miscellaneous programs ($1M).

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2019

Note 11 Explanatory statement (continued)

Statement of financial position	Note	Estimates 2019 $000	Actuals 2019 $000	Variance between actual and estimate $000
Assets				
Current assets				
Cash and cash equivalents		104,717	135,893	31,175
Restricted cash and cash equivalents		27,584	28,706	1,121
Receivables		31,830	30,119	(1,712)
Inventories		5,091	4,519	(571)
Other current assets		874	1,207	333
Total current assets		**170,096**	**200,444**	**30,348**
Non-current assets				
Restricted cash and cash equivalents		10,168	9,710	(458)
Amounts receivable for services		481,821	481,822	1
Property, plant and equipment		890,769	875,506	(15,263)
Intangible assets		2,027	1,221	(806)
Other non-current assets		150	37	(113)
Total non-current assets		**1,384,935**	**1,368,296**	**(16,639)**
Total assets		**1,555,031**	**1,568,740**	**13,709**
Liabilities				
Current liabilities				
Payables		73,994	82,321	8,327
Borrowings		22	839	817
Employee benefits provisions		163,176	169,305	6,129
Other current liabilities		188	461	273
Total current liabilities		**237,380**	**252,926**	**15,545**
Non-current liabilities				
Employee benefits provisions		26,913	40,984	14,072
Borrowings		839	-	(839)
Total non-current liabilities		**27,752**	**40,984**	**13,233**
Total liabilities		**265,132**	**293,910**	**28,778**
Net assets		**1,289,899**	**1,274,830**	**(15,069)**
Equity				
Contributed equity		1,143,830	1,132,398	(11,432)
Reserves		87,859	78,633	(9,226)
Accumulated surplus		58,210	63,799	5,588
Total equity		**1,289,899**	**1,274,830**	**(15,069)**

Note 11 Explanatory statement (continued)

Significant variances between estimates and actuals - statement of financial position

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2019

Note 11 Explanatory statement (continued)

Statement of changes in equity	Estimates 2019 $000	Actuals 2019 $000	Variance between actual and estimate $000
Contributed equity			
Balance at start of period	1,120,446	1,120,444	(2)
Transactions with owners in their capacity as owners:			
Capital appropriations	22,587	11,698	(10,889)
Other contributions by owners	797	256	(541)
Distributions to owners	-	-	-
Balance at end of period	**1,143,830**	**1,132,398**	**(11,432)**
Reserves			
Asset revaluation reserve			
Balance at start of period	87,859	89,076	1,216
Other comprehensive income for the period	-	(10,443)	(10,443)
Balance at end of period	**87,859**	**78,633**	**(9,226)**
Accumulated surplus			
Balance at start of period	58,481	56,984	(1,497)
Changes in accounting policy	-	(461)	(461)
Restated balance at start of period	58,481	56,523	(1,958)
Surplus for the period	(271)	7,276	7,547
Balance at end of period	**58,210**	**63,799**	**5,589**
Total equity			
Balance at start of period	1,266,786	1,266,504	(282)
Changes in accounting policy	-	(461)	(461)
Restated balance at start of period	1,266,786	1,266,043	(743)
Total comprehensive income/(loss) for the period	(271)	(3,167)	(2,896)
Transactions with owners in their capacity as owners	23,384	11,954	(11,431)
Balance at end of period	**1,289,899**	**1,274,830**	**(15,069)**

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2019

Note 11 Explanatory statement (continued)

Statement of cash flows	Note	Estimates 2019 $000	Actuals 2019 $000	Variance between actual and estimate $000
Cash flows from State Government				
Service appropriations		674,058	672,398	(1,659)
Capital appropriations		22,587	10,901	(11,686)
Net cash provided by State Government		**696,645**	**683,299**	**(13,345)**
Utilised as follows:				
Cash flows from operating activities				
Payments				
Employee benefits		(823,627)	(818,493)	5,134
Supplies and services		(595,861)	(585,209)	10,653
Finance costs		-	(1)	(1)
Receipts				
Receipts from customers		69,423	66,091	(3,332)
Commonwealth grants and contributions	1	425,329	499,647	74,318
Other grants and contributions	1	178,550	132,697	(45,854)
Donations received		546	142	(404)
Other receipts		71,311	67,106	(4,205)
Net cash used in operating activities		**(674,329)**	**(638,020)**	**36,310**
Cash flows from investing activities				
Payments				
Purchase of non-current assets		(22,587)	(13,784)	8,803
Receipts				
Proceeds from sale of non-current assets		-	96	96
Net cash used in investing activities		**(22,587)**	**(13,688)**	**8,899**
Cash flows from financing activities				
Payments				
Repayment of finance lease liabilities		-	(22)	(22)
Net cash used in financing activities		**-**	**(22)**	**(22)**
Net increase in cash and cash equivalents		(271)	31,569	31,840
				-
Cash and cash equivalents at the beginning of the period		142,740	142,740	-
Total cash and cash equivalents at the end of the period		**142,469**	**174,309**	**31,840**

Note 11 Explanatory statement (continued)

Significant variances between estimates and actuals - statement of cash flows

1. Refer to the explanation of variance between estimates and actuals for Commonwealth and other grants and contributions in the Statement of Comprehensive Income.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2019

Note 11 Explanatory statement (continued)

All variances between actual results for 2019 and 2018 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 2019 $000	Actuals 2018 $000	Variance between 2019 and 2018 results $000
Expenses				
Employee benefits expense	1	841,079	791,277	49,803
Fees for visiting medical practitioners		29,710	25,200	4,510
Contracts for services		288,127	274,334	13,794
Patient support costs		215,116	214,528	588
Finance costs		40	65	(25)
Depreciation and amortisation expense		44,084	44,258	(173)
Asset revaluation decrement		2,010	3,130	(1,121)
Loss on disposal of non-current assets		805	85	720
Repairs, maintenance and consumable equipment		24,395	26,257	(1,862)
Other supplies and services		7,712	6,707	1,005
Other expenses		79,299	81,572	(2,274)
Total cost of services		**1,532,377**	**1,467,413**	**64,962**
Income				
Revenue				
Patient charges		67,689	64,787	2,902
Other fees for services		48,184	52,481	(4,297)
Commonwealth grants and contributions	2	499,647	451,887	47,761
Other grants and contributions		132,697	123,985	8,712
Donation revenue		196	2,075	(1,881)
Commercial activities		154	98	56
Other revenue		18,587	8,146	10,443
Total income other than income from State Government		**767,154**	**703,459**	**63,696**
Net cost of services		**765,223**	**763,954**	**1,266**
Income from State Government				
Service appropriations		718,928	714,341	4,587
Assets assumed		95	97	(2)
Services received free of charge		53,476	56,196	(2,719)
Total income from State Government		**772,499**	**770,634**	**1,865**

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2019

Note 11 Explanatory statement (continued)

Statement of comprehensive income	Actuals 2019 $000	Actuals 2018 $000	Variance between 2019 and 2018 results $000
Surplus / (deficit) for the period	**7,276**	**6,680**	**598**
Other comprehensive income			
Changes in asset revaluation reserve	(10,443)	14,183	(24,626)
Total other comprehensive income	**(10,443)**	**14,183**	**(24,626)**
Total comprehensive income/(loss) for the period	**(3,167)**	**20,863**	**(24,028)**

Significant variances between 2019 and 2018 actuals - statement of comprehensive income

1. Employment costs increased by $49.8m (6%) mainly due to an overall increase in the number of employees mainly at Armadale and Royal Perth hospitals as a result of increased patient activity ($31M), an increase in employee benefits expense recognised as a result of the actuarial valuation of the employee benefits provisions ($10M) and salary award entitlement increases ($8.9M).

2. Commonwealth grants and contributions increase in total by $47.8M due to increased Commonwealth National Health Reform Agreement funding associated with increased patient activity ($36.1M) and funding received from the Department of Veterans' Affairs ($11.7M); no Department of Veterans' Affairs funding was received in 2018.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2019

Note 11 Explanatory statement (continued)

Statement of financial position	Actuals 2019 $000	Actuals 2018 $000	Variance between 2019 and 2018 results $000
Assets			
Current assets			
Cash and cash equivalents	135,893	108,797	27,096
Restricted cash and cash equivalents	28,706	27,584	1,121
Receivables	30,119	31,893	(1,775)
Inventories	4,519	5,091	(570)
Other current assets	1,207	876	331
Total current assets	**200,444**	**174,241**	**26,202**
Non-current assets			
Restricted cash and cash equivalents	9,710	6,359	3,351
Amounts receivable for services	481,822	435,334	46,489
Property, plant and equipment	875,506	915,969	(40,464)
Intangible assets	1,221	2,027	(806)
Other non-current assets	37	150	(113)
Total non-current assets	**1,368,296**	**1,359,839**	**8,457**
Total assets	**1,568,740**	**1,534,080**	**34,659**
Liabilities			
Current liabilities			
Payables	82,321	74,486	7,835
Borrowings	839	819	19
Employee benefits provisions	169,305	155,913	13,392
Other current liabilities	461	190	271
Total current liabilities	**252,926**	**231,408**	**21,516**
Non-current liabilities			
Employee benefits provisions	40,984	35,329	5,655
Borrowings	-	839	(839)
Total non-current liabilities	**40,984**	**36,168**	**4,816**
Total liabilities	**293,910**	**267,576**	**26,334**
Net assets	**1,274,830**	**1,266,504**	**8,325**
Equity			
Contributed equity	1,132,398	1,120,444	11,953
Reserves	78,633	89,076	(10,443)
Accumulated surplus	63,799	56,984	6,815
Total equity	**1,274,830**	**1,266,504**	**8,326**

Note 11 Explanatory statement (continued)

Significant variances between 2019 and 2018 actuals - statement of financial position

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2019

Note 11 Explanatory statement (continued)

Statement of changes in equity	Note	Actuals 2019 $000	Actuals 2018 $000	Variance between 2019 and 2018 results $000
Contributed equity				
Balance at start of period		1,120,444	1,111,364	9,080
Transactions with owners in their capacity as owners:				
Capital appropriations		11,698	13,613	(1,916)
Other contributions by owners		256	37	219
Distributions to owners		-	(4,570)	4,570
Balance at end of period		**1,132,398**	**1,120,444**	**11,954**
Reserves				
Asset revaluation reserve				
Balance at start of period		89,076	74,893	14,183
Other comprehensive income for the period		(10,443)	14,183	(24,626)
Balance at end of period		**78,633**	**89,076**	**(10,443)**
Accumulated surplus				
Balance at start of period		56,984	50,304	6,680
Changes in accounting policy		(461)	-	(461)
Restated balance at start of period		56,523	50,304	6,219
Surplus for the period		7,276	6,680	595
Balance at end of period		**63,799**	**56,984**	**6,815**
Total equity				
Balance at start of period		1,266,504	1,236,561	29,943
Changes in accounting policy		(461)	-	(461)
Restated balance at start of period		1,266,043	1,236,561	29,482
Total comprehensive income/(loss) for the period		(3,167)	20,863	(24,030)
Transactions with owners in their capacity as owners		11,954	9,080	2,873
Balance at end of period		**1,274,830**	**1,266,504**	**8,326**

Significant variances between 2019 and 2018 actuals - statement of changes in equity

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2019

Note 11 Explanatory statement (continued)

Statement of cash flows	Note	Actuals 2019 $000	Actuals 2018 $000	Variance between 2019 and 2018 results $000
Cash flows from State Government				
Service appropriations		672,398	670,035	2,362
Capital appropriations		10,901	12,890	(1,989)
Net cash provided by State Government		**683,299**	**682,925**	**374**
Utilised as follows:				
Cash flows from operating activities				
Payments				
Employee benefits	1	(818,493)	(776,312)	(42,181)
Supplies and services		(585,209)	(559,172)	(26,036)
Finance costs		(1)	(3)	3
Receipts				
Receipts from customers		66,091	60,703	5,389
Commonwealth grants and contributions	2	499,647	451,887	47,761
Other grants and contributions		132,697	123,985	8,713
Donations received		142	187	(45)
Other receipts		67,106	59,774	7,332
Net cash used in operating activities		**(638,020)**	**(638,951)**	**935**
Cash flows from investing activities				
Payments				
Purchase of non-current assets		(13,784)	(14,518)	734
				-
Receipts				-
Proceeds from sale of non-current assets		96	95	(1)
Net cash used in investing activities		**(13,688)**	**(14,423)**	**733**
Cash flows from financing activities				
Payments				
Repayment of finance lease liabilities		(22)	(30)	8
Net cash used in financing activities		**(22)**	**(30)**	**8**
Net increase in cash and cash equivalents		31,569	29,521	2,048
Cash and cash equivalents at the beginning of the period		142,740	113,219	29,521
Total cash and cash equivalents at the end of the period		**174,309**	**142,740**	**31,569**

Note 11 Explanatory statement (continued)

Significant variances between 2019 and 2018 actuals - statement of cash flows

1. Refer to the explanation of variance between current year actuals and prior year actuals for the employee benefits expense in the Statement of Comprehensive Income.

2. Refer to the explanation of variance between 2019 actuals and 2018 actuals for Commonwealth grants and contributions in the Statement of Comprehensive Income.

East Metropolitan Health Service

Disclosure & legal compliance

Royal Perth Hospital

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, investment activities and financing activities.

The Minister for Health's expectations regarding the priorities and accountabilities of the EMHS Board are clearly outlined in the 2018-19 Statement of Expectations, to which the EMHS Board released a Statement of Intent in response. Both of these documents are available on the EMHS website: emhs.health.wa.gov.au/About-Us/Health-Service-Board.

These Statements outlined the Health Service's ongoing focus on progression of the Government's election commitments; implementation of the recommendations of the Sustainable Health Review; consumer engagement; safety and quality; culture; performance; and governance.

Key achievements aligned with these Statements during 2018-19 included:

- Ongoing work towards the development of a MHEC at RPH, which is scheduled to open in late 2019.
- Continued planning towards the establishment of an Innovation Hub at RPH.
- Continued planning towards the development of a Medihotel and Command Centre at RPH.
- Initiatives to support staff in the management of aggressive incidents, with the aim to actively reduce and prevent aggression.
- Active use of the Patient Opinion platform to receive real-time feedback from our consumers, with more than 143 stories received during 2018-19.
- Prioritising the improvement of staff morale, culture and performance through staff engagement initiatives such as leader rounding and the Minister's Your Voice in Health Survey.
- Continued focus on performance measures such as WEAT and WEST.

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 2018-19, 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 or Executive members held interests in an existing or proposed contract that has, or could result in, the member receiving financial benefits.

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 page 224.

Board/committee	Total remuneration ($)
East Metropolitan Health Service Board	421,377
Armadale Kalamunda Group Consumer Advisory Council	4770
Bentley Health Service Community Advisory Committee	1920
Royal Perth Hospital Community Advisory Committee	5040
Midland Mental Health Consumer Advisory Group	2400
Royal Perth Bentley Group Lived Experience Advisory Group	2760
Armadale Kalamunda Aboriginal Health Community Advisory Group	4682
Bentley Aboriginal Health Community Advisory Group	4975
Swan Hills/Midland Aboriginal Health Community Advisory Group	5417
Royal Perth Hospital and Inner City Aboriginal Health Community Advisory Group	3925
Wungen Kartup Aboriginal Consumer and Carer Advisory Group	1590
Aboriginal Health Advisory Council	2907
Royal Perth Hospital Animal Ethics Committee	24,719
Royal Perth Hospital Human Research Ethics Committee	356

Uncle Ben, member of Royal Perth Hospital and Inner City Aboriginal Health Community Advisory Group

Pricing policy

EMHS complies with the *Health Insurance Act 1973*, the National Health Reform Agreement 2011, and the *WA Health Services Act 2016* regarding prices set for public hospital fees and charges.

The WA Health Patient Fees and Charges Manual sets out the rules and prices set for public hospital fees and charges in accordance with these regulations, and provides the pricing framework which EMHS abides by.

As outlined in the National Health Reform Agreement 2011 (NHRA 2011), "Where an eligible person receives public hospital services as a public patient [or a publicly contracted bed in a private hospital] no charges will be raised, except for [certain] services [and pharmaceuticals] provided to non-admitted patients". (NHRA 2011, Schedule G1.) The NHRA 2011 also states that "Private patients, compensable patients and ineligible persons may be charged an amount for public hospital services as determined by the State". (NHRA 2011, Schedule G3.)

The State annually reviews the pricing and rules in relation to fees and charges that may apply for health services, goods and other services in WA Health Patient Fees and Charges Manual. EMHS annually refers to the Manual to update new patient fees and charges and to ensure the health services are compliant. As stated in the Manual, EMHS can charge accommodation, professional services, prostheses and other 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 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 provider.
- Overseas visitors holding a valid visa and being a resident of a Reciprocal Health Care Agreement (RHCA) country are eligible for 'medically necessary' treatment. 'Medically necessary' treatment covers ill-health or injury that occurs while visiting Australia and requires treatment before their return home.
- 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. If an overseas visitor elects to be private, they are ineligible under a RHCA and will be charged as a Medicare ineligible patient.
- 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 qualified 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 do not charge medical treatment to eligible war service veterans. Instead, medical charges are fully recouped from DVA.
- Workers compensation: patients who are making a workers 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 2018.

Unauthorised use of WA Government purchasing cards

WA 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 $26) where a purchasing card was used for personal purposes in 2018-19. 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.

$26

Aggregate amount of personal use expenditure for the reporting period

$22

Aggregate amount of personal use expenditure settled by the due date (within five working days)

$4

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

Expenditure on advertising

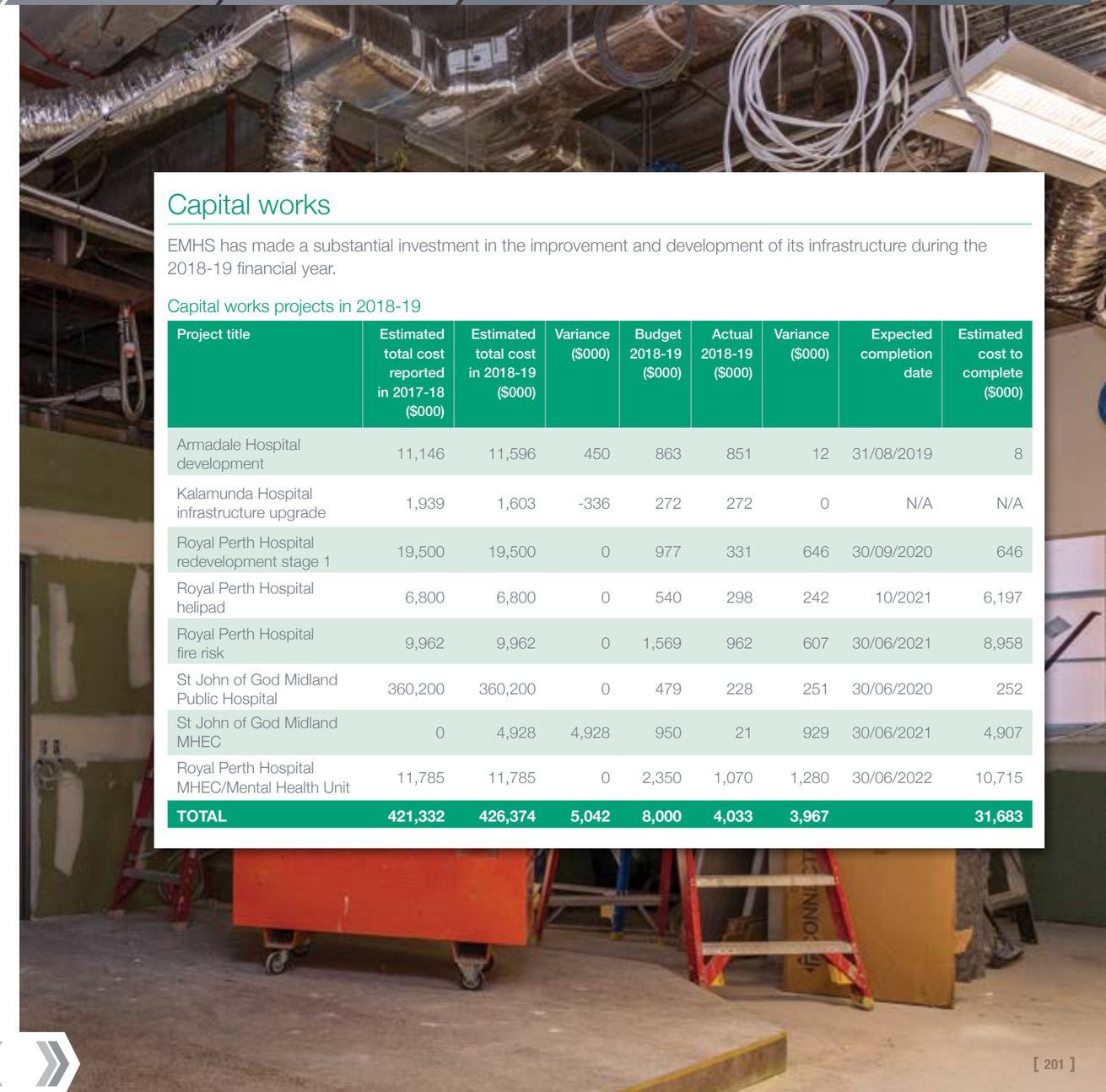
In 2018–19 in accordance with section 175Z of the *Electoral Act 1907* EMHS incurred a total advertising expenditure of $20,877.

Advertising (for recruitment and interest in consumer and community advisory participation) and market research was procured and the amount paid to the following organisations:

Summary of advertising	Amount ($)
Advertising agencies	
Total	**0**
Market research organisations	
Metrics Consulting Pty Ltd	9400
Total	**9400**
Polling organisations	
Total	**0**
Direct mail organisations	
Total	**0**
Media advertising organisations	
Adcorp Australia Ltd	10,932
The Royal Australasian College of Medical Administrators	545
Total	**11,477**
TOTAL ADVERTISING EXPENDITURE	**20,877**

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.



Capital works

EMHS has made a substantial investment in the improvement and development of its infrastructure during the 2018-19 financial year.

Capital works projects in 2018-19

Project title	Estimated total cost reported in 2017-18 ($000)	Estimated total cost in 2018-19 ($000)	Variance ($000)	Budget 2018-19 ($000)	Actual 2018-19 ($000)	Variance ($000)	Expected completion date	Estimated cost to complete ($000)
Armadale Hospital development	11,146	11,596	450	863	851	12	31/08/2019	8
Kalamunda Hospital infrastructure upgrade	1,939	1,603	-336	272	272	0	N/A	N/A
Royal Perth Hospital redevelopment stage 1	19,500	19,500	0	977	331	646	30/09/2020	646
Royal Perth Hospital helipad	6,800	6,800	0	540	298	242	10/2021	6,197
Royal Perth Hospital fire risk	9,962	9,962	0	1,569	962	607	30/06/2021	8,958
St John of God Midland Public Hospital	360,200	360,200	0	479	228	251	30/06/2020	252
St John of God Midland MHEC	0	4,928	4,928	950	21	929	30/06/2021	4,907
Royal Perth Hospital MHEC/Mental Health Unit	11,785	11,785	0	2,350	1,070	1,280	30/06/2022	10,715
TOTAL	**421,332**	**426,374**	**5,042**	**8,000**	**4,033**	**3,967**		**31,683**

Staff development

The provision of ongoing staff development is an essential contributing factor to quality service delivery, employee engagement, performance and retention within EMHS. The health service 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 and interprofessional education
- clinical scenario training and innovative unit based specialty simulations aimed at developing technical and non-technical skills
- access to a range of online learning resources
- collaboration and partnering in scenario-based clinical exercises with external health care providers.

In addition, a range of team development training opportunities are provided to support service staff.

Royal Perth Hospital

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.

Compliance with public sector standards and ethical codes

The following policies and guidelines cover EMHS and are consistent with the public sector standards. They are available to all employees on the EMHS intranet and/or WA Health policy frameworks internet pages.

- 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 Peak Performance Policy, Guidelines and generic template
- EMHS Employee Separation Policy
- EMHS Expression of Interest Guidelines and template.

Information relating to the Public Sector Standards and the breach of standard claim process is available via:

- notification of the breach claim process and period as a part of the appointment process
- provision of information about the 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
- EMHS intranet page – Public Sector Standards in Human Resource (HR) Management
- recruitment, selection and appointment training
- peak performance training for line managers.

Compliance with the public sector standards in HR management are monitored via review of breach claims. During 2018-19, 14 breach of standard claims were lodged against the employment standard. Of the claims, five were resolved internally and/or were withdrawn, eight were referred to the Public Sector Commission (PSC) (one withdrawn, seven dismissed, nil conciliated) and one was ongoing (being managed internally as at 30 June 2019). There were no claims against the grievance resolution, performance management, termination or redeployment standards.

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.

EMHS informs and educates employees about the principles of workplace behaviour and conduct required by the WA Health Code of Conduct in the following ways:

- new employee acknowledgement of the Code of Conduct
- provision of information within all induction programs
- mandatory accountable and ethical decision making training
- mandatory prevention of workplace bullying training.

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 in accordance with the WA Health Discipline Policy. During 2018-19, EMHS had 136 reported cases of potential breaches of discipline. Of the claims that were closed during the financial year, 29 were substantiated.

EMHS maintains and supports an Employee Support Officer Network. This network of trained volunteer employees is available to provide confidential support and information about processes and resources to employees who have a workplace concern or query.

Line Managers are able to access HR Consultants for information and support in relation to compliance with public sector standards, management of breach claims, and case management of suspected breaches of the Code of Conduct.

HR Consultants offer an overview of HR essentials training to line managers. This session, delivered as a guided conversation, aims to provide familiarity with key legislative and policy requirements, and to guide navigation of HR responsibilities, resources and supports.

Substantive equality

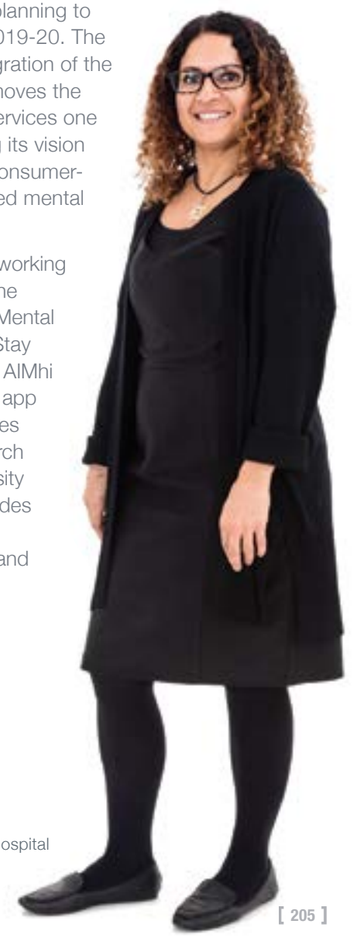
EMHS is committed to achieving substantive equality by eliminating systemic forms of discrimination in the provision of services and promoting awareness of the different needs of our client groups.

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:

- Implementation of EMHS Aboriginal Health and Wellbeing Framework action plan that includes Aboriginal Health strategies under the portfolios of Cultural Security, Community Engagement and Aboriginal Workforce; Strategic Actions to reduce gap in life expectancy between Aboriginal and non-Aboriginal Western Australians and reduction in the gap in mortality rates for Aboriginal children under five, and six strategic directions, promote good health across the life course; prevention and early intervention, a culturally respectful and non-discriminatory health system, individual family and community wellbeing, a strong, skilled and growing Aboriginal health workforce and equitable and timely access to the best quality and safe care with input from the EMHS AHCAGs and staff.
- EMHS has an established strategic partnership with the Aboriginal community in its catchment through the formation of the four AHCAGs and the AHAC which has been operating since 2016. Five working groups were established to support the development and implementation of strategic actions on building the cultural foundation of EMHS, Aboriginal workforce, Aboriginal volunteer program, dental and youth. Members also contribute to strategies to address Discharge Against Medical Advice (DAMA); development of Aboriginal patient journey continuum of care, mental health and other EMHS committees.
- Using the Aboriginal Impact Statement and Declaration process which aims to ensure that the needs, interests and circumstances of Aboriginal consumers and employees are incorporated into the development of new and revised policies, programs, strategies, practices, resources, reports and frameworks.
- 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 programs, Aboriginal Maternity services and Aboriginal Acute Care Coordination program.
- 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; implementation of a number of cultural learning courses and training within EMHS Cultural Learning Program.
- Implementing strategies to be more culturally respectful and welcoming which include:
  - Engagement in activities and events of cultural significance in the Aboriginal community.
  - Cultural protocols that respect and acknowledge Aboriginal ways of communicating and engaging in all aspects of health service delivery.
  - Formal practice of Welcome to Country and Acknowledgment of Traditional Owners, flag raising ceremonies and smoking ceremonies; creation of acknowledgement plaques and artwork for EMHS.
  - Supporting EMHS sites to develop and create culturally safe spaces, programs and culturally informed workforce.
  - The Noongar language translation is used in EMHS vision, goals, key documents, in brochures relating to accessing and receiving care.
  - Supporting WA Country Health Service (WACHS) initiatives to supply Telehealth Services to the Kimberley to not dislocate patients from country and to support wrap-around services when needing to remain in Perth e.g. renal dialysis.
- Development and implementation of EMHS Aboriginal Workforce Strategic Direction that is inclusive of the following:
  - Ongoing engagement and support of EMHS Aboriginal workforce through Aboriginal Workforce Engagement Group to share information, 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, engaging three Aboriginal trainees and two Aboriginal Cadets.
  - Ongoing leadership development opportunities provided for existing Aboriginal staff through the Leadership Excellence And Development (LEAD) program.
  - Allied health departments liaising with University Clinical Placement Coordinators to allocate as many undergraduate students as possible at EMHS sites so we may progress their graduate employment opportunities.

EMHS is also committed to contributing to substantive equality for mental health consumers, their carers and family. A Peer Support Program was implemented in RPBG in 2018-19, employing two lived experienced Peer Support Workers at East Metropolitan Youth Unit (EMyU). The two positions are in addition to a Peer Support Worker position in place at the Midland Adult Community Mental Health Service with Armadale Mental Health Service planning to establish positions in 2019-20. The establishment and integration of the Peer Support Service moves the RPBG Mental Health Services one step closer to achieving its vision and mission of a truly consumer-centred recovery focused mental health service.

RPBG Mental Health is working towards implementing the Aboriginal and Islander Mental Health Initiative (AIMhi) Stay Strong App in 2019-20. AIMhi Stay Strong is an online app developed by the Menzies School of Health Research and Queensland University of Technology that provides tools to assist clinicians to work with Aboriginal and Islander people.



Social Worker, Royal Perth Hospital

Royal Perth and Bentley Hospitals' mental health service sets the standard for LGBTI inclusive health care

In April 2019 RPBG's inpatient mental health services became the first public health service in Western Australia to achieve a milestone "Rainbow Tick" accreditation in recognition of their commitment to safe, inclusive, and welcoming health services for lesbian, gay, bisexual, transgender and intersex (LGBTI) people.

This milestone achievement was celebrated by raising a Rainbow Flag at BH - signalling our commitment to ensuring that all inpatient mental health services (including youth, adult and older adult inpatient) are accessible and inclusive for everyone visiting or seeking treatment, as well as providing a friendly and welcoming place of work for LGBTI staff.

RPBG inpatient mental health services completed Rainbow Tick accreditation to help overcome some of the barriers that impact upon LGBTI peoples' willingness to seek support and treatment for mental health issues, including perceived feelings of discrimination and stigma in relation to mental health care.

The Rainbow Tick accreditation requires achievement against a set of nationally agreed standards administered by independent accreditation provider Quality Innovation Performance and developed by Rainbow Health Victoria – Australian Research Centre in Sex, Health and Society, La Trobe University in response to the growing number of LGBTI consumers seeking information on inclusive health professionals and services.

The six standards are; organisational capacity; workforce development; consumer participation; a welcoming and accessible organisation; disclosure and documentation; and culturally safe and acceptable services.

The hospitals had been working toward achieving Rainbow Tick accreditation since February 2016 which included an extensive education program, and policy and practice review across the two sites to better promote and inform staff of practices that support inclusivity of patients, carers and staff who identify as being LGBTI.

As part of that process, a number of staff volunteered as 'Rainbow Champions', and it was their role, along with lived-experience representatives and LGBTI community members, to support staff during the stringent accreditation process.

Research indicates that compared to the general population LGBTI people are up to fourteen times more likely to attempt suicide than their peers, rates of depression are over five times higher among transgender people and 3.5 times higher among lesbian, gay and bisexual people.

RPBG will be working to expand inclusive practice and education tools to community mental health services in preparation for the inpatient mental health services three year accreditation review.

Mental Health Emergency Centre

A new MHEC is scheduled to open at RPH in October 2019, within the ED. An important component of this MHEC will be the inclusion of an Aboriginal Mental Health Worker, to offer culturally appropriate models of mental health practice for Aboriginal patients and their families.

Royal Perth Hospital

Disability access and inclusion plan

EMHS continues to ensure that people with disability, their families and carers are provided with the same opportunities and afforded the same rights and responsibilities as other people in the community.

The EMHS Disability Access and Inclusion Plan (DAIP) is, in accordance with the statutory responsibilities of the *Disability Services Act Regulations 2004* and other related legislation, based on the seven desired outcomes for translating the principles and objectives of the Act into tangible, achievable results. The EMHS DAIP, found at emhs.health.wa.gov.au/Patient-Care/DAIP, acknowledges the WA Health Disability Access and Inclusion Plan 2016-20 and the requirement for all staff to actively work towards providing better access and inclusion in their workplace.

Some examples of EMHS improvements and achievements in 2018-19 include:

- regular site visits by members of the CAC and discussions with staff about how to improve disability access and inclusion
- undertaking of a parking survey at AH to ensure adequate accessible parking bays
- celebrations across EMHS during Disability Week 2018 including interactive displays
- improving staff awareness via internal communications
- Better Hearing Cards have been allocated to areas of need post-audit (AKG)
- working with community accommodation providers to improve their residents' health journey when admitted to hospital
- improved access to KH reception area
- installation of an electronic door for improved access to the RPH Library
- new toilet amenities for booked admission cases at RPH.

Planning is also underway at RPH for providing short term drop-off bays for outpatients and redirecting vehicle entry via Goderich Street as well as the provision of a concierge service by volunteers.

Access to information

EMHS is currently rolling out multilingual cue cards across all inpatient wards to assist in communicating with non-English speaking patients. For patients with cultural and linguistically diverse backgrounds, the cards help to improve safety, reduce anxiety, and provide a better consumer experience. This resource is a combination of basic translated sentences and pictures.

Better Hearing cards is a resource used to remind staff of critical factors when interacting with people who are hard of hearing, largely intended for use by clerical and reception staff. The availability of these cards, and also of staff awareness of these resources, is regularly audited in patient reception areas by Patient Information Management Services.

Noongar Language translation is used in our vision, goals, key documents and brochures relating to accessing and receiving care. At BH, patient information brochures on key services have been translated into the top five most commonly used languages.

Access to services and events

Access to EMHS corporate offices located in the heritage-listed Kirkman House has provided challenges in the past due the age of the building and the restrictions placed on renovation of heritage-listed buildings. Events held in this facility for the community including bereavement and carers support days, access for inter-jurisdictional visitors or staff with disability has been difficult in the past as the building has two stairwells and an old lift. The lift has now been upgraded and made compliant for regular wheelchairs, includes hand rails and tactile push buttons.

AKG undertook a two month survey in 2018 based on feedback regarding parking difficulties. Outcome strategies implemented include moving health student parking to a staff parking area, accessible parking bays repainted and travel awareness options listed on the AH website.

Participation in public consultation

EMHS holds a monthly Consultation and Engagement Executive Committee comprising Area Executive and key staff where area-wide initiatives are considered and reviewed, consistent with the Consumer Experience and Engagement Framework. The Walk a Day in My Shoes strategy is an overarching initiative which is designed to improve communication, engagement and practices by building on patient, carer and staff perspectives, driving organisational activities including customer service and frontline etiquette training. The Amazing Nursing and Midwifery Care program promotes patient empowered handover and communication plans and leader rounding also provides consumers with the opportunity to provide feedback.

Other examples of consumer input include the Mental Health "Yes" survey, Inpatient and Outpatient surveys and the Health and Disability Services Complaints Office reporting on complaints.

Quality of service by staff

Over the course of a week in December 2018, RPBG held a number of displays for staff and visitors relating to the Disability Access and Inclusion Plan. The key focus was to highlight disability service achievements over the year in improved access and inclusion meeting Accreditation Standards, and to celebrate the provision of accessibility related services. Highlights included physical access improvements at both RPH and BH, Telehealth video conferencing, patient information sheets made available in different languages, and volunteer concierge services for wayfinding.

Also in December 2018, AH installed interactive displays in their main entry foyer to raise staff awareness of care needs for people with disability. The displays included activities such as wearing eye glasses to simulate visual impairment, tactile signs and using your non-dominant hand to perform daily living activities. It was also an opportunity for encouraging staff to seek feedback from patients with disability and to highlight the methods available for feedback and consumer engagement including Patient Opinion, hospital and health service websites, email, telephone and feedback forms.

Opportunity to provide feedback

The RPBG DAIP Committee has a standing agenda item for complaints from people with disability. During 2018-19, 15 complaints were tabled ranging from lack of accessible parking at BH, issues with access to basic amenities and the availability of wheelchair and voluntary transport. The majority of these issues were resolved in a timely manner.

Across EMHS, the web-based, consumer-initiated feedback system Patient Opinion is promoted and readily used by patients for complaints, compliments and suggestions. Patient Opinion provides another avenue for people with disability to describe their experiences interacting with the health service, with the option to remain anonymous and allows the EMHS Executive team to respond.

> "I had a lot of trouble finding outpatients clinic from the car park".
>
> Source: Patient phone call

Opportunities to obtain and maintain employment

RPBG held a workshop aimed at building solutions that support the many staff that also undertake carer roles, 'Calling All Carers'. The workshop engaged people from all backgrounds to better understand and suggest viable solutions in providing carer support. Another goal was to increase awareness of challenges people face as a carer and to discuss methods to address these challenges.

EMHS also recognises that staff with a disability may find daily activities becoming progressively more difficult, due to late effects of disability. Various programs and activities have been undertaken this year to provide assistance including upgrades to facilities and processes.

Many of our EMHS site activities have ongoing strategies to accept and support new staff with disability and to provide ongoing support for existing staff with disability through welfare and wellbeing programs, employee assistance programs and Work Health and Safety (WHS).

Access to buildings and facilities

Patient transport vehicles at RPBG have been upgraded to larger vehicles that cater for two patients in wheelchairs to travel at a time. Previous transport required patients to be ambulant and capable of using a commercial vehicle or ambulance-type transport.

Moodjar Adult Mental Health Ward at AH has replaced bathroom basins to allow wheelchair access, with one bathroom renovated to allow bariatric wheelchair access. The ward also added shade cloth to the courtyard to allow patients with photosensitivity to access exercise equipment.

Following feedback received at RPH regarding the difficulty in locating outpatient clinics in a building adjacent to the main hospital campus, additional signage at the main entrance and ED, as well as improved signage on the side of the outpatients building, has been erected and location maps have been included on appointment letters to improve self-navigation.

A new public toilet has been installed by the lift near the main admission area to surgical services at RPH for patient and public convenience in response to the increase in the number of booked admissions for elective surgery over the past year.

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*.

Please see page 238 for site contact details.

In the 2018-19 financial year, EMHS received 3155 new applications under FOI legislation. This included:

AKG

490	33
Personal access applications	Non-personal access applications

Includes Swan District Hospital (SDH) from February 2019

RPH

1806	308
Personal access applications	Non-personal access applications

BHS

297	13
Personal access applications	Non-personal access applications

Includes Swan District Hospital (SDH) mental health records from February 2019

EMHS

1	13
Personal access applications	Non-personal access applications

SDH

194	0
Personal access applications	Non-personal access applications

July 2018 to February 2019 only

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).
ahs.health.wa.gov.au/For-patients-and-visitors/Freedom-of-Information

Royal Perth Hospital
rph.health.wa.gov.au/For-patients-and-visitors/FOI

Bentley Hospital (also contact for FOI applications for SDH mental health records).
bhs.health.wa.gov.au/For-patients-and-visitors/Access-to-health-records

East Metropolitan Health Service
emhs.health.wa.gov.au

Office of the Information Commissioner of Western Australia
foi.wa.gov.au/ThePublic

Recordkeeping plans

The EMHS Recordkeeping Plan (RKP) 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 the commitment by EMHS 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. In December 2018, EMHS commenced a project to implement HP Records Manager as a dedicated corporate recordkeeping system. Pilot areas were identified and training was undertaken. Since December 2018, EMHS has rolled out the system to six departments and currently have more than 53 000 corporate records saved in TRIM.

With the success of the phase one rollout, a dedicated Corporate Recordkeeping Coordinator position has been approved to lead and manage further rollout to EMHS corporate areas and hospital sites.

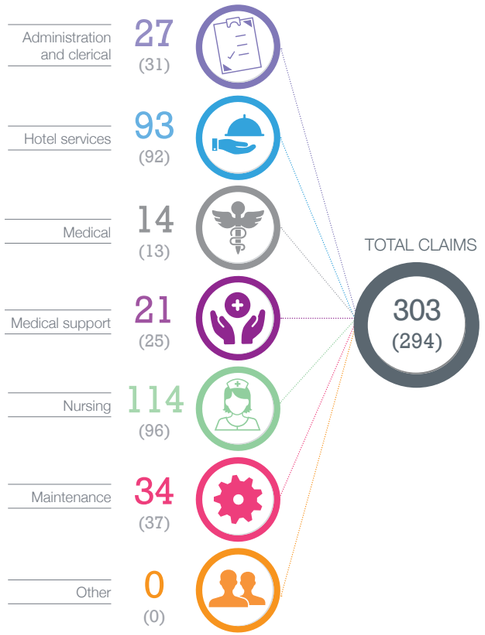
The Corporate Recordkeeping Coordinator will also be responsible for providing further education sessions, developing further resources and be available to provide specialist advice regarding corporate recordkeeping.

Workers' compensation

The WA 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 2018-19, a total of 303 workers' compensation claims were made.

Total workers' compensation claims for the 2018-19 financial year



Total in brackets indicates 2017-18 comparison

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:

- Promote a culture that integrates safety as a core activity into all aspects of work.
- Support employees in maintaining and improving their health and wellness, through facilitation of wellness programs and strategies across EMHS.
- Ensure all employees understand their duty of care and encourage them to take responsibility for the safety and health of themselves and others at work.
- Provide practical instruction, supervision, training, and ready access to information for all employees to enable and facilitate safe work practices.
- Enable communication, consultation and collaboration with EMHS employees and WHS representatives to ensure that all practicable measures are undertaken to improve WHS performance.
- Promote, train and support safety and health representatives.

The commitment to safety is consistent with the EMHS values of kindness, respect, integrity, excellence, accountability and collaboration.

The EMHS Executive Occupational Safety and Health (OSH) Steering Group is responsible for the ongoing monitoring and review of OSH management requirements and Area Strategic OSH Plan initiatives and action plans. Following the completion of the OSH service review in October 2018 a new central services operations model is currently being implemented and the development of a future strategic plan is being developed and will be implemented by October 2019.

Employee consultation

Consultation with employees is undertaken by site WHS committee members at departmental meetings through standing agenda items. All EMHS sites have WHS Committees, which 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.

WHS 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 - 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. The guidelines currently 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.

Junior doctors wellbeing program, RPH

- 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.

Best practice injury management strategies implemented across EMHS are currently being reviewed based on the recent review of OSH services. Recommendations are to be integrated in the revised IMS and guidelines and training tools will be developed for supervisors and managers for a stronger collaboration between departments, injury management and the injured worker. These changes are expected to be completed by October 2019.

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:

- Current IMS and injury management policies and guidelines.
- Fitness for work policy and program including occupational physician assessments.
- Employee Assistance Program.
- Provision of 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 with all stakeholders.

Assessment of the OSH management system and performance indicators

OSH management system audits have been completed at AHS and KH (2013), BH (2014) and RPH (2016) against Australian/New Zealand Standards (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. The procurement and delivery of these audits are currently underway and will be conducted in the second part of 2019 for both BHS and AKG. The RPH audit is scheduled for 2020.

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. Provisions have been made for the audit to be conducted in 2020 across EMHS.

Action plans for all audit programs are monitored through each of the hospital's WHS. EMHS monitors and manages any WorkSafe improvement notices through the site OSH Committees and centrally through the WHS steering group 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.

Currently all actions from the OSH and chemical audits have been fully completed. In liaison with South Metropolitan Health Service (SMHS), EMHS WHS continues to develop the Combined Hazard or Incident Reporting (CHoIR) system. Recently a dashboard has been developed and will be made available early in the 2019-20 financial year for Executive and Safety committees to have line of sight and produce reports for the sites to drive improved performance and visibility of trends.

Performance reported for EMHS for OSH and injury indicators for 2018-19 is summarised below.

EMHS Performance against Public Sector Commission *Code of Practice: OSH in the WA Public Sector*

[1-5] please see additional notes in appendix on page 236

Number of fatalities

[1]Lost Time Injury and Disease (LTI/D) incident rate (per 100)

Target not met, but significant improvement and positive trend against both 2016-17 and 2017-18 years noted.

[2]LTI/D severity rate (percentage of LTI/D)

Severity rate has deteriorated, with significant claims over 60 days (as a proportion of total lost time claims) having increased. Noted contributing factors include ageing workforce, surgical interventions and extended recovery times for injured staff.

[3]Percentage of workers returned to work within 13 weeks

This result relates to the level of recovery in the initial three months post claim. Noted contributing factors include ageing workforce, surgical interventions and extended recovery times for injured staff.

[4]Percentage of workers returned to work within 26 weeks

Target not met, but significant improvement and positive trend against both 2016-17 and 2017-18 years noted.

[5]Percentage of managers trained in OSH and IM responsibilities

Significant efforts are made for managers and supervisors at all levels to comply, and are continuing with good results. Further systems are being put in place to send early reminders to complete the training.

Annual estimates for 2019-20

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 2019–20, as approved by the Minister for Health.

Part A: Statement of comprehensive income

East Metropolitan Health Service	2019-20 estimate
Statement of Comprehensive Income	$000
Cost of services	
Expenses	
Employee benefits expense	838,449
Fees for visiting medical practitioners	29,350
Contracts for services	310,420
Patient support costs	223,660
Finance costs	529
Depreciation and amortisation expense	46,008
Repairs, maintenance and consumable equipment	23,973
Other supplies and services	6,624
Other expenses	95,879
Total cost of services	**1,574,892**
Income	
Revenue	
Patient charges	63,570
Other fees for services	58,118
Commonwealth grants and contributions	472,713
Other grants and contributions	180,207
Donation revenue	9
Other revenue	12,194
Total revenue	**786,811**
Total income other than income from State Government	**786,811**
Net cost of services	**788,081**
Income from State Government	
Service appropriations	731,435
Services received free of charge	56,367
Total income from State Government	**787,802**
Deficit for the period	**(279)**

The above figures are based on the approved Service Agreement with the Department of Health and the Mental Health Commission as at 30 June 2019.

Part B: Statement of financial position

East Metropolitan Health Service	2019-20 estimate
Statement of Financial Position	$000
Assets	
Current assets	
Cash and cash equivalents	132,119
Restricted cash and cash equivalents	28,706
Receivables	32,126
Inventories	4,519
Other current assets	1,207
Total current assets	**198,677**
Non-current assets	
Restricted cash and cash equivalents	13,183
Amounts receivable for services	527,830
Property, plant and equipment	867,246
Right-of-use Assets	10,610
Intangible assets	1,221
Other non-current assets	38
Total non-current assets	**1,420,128**
Total assets	**1,618,805**
Liabilities	
Current Liabilities	
Payables	83,230
Borrowings	10,808
Employee benefits provisions	165,521
Other current liabilities	824
Total current liabilities	**260,382**
Non-current liabilities	
Employee benefits provisions	36,640
Total non-current liabilities	**36,640**
Total liabilities	**297,023**
Net assets	**1,321,782**
Equity	
Contributed equity	1,171,203
Reserves	78,633
Accumulated surplus	71,946
Total equity	**1,321,782**

The above figures are based on the approved Service Agreement with the Department of Health and the Mental Health Commission as at 30 June 2019.

Part C: Statement of cash flows

East Metropolitan Health Service Statement of Cash Flows	2019-20 estimate $000 Inflows/(Outflows)
Cash flows from State Government	
Service appropriations	685,409
Capital appropriations	37,964
Net cash provided by State Government	**723,373**
Utilised as follows:	
Cash flows from operating activities	
Payments	
Employee benefits	(838,449)
Supplies and services	(628,167)
Finance costs	(511)
Receipts	
Receipts from customers	58,198
Commonwealth grants and contributions	472,713
Other grants and contributions	180,207
Donations	9
Other receipts	70,312
Net cash used in operating activities	**(685,688)**
Cash flows from investing activities	
Payments	
Purchase of non-current assets	(37,210)
Net cash used in investing activities	**(37,210)**
Cash flows from financing activities	
Payments	
Repayment of finance lease liabilities	(754)
Receipts	
Net cash used in financing activities	**(754)**
Net increase/(decrease) in cash and cash equivalents	(279)
Cash and cash equivalents at the beginning of the period	135,870
Restricted cash at the beginning of the period	38,416
CASH AND CASH EQUIVALENTS AT THE END OF PERIOD	**174,007**

The above figures are based on the approved Service Agreement with the Department of Health and the Mental Health Commission as at 30 June 2019.

Part D: Statement of changes in equity

East Metropolitan Health Service Statement of Changes in Equity	2019-20 estimate $000
Contributed equity	
Balance at start of period	1,132,399
Transactions with owners in their capacity as owners:	
Capital appropriations	37,211
Other contributions by owners	1,593
Balance at end of period	**1,171,203**
Reserves	
Asset revaluation reserve	
Balance at start of period	78,632
Balance at end of period	**78,632**
Accumulated surplus	
Balance at start of period	72,226
Deficit for the period	(279)
Balance at end of period	**71,947**
Total equity	
Balance at start of period	1,283,256
Total comprehensive loss for the period	(279)
Transactions with owners in their capacity as owners	38,805
Balance at end of period	**1,321,782**

The above figures are based on the approved Service Agreement with the Department of Health and the Mental Health Commission as at 30 June 2019.

East Metropolitan Health Service

Appendix

Acronyms index

Acronym	In full
AAP	Alcohol Action Plan
ACG LDAG	Armadale, Canning And Gosnells Local Drug Action Group
ACHS	Australian Council on Healthcare Standards
AH	Armadale Hospital
AHAC	Aboriginal Health Advisory Council
AHCAG	Aboriginal Health Consumer Advisory Group
AHS	Armadale Health Service
AKG	Armadale Kalamunda Group
AM	Member of the Order of Australia
AMA	Australian Medical Association
BH	Bentley Hospital
BHS	Bentley Health Service
BMW	Building Management and Works
CAC	Community Advisory Committee
CAG	Consumer Advisory Group
CBD	Central Business District
CCTV	Closed Circuit Television
CRAB	Copeland's Risk Adjusted Barometer
CSP	Clinical Service Plan
DAIP	Disability Access and Inclusion Plan
DAMA	Discharge Against Medical Advice
DDI	Data and Digital Innovation
DoH	Department of Health
ED	Emergency Department
EMHS	East Metropolitan Health Service
EMyU	East Metropolitan Youth Unit
ESWL	Elective Services Wait List
FNOF	Fractured Neck of Femur
FOI	Freedom of Information
FTE	Full Time Equivelent
GBS	Government Budget Statements
GP	General Practitioner
GST	Goods and Services Tax
HA-SABSI	Healthcare Associated Staphylococcus Aureus Bloodstream Infections
HR	Human Resources
HSA	Health Services Act
HSP	Health Service Provider
HSS	Health Support Services
ICU	Intensive Care Unit
ICWA	Insurance Commission of Western Australia
IMC	Injury Management Consultant
IMS	Injury Management System
IR	Industrial Relations
KH	Kalamunda Hospital
KPI	Key Performance Indicators
MCOT	Mobile Clinical Outreach Team
MHEC	Mental Health Emergency Centre
MLA	Member of Legislative Assembly
NMHS	North Metropolitan Health Service
NAIDOC	National Aborigines and Islanders Day Observance Committee
NHRA	National Health Reform Agreement
OBM	Outcome Based Management
OSH	Occupational Safety and Health
PSC	Public Sector Commission
PSM	Public Service Medal
RPBG	Royal Perth Bentley Group
RPH	Royal Perth Hospital
SAC1	Severity Assessment Code 1
SDH	Swan District Hospital
SJGML	St John of God Mount Lawley
SJGMPH	St John of God Midland Public Hospital
SJGHC	St John of God Health Care
SMHS	South Metropolitan Health Service
WA	Western Australia
WACHS	Western Australian Country Health Service
WADIMS	Walk A Day In My Shoes
WAU	Weighted Activity Unit
WEAT	Western Australian Emergency Access Target
WEBPAS	Web Patient Administration Systems
WEST	Western Australian Elective Services Target
WHS	Work Health and Safety

Board and committee remuneration

Please see the following remuneration for EMHS boards and committees for the 2018-19 financial year:

East Metropolitan Health Service Board

Position	Name	Type of remuneration	Period of membership (within the financial year)	Total remuneration for financial year ($)[1]
Board Chair	Ian Smith PSM	Annual	12 months	66,078
Board member (Deputy Chair)	Suzie May	Annual	12 months	39,647
Board member	Laura Colvin	Annual	12 months	38,885
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	39,647
Board member	Richard Guit	Annual	12 months	39,647
Board member	Ross Keesing	Annual	12 months	39,647
Board member	Amanda Gadsdon	Annual	12 months	38,885
Board member	Debra Zanella	Annual	12 months	39,647
			Total	421,377

[1]Excludes superannuation.

Consumer advisory committees (general)

Armadale Kalamunda Group Consumer Advisory Council

Position	Name	Type of remuneration	Period of membership (within the financial year)	Total remuneration for financial year ($)[2]
Chair	Dorothy Harrison	Per meeting	12 months	1380
Deputy Chair	Julie Hoey	Per meeting	12 months	2100
Carer representative	Sheryl Little	Per meeting	12 months	870
Member	Eric Wynne	Per meeting	12 months	390
Mental health consumer representative	Member 5	Per meeting	11 months	30
			Total	4770

[2] May include payment for other duties undertaken as a consumer representative, not just council meetings.

Bentley Health Service Community Advisory Committee

Position	Name	Type of remuneration	Period of membership (within the financial year)	Total remuneration for financial year ($)
Chair	Colin Stevenson	Per meeting	12 months	540
Member	Linda Beresford	Per meeting	12 months	540
Member	Alma Digweed	Per meeting	12 months	420
Member	Philip Lim	Per meeting	12 months	420
			Total	1920

Royal Perth Hospital Community Advisory Committee

Position	Name	Type of remuneration	Period of membership (within the financial year)	Total remuneration for financial year ($)
Chair	Robert McCormack	Per meeting	12 months	660
Member	Angela Dominish	Per meeting	6 months	240
Member	Eric Wynne	Per meeting	12 months	420
Member	Greg Swensen	Per meeting	12 months	420
Member	Joanne Treacy	Per meeting	12 months	600
Member	Maureen Meixner	Per meeting	12 months	600
Member	Patricia Clark	Per meeting	12 months	420
Member	Peter Evans	Per meeting	12 months	480
Member	Peter Grocott	Per meeting	12 months	480
Member	Suzanne Matthews	Per meeting	12 months	480
Member	Patricia Canning	Per meeting	12 months	0
Member	Madeline Kelly	Per meeting	6 months	240
Member	Robert Matthews	Per meeting	12 months	0
Member	Robin Watts	Per meeting	12 months	0
			Total	5040

Consumer advisory committees (mental health)

Midland Mental Health Consumer Advisory Group

Position	Name	Type of remuneration	Period of membership (within the financial year)	Total remuneration for financial year ($)
Co-Chair	Member 1	Per meeting	9 months	540
Co-Chair	Member 2	Per meeting	8 months	540
Member	Member 3	Per meeting	6 months	420
Member	Member 4	Per meeting	9 months	540
Member	Member 5	Per meeting	5 months	300
Member	Member 6	Per meeting	1 month	60
			Total	2400

Royal Perth Bentley Group Lived Experience Advisory Group

Position	Name	Type of remuneration	Period of membership (within the financial year)	Total remuneration for financial year ($)
Co-Chair	Member 1	Per meeting	7 months	420
Co-Chair	Member 2	Per meeting	7 months	420
Member	Member 3	Per meeting	4 months	240
Member	Member 4	Per meeting	3 months	180
Member	Member 5	Per meeting	1 month	60
Member	Member 6	Per meeting	8 months	480
Member	Member 7	Per meeting	1 month	60
Member	Member 8	Per meeting	7 months	420
Member	Member 9	Per meeting	4 months	0
Member	Member 10	Per meeting	1 month	60
Member	Member 11	Per meeting	6 months	360
Member	Member 12	Per meeting	1 month	60
			Total	2760

Aboriginal health advisory groups

Armadale Kalamunda Aboriginal Health Community Advisory Group

Position	Name	Type of remuneration	Period of membership (within the financial year)	Total remuneration for financial year ($)
Chairperson	Leon Hayward	Per meeting	12 months	495
Vice Chairperson	Delson Stokes	Per meeting	6 months	242
Member	Raelene Hayward	Per meeting	12 months	465
Member	Eunice Bynder	Per meeting	12 months	620
Member	Madge Hill	Per meeting	12 months	495
Member	Ian Taylor	Per meeting	6 months	240
Member	Mason Nicholson	Per meeting	6 months	120
Member	Liz Hayden	Per meeting	6 months	0
Member	Rhonda Pickett	Per meeting	6 months	0
Member	Norm Pickett	Per meeting	6 months	0
Member	Eric Wynne	Per meeting	12 months	635
Member	Victor Ronan	Per meeting	6 months	260
Member	Tammy Bennell	Per meeting	6 months	260
Member	Yvonne Yarran	Per meeting	6 months	120
Member	Clive Hayden	Per meeting	6 months	120
Member	Wendy Hayden	Per meeting	6 months	120
Member	Amanda Wilkes	Per meeting	6 months	90
Member	Olive Bennell	Per meeting	6 months	140
Member	Fred Penny	Per meeting	6 months	260
			Total	4682

Bentley Aboriginal Health Community Advisory Group

Position	Name	Type of remuneration	Period of membership (within the financial year)	Total remuneration for financial year ($)
Chairperson	Brenda Greenfield	Per meeting	12 months	635
Vice Chairperson	Shirley Voss	Per meeting	12 months	515
Member	Kerry Thorne	Per meeting	12 months	755
Member	Joanne Hayward	Per meeting	12 months	500
Member	Dorothy Winmar	Per meeting	12 months	485
Member	Albert Knapp	Per meeting	12 months	360
Member	Minyulo (formerly Charmaine) Bartlett	Per meeting	6 months	90
Member	Herman Eades	Per meeting	6 months	135
Member	Nina Chadd	Per meeting	12 months	380
Member	Kay Jones	Per meeting	6 months	260
Member	Katherine Quartermaine	Per meeting	6 months	380
Member	Roslyn Eades	Per meeting	6 months	120
Member	Robyn Henry	Per meeting	6 months	120
Member	Darryl Ogilvie	Per meeting	6 months	120
Member	Margaret Ogilvie	Per meeting	6 months	120
			Total	4975

Royal Perth Hospital and Inner City Aboriginal Health Community Advisory Group

Position	Name	Type of remuneration	Period of membership (within the financial year)	Total remuneration for financial year ($)
Chairperson	Eric Wynne	Per meeting	12 months	540
Vice Chairperson	Peter Phillips	Per meeting	12 months	300
Member	May McGuire	Per meeting	12 months	300
Member	Chris McGibbon	Per meeting	12 months	180
Member	Tania Harris	Per meeting	6 months	120
Member	Jeanette Williams	Per meeting	6 months	120
Member	Victor Ronan	Per meeting	12 months	615
Member	Jennifer Bonney	Per meeting	12 months	635
Member	Barbara McGillivray	Per meeting	12 months	260
Member	Dianne Ryder	Per meeting	6 months	60
Member	Shirley Lumai	Per meeting	6 months	315
Member	Val Dorizzi	Per meeting	6 months	140
Member	Shirley Thorne	Per meeting	6 months	140
Member	Ben Taylor	Per meeting	6 months	60
Member	Graham Blacklock	Per meeting	6 months	140
Member	Miranda Farmer	Per meeting	6 months	0
Member	Peter Farmer	Per meeting	6 months	0
			Total	3925

Swan Hills/Midland Aboriginal Health Community Advisory Group

Position	Name	Type of remuneration	Period of membership (within the financial year)	Total remuneration for financial year ($)
Chairperson	Denis Hayward	Per meeting	12 months	515
Vice Chairperson	Yolande Yarran-Ward	Per meeting	12 months	635
Member	Chelsea Bell	Per meeting	12 months	482
Member	Tina Yarran	Per meeting	12 months	635
Member	Doreen Creed	Per meeting	12 months	500
Member	Shirley Harris	Per meeting	12 months	515
Member	Joan Lyndon	Per meeting	12 months	615
Member	Glynis Watt	Per meeting	6 months	240
Member	Dianne Ryder	Per meeting	12 months	120
Member	Roy Fraser	Per meeting	6 months	90
Member	Annette Dennis	Per meeting	6 months	0
Member	Patricia Adams	Per meeting	6 months	120
Member	Sheila Humphries	Per meeting	6 months	120
Member	Lynette Yarran	Per meeting	6 months	120
Member	Thomas Yarran	Per meeting	6 months	120
Member	Cassandra Abraham	Per meeting	6 months	210
Member	Darryl Indich	Per meeting	6 months	380
			Total	5417

Wungen Kartup Aboriginal Consumer and Carer Advisory Group (Mental Health)

Position	Name	Type of remuneration	Period of membership (within the financial year)	Total remuneration for financial year ($)
Member	Member 1	Per meeting	6 months	330
Member	Member 2	Per meeting	7 months	330
Member	Member 3	Per meeting	3 months	180
Member	Member 4	Per meeting	4 months	240
Member	Member 5	Per meeting	3 months	180
Member	Member 6	Per meeting	3 months	150
Member	Member 7	Per meeting	2 months	120
Member	Member 8	Per meeting	1 month	60
			Total	**1590**

Aboriginal Health Advisory Council

Position	Name	Type of remuneration	Period of membership (within the financial year)	Total remuneration for financial year ($)
Chairperson	Eric Wynne	Per meeting	12 months	532
Vice Chairperson	Brenda Greenfield	Per meeting	12 months	462
Member	Leon Hayward	Per meeting	12 months	375
Member	Delson Stokes	Per meeting	6 months	297
Member	Minyulo (formerly Charmaine) Bartlett	Per meeting	6 months	45
Member	Shirley Voss	Per meeting	6 months	297
Member	Dianne Ryder	Per meeting	6 months	0
Member	Peter Phillips	Per meeting	6 months	0
Member	Annette Dennis	Per meeting	6 months	0
Member	Denis Hayward	Per meeting	6 months	297
Member	Yolande Yarran-Ward	Per meeting	6 months	70
Proxy	Chelsea Bell	Per meeting	N/A	140
Proxy	Victor Ronan	Per meeting	N/A	272
Proxy	Dorothy Winmar	Per meeting	N/A	120
			Total	**2907**

Ethics Committee

Royal Perth Hospital Animal Ethics Committee

Position	Name	Type of remuneration	Period of membership (within the financial year)	Total remuneration for financial year ($)
Chair	Member 1	Sessional	12 months	18,319
Category A	Member 2	Per meeting	12 months	1000
Category A deputy	Member 3	Per meeting	12 months	800
Category B	Member 4	N/A	12 months	0
Category B deputy	Member 5	Per meeting	12 months	1000
Category C	Member 6	Per meeting	12 months	1000
Category C deputy	Member 7	Per meeting	12 months	600
Category D	Member 8	Per meeting	12 months	1000
Category D deputy	Member 9	Per meeting	12 months	1000
Category E / Executive officer (EO)	Member 10	N/A	12 months (EO 3 months)	0
Executive Officer	Member 11	N/A	9 months	0
			Total	24,719

Position Key
Category A = Vet
Category B = Researcher
Category C = Animal Welfare
Category D = Community Member
Category E = Animal Facility Representative

Royal Perth Hospital Human Research Ethics Committee

Position	Name	Type of remuneration	Period of membership (within the financial year)	Total remuneration for financial year ($)
Chair	Member 1	Sessional	1 week	356
Lay Person	Member 2	N/A	12 months	0
Lay Person	Member 3	N/A	12 months	0
Lay Person	Member 4	N/A	12 months	0
Lay Person	Member 5	N/A	12 months	0
Professional Care Member	Member 6	N/A	10 months	0
Professional Care Member	Member 7	N/A	12 months	0
Pastoral Care	Member 8	N/A	12 months	0
Pastoral Care	Member 9	N/A	12 months	0
Lawyer	Member 10	N/A	12 months	0
Lawyer	Member 11	N/A	12 months	0
Medical Research / Chair	Member 12	N/A	12 months (Chair 51 weeks)	0
Medical Research	Member 13	N/A	12 months	0
Medical Research	Member 14	N/A	12 months	0
Medical Research	Member 15	N/A	12 months	0
Medical Research	Member 16	N/A	12 months	0
Medical Research	Member 17	N/A	12 months	0
Medical Research	Member 18	N/A	3.5 months	0
			Total	356

Important note about our staff

All information 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 St John of God Health Care.

Notes for OSH performance

[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% improvement on base year (01/07/16 - 30/06/17) 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% improvement on base year (01/07/16 - 30/06/17) performance.

[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 OSH and 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.

Data inclusions and exclusions

Please see the following inclusions and exclusions for the data found in the year in review section.

Data	Inclusions / exclusions
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. Contributing sites: AH, BH, KH, RPH, SJGMPH, SJGML (public patients).
Occasions of service for community mental health services	Data source: MI$_N$D Reader: Community Mental Health Service Events and Contacts. Service event items are the actual service activity/intervention delivered, such as counselling, assessment or travel. Contributing sites: EMHS public community mental health services.
Patients brought by helicopter	Count of ED presentations with arrival means recorded as 'helicopter', with arrival date in the reportable period. Contributing site: RPH.
Patients brought by Royal Flying Doctor Service or air ambulance	Count of ED presentations with arrival means recorded as Royal Flying Doctor Service (RFDS) or air ambulance, with arrival date in the reportable period. Contributing sites: RPH, SJGMPH.
Patients arrived at ED by ambulance	Count of ED presentations with arrival means recorded as Ambulance Service WA (ASWA), with arrival date in the reportable period. Contributing sites: AH, RPH, SJGMPH.
ED presentations	Count of patients who presented to an ED, with arrival date in the reportable period. Includes all presentations, including did not wait (DNW). Contributing sites: AH, RPH, SJGMPH.
Babies born	Count of live born births delivered in hospital with discharge date in the reportable period. Contributing sites: AH, BH, SJGMPH.
Multiple births	Count of mothers that delivered multiple live born babies with discharge date in the reportable period. Contributing sites: AH, BH, SJGMPH.
Number of inpatients	Count of inpatients with admission date in the reportable period. Excludes boarders, unqualified newborns, contracted services and organ procurements. Contributing sites: AH, BH, KH, RPH, SJGMPH, SJGML (public patients).
Number of outpatients	Count of seen/attended outpatient appointments with appointment date in the reportable period. Excludes cancelled, did not wait, left not seen, late not seen. Also excludes chart review/case conference where the patient is not present. Contributing sites: AHS, BHS, KH, RPH, SJGMPH, SJGML (public patients).
Number of operations performed	Count of operations performed in any theatre with operation date in the reportable period. Where status indicates that an operation occurred and was completed (i.e. operation was not cancelled). Contributing sites: AH, BH, KH, RPH, SJGMPH.

Data	Inclusions / exclusions
Top 5 countries of birth	Inpatients: Subset of count of inpatients discharged, using same criteria and base exclusions, identifying patient's country of birth. Outpatients: Subset of count of outpatient attendances, using same base exclusions, identifying patient's country of birth. Contributing sites: AHS, BHS, KH, RPH.
ED presentations with broken bones	Count of ED presentations containing 'fracture' within the diagnosis description, with arrival date in the reportable period. Contributing sites: AH, RPH.
Patients of no fixed address	Inpatients: Distinct count of discharged patients with No Fixed Permanent Address (NFPA) recorded. Subset of count of inpatients discharged, using same criteria and base exclusions. Outpatients: Distinct count of patients attending appointments with No Fixed Permanent Address (NFPA) recorded. Subset of count of outpatient attendances, using same base exclusions. Contributing sites: AHS, BHS, KH, RPH, SJGMPH.
Flu related admissions	Count of ED presentations with symptoms or diagnoses as per the Winter Respiratory Illness (WRI) definition. Contributing sites: AH, RPH, SJGMPH.
ED presentations per day	Highest daily: Highest daily number of ED presentations with arrival date in the reportable period. Includes DNW. Average daily: Daily average for number of Emergency presentations with arrival date in the reportable period. Includes DNW. Contributing sites: AH, RPH, SJGMPH.
Aboriginal patients	Inpatients: Count of discharges where the patient has an indigenous status of Aboriginal, Torres Strait Islander (TSI) or Aboriginal/TSI. Subset of count of inpatients discharged, using same criteria and base exclusions, which will be used as denominator for percentage calculation. Outpatients: Count of outpatients appointments attended where the patient has an indigenous status of Aboriginal, TSI or Aboriginal/TSI. Subset of count of outpatient attendances, using same base exclusions, which will be used as denominator for percentage calculation. Contributing sites: AHS, BHS, KH, RPH, SJGMPH, SJGML (public patients).
Age of oldest patient	Inpatient: Maximum age of inpatient at admission. Subset of count of inpatients discharged, using same criteria and base exclusions. Outpatient: Maximum age of outpatient at appointment attendance. Subset of count of outpatient attendances, using same base exclusions. Contributing sites: AHS, BHS, KH, RPH, SJGMPH, SJGML (public patients).

Site locations and contact details

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Bentley Health Service

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BENTLEY WA 6102

Postal address:
PO Box 158
BENTLEY WA 6982

Telephone: (08) 9416 3666
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bhs.health.wa.gov.au

Armadale Kalamunda Group (AKG)

Armadale Health Service

3056 Albany Highway
MOUNT NASURA WA 6112

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ARMADALE WA 6992

Telephone: (08) 9391 2000
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Kalamunda Hospital

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Telephone: (08) 9257 8100
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St John of God Health Care (SJGHC)

St John of God Midland Public Hospital

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This publication is available in alternative formats on request for a person with a disability. Please contact EMHS for additional information.

Within Western Australia, the term Aboriginal is used in preference to Aboriginal and Torres Strait Islander, in recognition that Aboriginal people are the original inhabitants of Western Australia. No disrespect is intended to our Torres Strait Islander colleagues and community.